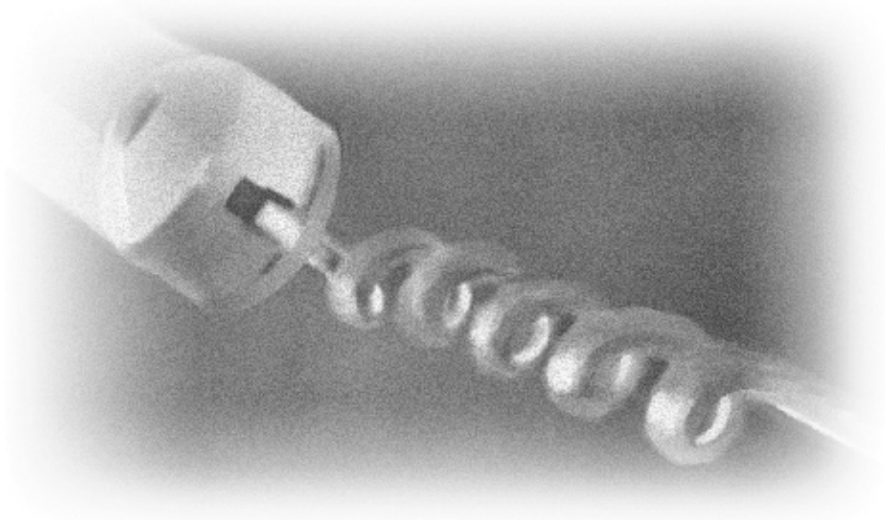


# Assessing the Conditions and Quality of Counselling Related to Sexuality and Sexual Health



**ASSESSING THE CONDITIONS AND QUALITY  
OF COUNSELLING RELATED TO  
SEXUALITY AND SEXUAL HEALTH**

**A Review of the TARSHI Helpline**

A report  
*by*  
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New Delhi, India

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**December 15, 2007**



## Executive Summary

Expanding Reproductive Health (RH) services to better address sexuality and sexual health issues continues to be challenging in many countries. There is still very little evidence for the most effective duration, content and follow up of training of various cadres of health staff in counselling on sexuality and on how to sustain good quality counselling. As a result, despite best intentions to expand RH services to the broader Sexual and Reproductive Health (SRH) concept as prescribed in ICPD Platform for Action, many programmes continue to struggle with the content of the 'S' in SRH. In the era of HIV/AIDS, the importance of better understanding sexuality to improve sexual health becomes increasingly critical.

In order to generate an evidence base for the development of guidelines for providing good quality sexuality related counselling, WHO and KIT decided to conduct descriptive studies of four programmes in different countries which are currently providing counselling that specifically address sexuality related issues within the context of their programmes. The documentation of these promising practices would contribute to the knowledge base as to what is required for scaling up counselling services on issues related to a healthy sexual life.

Programmes selected met the following criteria:

- Counselling is currently been done, as an intervention or part of an intervention.
- Evidence exists (programme evaluation reports) for the quality of the sexuality counselling interventions.
- The intervention has been in place more than the 3 past years.
- Comprehensiveness of counselling on sexuality related issues.
- Type of service and target groups with preference for cultural and programme diversity.

Based on the above criteria, the following four programmes were selected:

- TASO (The AIDS Support Organisation) in Uganda
- FHOK (Family Health Options Kenya – formerly FPAK, Family Planning Association of Kenya)
- The Coletivo Feminista Sexualidade e Saúde in São Paulo, Brazil
- TARSHI (Talking About Reproductive and Sexual Health Issues) in New Delhi, India

This report is about TARSHI's telephone Helpline on sexuality counselling. The sexuality counselling services of TARSHI are provided through an anonymous telephone Helpline where people call in and discuss any issue relating to sexuality that they want. Callers are also able to seek information about referral to medical services and other centres of information. This is done in an anonymous setting, where the conversations with Callers are not recorded and the only identification is a Caller number for calls that the Caller may place to TARSHI again in the future. By using a telephone Helpline, this type of counselling uses a different method to address issues, which are taboo in the conservative setting in which TARSHI operates.



The objectives of the study were as follows:

### General Objective

To define the content of sexuality counselling and assess factors influencing the quality of counselling.

### Specific Objectives

1. To contextualise counselling services within a broader service delivery environment
2. To document the content of the counselling related to sexuality issues
3. To assess the quality of the counselling related to sexuality issues
4. To assess the way environmental factors influence the counselling content and quality

The study sought to answer the following research questions:

- i. What are the provider characteristics in relation to the promising/effective counselling services that positively address sexuality within the counselling session?
- ii. What are the key content elements of the interventions that are described as promising?
- iii. What contribution does the counselling have on behavioural, individual and health outcomes?
- iv. What contribution does the counselling intervention have on the broader SRH or HIV programme outcomes?
- v. What lessons can be learnt for scaling up future interventions?

The methodology of the study included: a desk review of policy and programme documents of Government of India, TARSHI's data, reports and published documents, other research papers; 24 Key Informant interviews; 5 Focused Group Discussions with proxy users of the Helpline; feedback from 7 callers through telephone interviews and internet questionnaire; analysis of selected (11) repeat callers' records.

The findings of the study were as follows:

1. Sexuality is a complex issue and since there is no place to talk about it, people face enormous difficulties which affect their personal lives, relationships and their self esteem. This fact is triangulated by all key informants, FGDs and callers' feedback.
2. This study highlights that the rapidly changing context of development of the markets, explosion of media and proliferation of the Internet, are leading to increasing commodification of sex and sexuality. The market driven modern notions of sexuality come into direct conflict with traditional values. So while on the one hand, there is increased reporting of sexual violence like rape and child sexual abuse, there are also increased honor killings based on traditional values. Conflicting messages by the media – sex for pleasure on the one hand, and sex within marriage for procreation, on the other; double standards for male and female sexuality – create enormous social confusion around sexuality. All these urgently call for increased sexuality counselling services.
3. The nature of issues that people want information on or counselling for, emerging from this study indicates that most of the questions arise from a lack of a very basic information about one's bodies, sex and sexuality, reproductive and sexual health (including menstruation and contraception). Some other questions are related to misconceptions and beliefs related to

sexuality, many of which are related to the social construction of male sexuality. And finally there are issues related to relationships, including sexual relationships and lack of communication between partners.

4. Sexuality issues are being addressed only by the National AIDS Control Programme and not by the Reproductive and Child Health Programme or the National Rural Health Mission. Sexuality counselling is not yet a part of SRH services in the country. Sex education in schools has run into serious problems because significant sections of policy makers, educationists as well as the general public feel that sex education goes against Indian values and culture. Sexuality counselling is being provided by a range of persons in the country from informal providers like *hakims* (local/traditional healers), sexology 'Clinics', Gynaecologists, Psychotherapists and Counsellors. These sexuality 'counselling' resources, if they can be so termed, are differentiated by their target clientele, their approach or world view, their level of training and expertise, their sense of professional ethics, and quality standards.
5. No formal comprehensive sexuality training for counsellors exists anywhere in the country. Some NGOs conduct sexuality training pertaining to their own primary issue of concern, for example for addressing child sexual abuse, or concerns of men who have sex with men.
6. In this context, TARSHI fulfills a need for quality, ethical, rights based gender sensitive, telephone sexuality counselling services. TARSHI's quality services are due to:
  - Careful selection of counsellors
  - Intensive induction training incorporating perspective building, value clarification, conceptual understanding and skill building around sexuality and sexuality counselling
  - Close supervision, ongoing support and learning
  - Burnout prevention systems
  - Reliable referral systems

Quality of the sexuality counselling provided by TARSHI is marked by an organisational commitment to:

- Confidentiality
- Evidence based information provision
- Non-judgmental attitude
- Facilitating exploration of options and absence of directiveness / prescriptions
- Managing boundaries
- Rights based, women-centered, gender sensitive perspective

TARSHI has built credibility for itself in the sexual and reproductive health constituency, for its contribution to the sexuality discourse. Its publications like the Red and Blue Books have been translated into several languages and disseminated widely. TARSHI is perhaps not very well known in the government departments, and has not engaged to adequately influence policy level discourse around sexuality.

7. The outcomes of sexuality counselling provided by TARSHI appear to be:
  - Demystification of sex and sexuality
  - Increase in information and awareness
  - Increased comfort with one's body, sexuality
  - Resolution of one's own sexual issues

- Easier communication around sexuality
  - Reduction in stigma and shame related to sexuality
  - Improvement in sexual relationships, pleasurable and fun sex
  - Respecting rights, reduction in coercion, abuse
  - Safer sexual behaviours
  - Increase in help seeking when necessary
  - Better sexual health
  - Attitudinal and behavioural change
8. The policy level context offers opportunities for mainstreaming sexuality. At least three ministries – Health including HIV/AIDS, Education and Youth Affairs – have mandates into which sexuality can be mainstreamed. However, there are several challenges that need to be addressed – patriarchal, conservative mindsets, lack of evidence based information, frequent transfers of officers and bureaucrats, agendas which are perceived to be far more critical than sexuality and a fear of negative results of sexuality education.
  9. These challenges need to be addressed through concerted, coordinated advocacy by a coalition of a wide range of organisations ranging from those in education, health, law and justice, women’s and children’s empowerment, youth affairs and so on. Advocacy strategies that should be used should be primarily educational explaining the criticality of addressing sexuality issues for social transformation.
  10. Simultaneously, in order to create openness and an environment for the development of sexuality related discourse, widespread information on sexuality should be disseminated. This information should be evidence based, rights based, gender sensitive, non-judgmental and non-moralistic. Sustained interaction with parents and regular sustained training with teachers should be planned. Widespread information dissemination will help to address a significant proportion of the sort of issues that TARSHI’s Helpline responds to. It will also help to ‘normalize’ several other issues like confusions around sexual identity.
  11. Sexuality counselling should be integrated within a service delivery model – for example, within the health care system, education system, women’s empowerment programmes, adolescents’ life skills or development programmes. These services can be situated at the neighborhood or community level, as well as within institutions like secondary hospitals, elementary and secondary level schools.
  12. Several opinions were obtained on the relative benefits of face-to-face sexuality counselling over telephone sexuality counselling. It appears that telephone counselling offers greater confidentiality and privacy for callers. However, it was also felt that face-to-face sexuality counselling should be offered for those who are prepared to avail of them.

Some other issues that the study highlighted were:

1. In anonymous telephone sexuality Helpline service, which respects the confidentiality of callers, it is not possible to systematically track the outcomes of the sexuality counselling that is provided.
2. Innovative measures need to be designed to obtain regular and systematic feedback from callers.

The report ends with two sets of recommendations, the first, specifically for TARSHI and the second, more general recommendations for programmes and policy as well as for further research.

## Chapter 1

# Introduction and Background

### Introduction and Rationale

Expanding Reproductive Health (RH) services to better address sexuality and sexual health issues continues to be challenging in many countries. There is still very little evidence for the most effective duration, content and follow up of training of various cadres of health staff in counselling on sexuality and on how to sustain good quality counselling alongside Sexual and Reproductive Health (SRH) services. As a result, despite best intentions to expand RH services to the broader SRH concept as prescribed in ICPD Platform for Action, many programmes continue to struggle with the content of the 'S' in SRH. In the era of HIV/AIDS, the importance of better understanding sexuality to improve sexual health becomes increasingly critical, and RH remains one of the best entry points.

Based on this realisation, in 2002, the WHO convened a strategic committee to define priorities for work on sexual health. For this meeting, a review was commissioned from the Royal Tropical Institute (KIT) on the status of the evidence on the integration of sexual health interventions into SRH programmes including HIV/AIDS programmes. It was felt that there was too little evidence to form the basis for service delivery guidelines with respect to the integration of sexual health services. During the strategic committee meeting, the need to develop evidence based guidelines on how to better address sexuality within SRH programmes, particularly in counselling sessions was highlighted. As a result, a new area of work was set out to build the evidence base for programming in sexuality and sexual health by documenting promising programmes that have successfully included the key sexual health interventions.

It was agreed that a systematic review of the

evidence on key sexual health interventions would be conducted. Based on this review, four to six programmes which appeared promising would be selected i.e. programmes that were successful as determined by a programme evaluation (versus an evaluation of specific interventions) and programmes that offered key sexual health interventions. The programmes, if they agreed, would then be assessed using a Rapid Assessment Methodology (RAM). Based on the RAM, promising programmes with the key intervention would be written up and published in a compendium of case studies.

Subsequently it was decided that WHO and KIT would conduct descriptive studies of four programmes which are currently providing counselling that specifically addresses sexuality related issues within the context of their programmes. The results of the research would contribute towards the generation of an evidence base for the development of guidelines for providing good quality sexuality related counselling in the provision of SRH and HIV services. The documentation of these promising practices would also contribute to the knowledge base as to what is required for scaling up counselling services on issues related to a healthy sexual life.

It was decided that the study would consist of a case study approach using qualitative techniques. The study would be a rapid appraisal taking, approximately three to four weeks for each site with a focus on understanding the content and context of the sexuality counselling offered and identification of factors influencing the quality of counselling and the relative outcome of the counselling intervention on the broader programme goals and objectives.

Criteria were established to select programmes

to be assessed. The criteria were based on the hypothesis that talking about sexuality is possible in a diverse cultural, population and geographical contexts and that implementation of sexuality counselling interventions in SRH or HIV programmes improves the general wellbeing/sexual health of the target group. Programmes selected would therefore meet the following criteria:

- Counselling is currently being done, as an intervention or part of an intervention
- Evidence exists (programme evaluation reports) for the quality of the sexuality counselling interventions
- The intervention should have been in place for more than 3 years
- Comprehensiveness of counselling on sexuality related issues
- Type of service and target groups with preference for cultural and programme diversity

Based on the above criteria, the following four programmes were selected:

- TASO (The AIDS Support Organisation) in Uganda
- FHOK (Family Health Options Kenya – formerly FPAK, Family Planning Association of Kenya)
- The Coletivo Feminista Sexualidade e Saúde in São Paulo, Brazil
- TARSHI (Talking About Reproductive and Sexual Health Issues) in New Delhi, India

The study used the following definitions:

‘Sexuality’, as defined by the WHO working definition, ‘is a central aspect of being human throughout life and 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, ethical, legal, historical, religious and spiritual factors’ (WHO, 2005).

‘Sexual health’, as defined by the WHO working definition, ‘is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled’ (WHO, 2005).

‘Sexuality counselling’ is defined as ‘counselling on issues related to one’s own sexual life experiences, problems, or concerns (e.g. avoiding unplanned pregnancies and sexually transmitted infections including HIV, sexual identity issues, unsatisfying sexual relationships, intimacy, and sexual violence) with the aim of creating a climate where clients can express themselves in a private and confidential environment and without fear of discrimination.’

This report documents the sexuality counselling provided by TARSHI in India.

## About TARSHI and the Context in India

The sexuality counselling services of TARSHI in New Delhi, India are provided through an anonymous telephone Helpline where people call in and discuss any issue relating to sexuality. Callers are also able to seek information about referral to medical services and other centres of information. This is done in an anonymous setting, where the conversations with Callers are not recorded and the only identification is a



Caller number for calls that the Caller may place to TARSHI again in the future. By using a telephone Helpline, this type of counselling uses a different method to address issues which are taboo in the conservative setting in which TARSHI operates. By ensuring anonymity, evidence based information and a non-judgmental attitude, TARSHI strives to adhere to highest standards of respecting rights of Callers. TARSHI's Helpline is not part of the national health system. The current context in India makes it difficult to raise sexuality issues in the public health system as shall be elaborated in Chapter 3. The next section describes the macro context in India in brief.

India is the second-most populous country in the world with an estimated 1.03 billion people<sup>1</sup>. India's per capita Gross National Income is \$530 per annum<sup>2</sup>. India is a land of great diversity and greater inequities with around 26.1% of citizens living in poverty<sup>3</sup> (26.1% equals 260.3 million people). The poverty line is defined by the Planning Commission of India at income less than Rs. 362.68 per month (1\$= 40 Rupees). Access to wealth and power varies considerably, and vast differences in economic status are evident everywhere.

The table below summarizes the key demographic indicators of India. There are

### India: Important Demographic Indicators<sup>4,5,6</sup>

Estimated Total Population	1.1 Billion
Age group 15 – 59 yrs	700 million
Age group 10 – 24 yrs	300 million
Living in Rural Areas	72.18%
Living in Urban Areas	27.82%
Literacy Rate	64.4% (Males– 75.6%, Females– 54.2%)
Juvenile Sex Ratio (0– 6 yrs)	927 females per 1000 males (Kerala has 960 females per 1000 males, while Punjab has 798)
Crude Birth Rate	26.4/1000 (Tamil Nadu, Kerala, Mizoram, Manipur: < 20/1000 Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan: > 30/1000)
Total Fertility Rate	3.3
Life Expectancy	Males: 61 years, Females: 63 years
Median age at first sex	Males: 21 years, Females: 19 years
Religion <sup>7</sup>	Hindus: 80.5%, Muslims: 13.4%, Sikhs: 1.9%, Christians: 2.3%, Buddhists: 0.8%

<sup>1</sup> National Summary Data Page. [Homepage of the Census of India] [Online] 2003. Available from URL: <http://www.censusindia.gov.in> (Accessed on 13/09/07)

<sup>2</sup> At a glance: India [Online] [2003]. Available from URL:

[http://www.unicef.org/infobycountry/india\\_statistics.html#28](http://www.unicef.org/infobycountry/india_statistics.html#28). (Accessed on 21/09/07)

<sup>3</sup> Poverty Statistics from the Ministry of Finance of the Government of India. Available from URL:

<http://indiabudget.nic.in/es2004-05/chapt2005/chap102.pdf>. (Accessed on 12/08/06)

<sup>4</sup> India at a glance: Female sex ratio. [Homepage of the Census of India] [Online] 1993. Available from URL:

[http://www.censusindia.gov.in/Census\\_Data\\_2004/India\\_at\\_glance/fsex.aspx](http://www.censusindia.gov.in/Census_Data_2004/India_at_glance/fsex.aspx). (Accessed on 13/09/07)

<sup>5</sup> Population and Human and Social Development – Facts [Online] May 2000. Available from: URL:

<http://populationcommission.nic.in/facts1.htm>. (Accessed on 07/09/07)

<sup>6</sup> Statistics: India [Online] [2006]. Available from: URL: <http://www.who.int/countries/ind/en/>. (Accessed on 14/09/07)

<sup>7</sup> Brief analysis. [Census Data 2001 – India at a Glance: Religious Composition] [Online] [Undated]. Available from: URL: [http://www.censusindia.gov.in/Census\\_Data\\_2001/India\\_at\\_glance/religion.aspx](http://www.censusindia.gov.in/Census_Data_2001/India_at_glance/religion.aspx). (Accessed on 13/09/07)

major differences between states. The urban-rural differences are also immense in all aspects, including the distribution of public health services. India's biggest metropolitan areas are Mumbai, Delhi, Kolkata and Chennai.

### Policies and Programmes

India is one of the first countries to have launched an official Family Planning Programme as far back as 1952<sup>8</sup>. With over five decades of preoccupation with preventing pregnancies, the Family Planning Programme has been implemented solely focusing on contraceptive methods, with hardly any discussions on sexual health and/or sexuality. Subsequent programmes of the Government of India – Family Welfare Programme (1984 – 85), Child Survival and Safe Motherhood Programme (1992 – 93), the Reproductive and Child Health Programme (Phases 1 and 2, 1997 to date), the National Rural Health Mission (initiated in 2005, to go on till 2012) – do not appear to consider sexuality as an important issue to focus on.

While abortion is legal in India under the Medical Termination of Pregnancy (MTP) Act 1979, there is large-scale lack of awareness about the fact that abortion is not a criminal act. Legality of abortion is countered by morality. Rates of unsafe abortions are very high contributing to high maternal mortality. Illegal and thus unreported abortions are estimated to outnumber legal abortions by a factor of between three and eight<sup>9</sup>.

Since the International Conference on Population and Development (Cairo, 1994) India has seen some progressive changes in its health policies and programmes. Policy and programme documents do focus on gender

issues, male involvement, RTIs and STDs but discussion of issues related to sexuality has by and large been left out. The Health Department has ventured into the areas of Reproductive Rights but not into Sexual Rights. It appears that sexuality has been left to be a concern of the National AIDS Control Organisation.

In 1992, the National AIDS Control Organisation (NACO) was established to coordinate an enhanced HIV/AIDS programme. NACO provides a national leadership and facilitated the development of State AIDS Societies in all states across India. NGOs are also involved in the work on HIV/AIDS and carry out important prevention and care activities. After the discovery of the first HIV infection in 1986, the Government of India initiated programmes of prevention and raising awareness under the Medium Term Plan (1990-92), the first plan (NACP- I, 1992 – 99) and the second plan (NACP- II, 1999 – 2006). Based on the lessons learnt and achievements made in Phase I and II, India has now developed the Third National AIDS Programme Implementation Plan – NACP 3 (2006-2011). NACO regularly carries out Behavioral Surveillance Surveys around sexual behaviours of high risk groups, like truck drivers, sex workers, men who have sex with men, and so on. NACO's targeted intervention programmes aim to change sexual behaviours of these high-risk groups<sup>10</sup>. How much and what kind of sexuality counselling is provided to these high-risk groups is not documented.

The Reproductive and Child Health (RCH) I Programme was launched in 1997. It claimed to replace the earlier Family Welfare Programme and incorporated several of ICPD Programme of Action elements like promoting gender

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<sup>8</sup> Family Welfare Program in India [Online] [Undated]. Available from: URL:

<http://mohfw.nic.in/dofw%20website/family%20welfare%20programme/intro.htm> (Accessed on 13/09/07)

<sup>9</sup> Chhabra, Rami and Sheel C. Nuna, (1994) Abortion in India: An overview. New Delhi: Veerendra Printers

<sup>10</sup> National AIDS Control Organisation (2006), National AIDS Control Programme Phase III, Ministry of Health and Family Welfare, Government of India

equity, male involvement, adolescent health, management and prevention of RTIs and STIs. In 2002 before framing the RCH II, lessons learnt from the implementation of RCH I were widely discussed<sup>11</sup>. However, despite the importance given to RTIs and STIs and adolescent health issues, the necessary emphasis on sexuality was once again bypassed. The National Family Health Survey II showed that 39% women reported at least one reproductive health problem, 36% reported vaginal discharge or urinary tract infection, 13% reported painful intercourse and 2% bleeding after intercourse – this data points out to the necessity to include nuanced communication around sexuality in the reproductive health discourse in the country<sup>12</sup>.

The National Rural Health Mission, otherwise a progressive and visionary mission based on a rights' approach, has sidelined reproductive rights possibly assuming that the RCH 2 programme will address these and absolutely leaving out discussion on sexual rights<sup>13</sup>. A Key Informant interviewed for this study points out:

*So policy as we were discussing on sexual health is rather silent. It's more reproductive health because their concerns are reducing total fertility, maternal mortality and reducing HIV, which actually forces them to talk about sex.*

(Male, K 9)

The National Population Policy (2000)<sup>14</sup> focuses on availability of contraceptives and not on sexuality education. Just like the MDGs, at least five Socio-Demographic Goals of the NPP, to be

achieved by 2010, offer an opportunity for sexuality education and counselling.

Government of India has committed to achieving the MDGs and the recent 11<sup>th</sup> Five Year Plan for the country has been driven by the MDGs across sectors. In at least four of the MDGs, there is an opportunity for sexuality education to be incorporated: in (a) Achieving Universal Primary Education, (b) promoting gender equality and empowerment of women, (c) improving maternal health, and (d) combating HIV/AIDS<sup>15</sup>.

### National Youth Policy (2003)<sup>16</sup>

The National Youth Policy covers 13 – 35 years in two groups – 13 – 19 years and 20 – 35 years. The first group is referred to as the adolescent age group. This is an inter-sectoral policy. In addition to a focus on education and health, the policy addresses citizenship, leadership and participation issues.

The section on Health only in the Population Education part (one out of five parts, others are General Health, Mental Health, Spiritual Health, AIDS / STDs / Substance Abuse) is 'responsible sexual behaviour' discussed and this is largely related to age at marriage and childbearing. Other aspects of sexuality of adolescents related to identity, development and mental health, do not find any mention in the policy.

A Working Group on Youth Affairs and Adolescents' Development appointed by the Planning Commission for the 11<sup>th</sup> Five Year Plan (2007 – 12) has seriously considered

<sup>11</sup> RCH II Document 2 the Principles and Evidence Base for State RCH II Project Implementation Plans (PIPs) Available from: URL: [http://www.whoindia.org/linkfiles/child\\_health\\_in\\_india\\_pip\\_doc\\_chapter01.pdf](http://www.whoindia.org/linkfiles/child_health_in_india_pip_doc_chapter01.pdf). (Accessed on 30/11/07)

<sup>12</sup> National Family Health Survey 2: Key Findings, 1998 – 1999, International Institute for Population Sciences, Mumbai, India, pp 14, 15, Available from: URL: <http://www.nfhsindia.org/data/india/keyfind.pdf> (Accessed on 30/11/07)

<sup>13</sup> National Rural Health Mission: Meeting peoples' health needs in rural areas – A Framework for Implementation 2005 – 2012, Ministry of Health and Family Welfare, GOI, New Delhi

<sup>14</sup> National Population Policy 2000, Ministry of Health and Family Welfare, GOI, New Delhi

<sup>15</sup> Millennium Development Goals Report 2005, United Nations, New York, 2005

<sup>16</sup> National Youth Policy (2003), <http://www.yuva.nic.in/downloads/NATIONALYOUTHPOICY2003.doc>



adolescent sexuality issues across the sectors of Education, Health (including Mental Health) and HIV/AIDS. The report of the Working Group<sup>17</sup> states that amongst grey areas in research, adolescent sexuality and sexual health need a special mention.

### Education Sector

While the National Curriculum Framework (2005) of the National Council for Education Research and Training, makes a clear mention of the need for appropriate and context specific sexuality education for adolescents, several states in India have banned sexuality education within schools because it is considered as against 'Indian culture and values'. In fact, as reported by one Key Informant, there exists in the country today a movement known as 'Shiksha Bachao Abhiyan' (Save Education Campaign) whose members are forbidding sexuality education within schools. There is no recognition of the fact that several studies indicate early initiation of sexual activity amongst boys and girls<sup>18,19</sup>.

Sexuality education within the school curriculum is being promoted either by the Population Education lobby or by NACO. The National Curriculum for Secondary Education, (NCERT, 2000) in Section 2.6 states '*During the period of secondary education, emergence of desire and inclinations of sexual nature is a normal feature of students' psychophysical development. This dimension deserves careful attention of the curriculum organizers. The idea that the Indian society does not approve of promiscuity and that self-control or 'Samyam' is one of the highly valued qualities ought to be underlined. This will generate among the youth healthy attitudes toward sex and respect for members of the opposite sex.*' This section does not recognize the reality that the age at first sex is around 19 years (as reported by the Durex Study mentioned in Chapter 3) and that if appropriate information is given, it can probably be a safeguard for adolescents.

This then is the general context within which TARSHI locates its services. Chapter 3 describes the context in greater detail.

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<sup>17</sup> Draft Final Report of the Working Group on Youth Affairs and Adolescents' Development for formulation of 11<sup>th</sup> 5 Year Plan (2007 – 12) March 2007, Vol I, GOI, Ministry of Youth Affairs, New Delhi

<sup>18</sup> Jejeebhoy, Shireen J (2004), Looking Back, Looking Forward: A Profile of Sexual and Reproductive Health in India, Rawat Publications and Population Council, New Delhi.

<sup>19</sup> Khanna, R., Gurbaxani S., Sengupta K. Sexuality And Sexual Behaviour: An Annotated Bibliography of Selected Studies (1990 – 2000). The Gender and Reproductive Health Initiative. WOHTRAC and CREA. New Delhi. 2002.

## Chapter 2

# Methodology

This chapter describes the methodology used for the TARSHI study. Since this was part of a four-country research, several research objectives and research questions were common with the other three studies. There were some differences in research methods, because of TARSHI's uniqueness of offering anonymous telephonic sexuality counselling. These are described in the subsequent sections.

### Research Objectives

#### General Objective

To define the content of sexuality counselling and assess factors influencing the quality of counselling.

#### Specific Objectives

1. To contextualise counselling services within a broader service delivery environment
2. To document the content of the counselling related to sexuality issues
3. To assess the quality of the counselling related to sexuality issues
4. To assess the way environmental factors influence the counselling content and quality

### Research Questions

- i. What are the provider characteristics in relation to the promising/effective counselling services that positively address sexuality within the counselling session?
- ii. What are the key content elements of the interventions that are described as promising?
- iii. What contribution does the counselling have on behavioural, individual and health outcomes?

- iv. What contribution does the counselling intervention have on the broader SRH or HIV programme outcomes?
- v. What lessons can be learnt for scaling up future interventions?

### Research Instruments

Table 2.1 provides details of various small studies done and the research instruments used. The table also describes the categories of Key Informants interviewed. Annexure 1 provides the Informed Consent Form and the Tool for each category.

#### Desk Review

Desk review was based on materials published by TARSHI, national data on Census 2001, National Family Health Survey 3, National AIDS Control Programme 3 (NACP – 3) document, Reproductive and Child Health Programme 2 (RCH – 2) document, other published and unpublished material.

#### In-depth Interviews with Key Informants

Stakeholders and categories of Key Informants to be interviewed were identified by the researchers and the Manager and Counsellor of TARSHI. Possible organisations and persons to be interviewed within each category were listed. Depending on their availability, during the data collection periods, Key Informants were selected and interviewed. A total of 24 Key Informant interviews were done. Five Key informants belonged to more than one category listed in Table 2.1. Three of the trainers are also persons whom the TARSHI Helpline refers Callers to. One trainer is on the governing board of TARSHI. One of these four persons was administered two questionnaires and three others were administered a combined questionnaire.

Table 2.1 Research Methods

1. Key Informant In-depth Interviews (24)	<ul style="list-style-type: none"> <li>• Policy Makers – Government Officials (3)</li> <li>• International organisations (2)</li> <li>• Representatives of Other Helplines (3)</li> <li>• Organisations to whom TARSHI refers callers (2)</li> <li>• Organisations familiar with TARSHI services and those in the field of SRHR (3)</li> <li>• Donors (2)</li> <li>• Trainers of TARSHI Counsellors (3)</li> <li>• Past Counsellors on TARSHI Helpline (3)</li> <li>• Counsellors and Manager (3)</li> </ul>
2. FGDs (5)	<ul style="list-style-type: none"> <li>• With young unmarried girls (1)</li> <li>• With married women (1)</li> <li>• With married men (1)</li> <li>• With young unmarried boys (2)</li> </ul>
3. Telephone and Internet Feedback from callers (7)	<ul style="list-style-type: none"> <li>• Internet based feedback (3)</li> <li>• Phone Calls (4)</li> </ul>
4. Analysis of callers' Case Records	11 repeat callers
5. Review of the Peer Assessment system	Performance assessment forms of four Past Counsellors

### Focused Group Discussions

Five FGDs were conducted. The participants of the FGDs had the characteristics of the users of the TARSHI Helpline. The selection criteria were:

- Unmarried boys, ages 20 to 24 years
- Married men, ages 26 to 29 years
- Young unmarried girls
- Married women
- All working class, mainly Hindi speaking

Community based FGDs were done in the areas where mostly people from lower income back-ground live. These areas were selected on the basis of discussions with TARSHI counsellors.

One FGD was done with 13 married working class women. The second FGD was with 11 young girls from low-income group. Participants for these FGDs were recruited through a community based women's organisations in the city (Action India). Field activists of this organisation were oriented to

the objectives and methodology of the study and they arranged the logistics for the FGDs.

Three FGDs were conducted with men by male facilitators. The first FGD with 11 men between the ages 20 and 24 was in the same sort of community as the women's FGD. The male field activists of Action India recruited participants. The second FGD with 7 men between the ages 20 and 25 was conducted with participants recruited through an open advertisement placed on a notice board of a public hospital in the city. The third FGD was done with married men between the ages 26 and 29 years.

To ensure that the profile of the FGD participants matched the callers of the Helpline, the two counsellors were asked to hear the recordings and assess the language, vocabulary, accent etc. According to the counsellors, there was a match between the FGD participants and the callers.

### Telephone and Internet Feedback from Callers

Exit interviews through telephone feedback

from repeat users of TARSHI's Helpline, were conducted to assess the quality of counselling. Callers who had called two or more times were given information about the study and asked to call the researcher on an independent telephone number. Four callers called in and gave their feedback. One first time caller also responded to the invitation to give feedback, when towards the end of the data collection period, first time callers were also asked if they would like to participate in the study.

Internet based feedback was also sought from callers who had access to the Internet. Annexure 1, section 2B gives the tool for Internet feedback. Three persons responded on the Internet.

Thus, a total of 7 callers gave feedback, which could be termed as exit interviews.

### Analysis of Callers' Case Records

Records of all callers who had called at least five times within one calendar year about sexual health concerns were retrieved. Callers' from 2002 were selected because during that year the TARSHI Helpline had the maximum number of counsellors (6). Records of callers fulfilling the above criteria, in 2005 and 2006 were also retrieved to assess whether quality of counselling has remained uniform.

The WHO – KIT framework to assess quality of sexuality counselling was reviewed, refined and applied to the retrieved case records.

### Study of Performance Evaluation System of Counsellors

TARSHI was following a Peer Assessment system for all its counsellors from year 1996 to 2003. Counsellors filled out a self-evaluation form for themselves and a peer evaluation form for their colleagues. After the forms were completed, the scores were compiled and then the counsellors had individual meetings with the supervisor where their scores were discussed and areas of improvement were also discussed.

#### WHO – KIT framework on Quality of Sexuality Counselling

- Confidentiality
- Privacy
- Choice
- Time / Duration
- Language
- Attitude of Provider
- Sex of Provider
- Age of Provider
- Information
- Interpersonal Communication
- Referral

#### Adapted framework to assess Quality of Sexuality Counselling

- Sexuality issues addressed
- Evidence of privacy and confidentiality
- Details of information provided
- Details of referrals made
- Validation: giving permission to talk
- Non-judgmental attitude
- Exploring and Probing
- Listening
- Woman centeredness
- Other aspects of quality counselling: not making decisions for client, managing dependence, evaluating own counselling etc

To see what effect this system had on the quality of counselling provided, we selected all the Performance Assessment forms of four counsellors (out of a total of 12) who had worked the longest in TARSHI. The trends on each counsellor's average score for each

indicator was analysed for each evaluation. The names of counsellors were whitened out from the copies and replaced with codes.

The counsellors who had worked the longest at TARSHI were included in the study, because it was felt that improvements in quality of counselling provided by them, could then be assessed over a longer period of time.

### Ethical Issues

- An independent Ethical Review Committee was established for the study. The protocol and all the tools were shared with the Committee. After the feedback from the members of the Ethical Review Committee, the methodology for the study was changed. For instance, past counsellors were included as Key Informants; a study of the Peer Assessment System was included to assess its effect on quality of counselling provided. Topic guidelines for the FGDs were also improved
- It was decided not to observe the counsellors while they attended calls because it was felt that this would firstly violate the confidentiality clause. Secondly it would affect the counsellor's attention, which would be reflected in her voice and breathing, and so on
- Each interview and FGD was recorded after the participants gave consent. One Key Informant did not want his interview to be recorded – only notes were taken
- One copy of the Informed Consent form with the researchers' email ids and phone numbers was left with each person interviewed
- Researchers signed a contract for keeping confidentiality
- Anonymity of all Key Informants and FGD participants was assured by giving them code numbers

- Only those Key Informants who gave their consent are acknowledged in the Acknowledgements section

### Data Analysis

Coding sheets were developed for each category of Key Informants' interviews and FGDs. At least two researchers coded each interview and FGD transcripts. The codes given by each were discussed and finalized.

### Quality Assurance

- Tools were pre-tested and modified
- Each interview and FGD transcript was checked against the original recording by the senior researcher. Detailed feedback was given to the research assistant in the earlier interviews and the transcriptions were rechecked to ensure that the feedback was incorporated. Subsequent transcriptions improved in quality and did not require detailed feedback incorporation
- Facilitators and note takers for the FGDs were given detailed orientation to the purpose and objectives of the study, and the expected outcomes of the FGDs. Facilitators were given feedback on how they could sharpen their probing and exploring in subsequent FGDs, based on the checking of the transcriptions

### Limitations of the Study

The biggest limitation was that exit interviews could not be done since the counselling was not *in situ*. Although 18 callers were invited to give feedback only seven chose to do so, five refused straightaway.

Possible biases in the study could be that the peer assessment forms of those counsellors were analysed who were in TARSHI the longest. Records of only those callers' who called more than five times were analysed.

Despite repeated efforts, appointments for interviews with some significant policy makers and programme managers could not be obtained.

Counsellors hypothesized that new callers would not be willing to give feedback until they know more about the service, felt confident that their confidentiality would not be compromised and also felt invested enough in the service to want to give feedback. Keeping this in mind, only repeat callers were initially asked if they would be willing to give feedback. Of those who were asked if they would be willing to speak to a researcher about their experience with the Helpline service, 3-4 new callers refused. The counsellors then decided to ask only repeat callers if they would be willing to speak to a researcher. Two agreed of which only one actually called the researcher on the designated date and spoke to her. One new caller was asked if he would be willing to participate in the study (on 19/3/07) and he readily agreed and called the researcher immediately after finishing the call on the Helpline.

Those who were calling from out-station and/or those who had Internet access were asked if they would be willing to fill out the Internet feedback form. All those who were approached, readily agreed to give feedback (8). However, only 3 of them actually were able to take the survey online. Of the 3 who filled in the online feedback form, one called back to tell the counsellor that he had completed the feedback form and another had to be reminded on a subsequent call to do so. One other person was reminded on a subsequent call to take the Internet feedback form. He said he remembered that he had to do it but was finding it difficult to find some private time at a computer to do the survey.

Other reasons why counsellors were not able to ask many callers to be part of the research:

- TARSHI timings are now much reduced – 3 days a week from 10 am to 4 pm
- Since the service is not being advertised, the Helpline receives fewer calls (an average of 8 calls a day)
- Some callers have terminated the call abruptly because they have received another call or visitors while they were speaking to the counsellor

The annexure contains the tools mentioned below. We also give below a guide to the codes assigned to different groups of Key Informants.

### List of Tools and Informed Consent Forms

1. **Key Informant Interview Guide**
  - A. Organisations/individuals who refer to TARSHI
  - B. Organisations/individuals that TARSHI refers to
  - C. Organisations familiar with TARSHI service and working in the field of SRHR
  - D. Policy makers and donors
  - E. International organisations
  - F. In-depth interviews with trainers
2. **Tool to Elicit Callers' Feedback**
  - A. Telephone Interview from a repeat caller
  - B. Internet Feedback Form
3. **Facility Questionnaire**
4. **Managers and Counsellors Interview Guide (including Past Counsellors)**
5. **Client FGD Guide**
6. **Informed Consent Letters**
7. **Framework to assess Quality of sexuality counselling from records**



### Guide to Interviewee's Codes

**Callers** – Repeat Callers whose records were studied

**C** – Counsellors

**K** – Key Informants

**M** – Managers

**MC** – Manager Counsellors

**PC** – Past Counsellors

**RK** – Callers interviewed over the telephone

**T** – Trainers

**TR** – Callers who filled the Internet feedback form

## Chapter 3

# Contextualisation of Sexuality Counselling

This chapter discusses in some detail the context within which sexuality counselling provided by TARSHI has to be situated. We begin by examining the social norms and values affecting sexuality. The next section discusses some laws having a bearing on sexuality. This is followed by a section on epidemiological information on sexual and reproductive health, sexual health services and the status of sexuality counselling in India.

### 3.1 Description of Norms and Values in Society

Historically, India has a rich tradition of sexuality. Kama Sutra an ancient text of sexuality has taught not only Indians but also people all over the world, about sexuality. India's old temples, Khajuraho, Sun Temple at Modhera, small *yogini* temples show the importance that was given to sex and sexuality and have been a source of sexuality education over the generations. With such a rich heritage of sexuality, it is paradoxically shrouded in secrecy. While Indian history celebrated sexuality, modern day culture induces notions of shame around sexuality. On the one hand, any open talk of sexuality is strictly taboo, on the other sexual jokes and innuendos abound. Norms and values regulate the lives of all people but not uniformly. The cultures that we live in regulate the lives of women more than they do that of men. Women's bodies and their perceived social roles determine the social norms that they have to live by. Little girls are better trained in the ways of culture and tradition than are little boys. They are taught from a young age how to talk, how to walk, how to sit with their legs together and even

how to think (about themselves in relation to others, their husbands, brothers). Most marriages are arranged in India between two families, not two individuals. Girls are property, held in safe keeping until they can be handed over to the husband whose property they then become. 'Izzat' or family honor is the most valuable thing that families must protect, all 'izzat' is embodied in the body and being of the daughter, the wife, the sister. Chastity is a virtue. Virginity in a bride is necessary. The 'first night' is associated with customs and practices that establish and prove that the bride is a virgin. When she marries, she is expected to be a good wife and perform all her duties, conjugal and otherwise. She must show the right amount of interest in sex – enough to 'keep' him, not too much or else she attracts suspicion!

Little boys are taught early in life to exhibit and demonstrate physical power, to be adventurous, to control others. It is 'manly' to do all this. Soon they learn to translate these notions into the domain of sexuality. They are taught to believe that even if a girl says 'no', she actually means 'yes' so it is okay – indeed, manly to overpower her sexually. They are taught to believe that they are 'real men' if they are sexually active and can demonstrate sexual prowess. The rules of sexuality appear to dictate that girls have to prove their virginity and boys their virility. Men learn early in life that double standards in sexuality are a way of life. While wives should be virgins, it is quite acceptable for men themselves to have premarital sex<sup>20</sup>.

Proving fertility is very important, for both men and women. So childbearing has to start early,

<sup>20</sup> The Associated Press (2006) *India's young men are conservative, confused, when it comes to sex, survey finds*. AC Nielsen-ORG-MARG Study for India Today, November 6. Available from: URL: [http://www.iht.com/articles/ap/2006/11/06/asia/AS\\_GEN\\_India\\_Sex\\_Survey.php](http://www.iht.com/articles/ap/2006/11/06/asia/AS_GEN_India_Sex_Survey.php) (Accessed on: 13/09/07)



before the family and neighbours begin doubting the woman's fertility. Additionally, women must bear sons. Sons after all carry the family name forward; inherit the family property, and so on. In order to bear sons, women go through repeated pregnancies, subject themselves to sexual demands of husbands. Once she bears a son, she moves to a somewhat higher and securer ground and can negotiate relationships, somewhat. Bearing children is so important, that in some communities, sexual relationships with other family men are permitted – in fact, engineered, if the husband cannot impregnate her.

Indian culture despite all its diversity, also defines sex as being 'real' only when it involves penetrative heterosexual intercourse. Thus, any other form of sexual engagement is not real sex. Men who have sex with men dismiss their behaviour as being only 'play' or 'fun' or 'masti'<sup>21</sup>. Same sex relationships are generally not visible. Attempts to discuss and debate same sex relationships publicly have drastic consequence. An example of this is the outcry and burning of cinema halls after the screening of the film 'Fire' which attempts to sensitively portray the relationship between two sisters-in-law who had unsatisfying relationships with their husbands. Similar intolerance is seen for gay relationships.

Sexuality in India, particularly in the urban, middle class context, is not discussed, or else discussion on sexuality is linked to gender (women) and restricted reproductive health (primarily birth control) and sexual violence (primarily against women). It is not surprising therefore, that non-normative gender/sexual expressions (e.g., related to same sex sexual expressions) are invisible or declared

unimportant – even in the face of severe and wide-ranging human rights violations<sup>22</sup>.

When non-normative gender/sexual identity is asserted or discovered, individuals may face emotional blackmail within the family, in-house imprisonment or eviction, job loss, coercion into marriage, harassment and extortion at the hands of the police, or conversion therapy at the hands of mental health professional (typically including strong drugs and shock therapy). The particular violations experienced depend upon gender, caste, and class-related factors<sup>23</sup>.

The work related to same sex sexualities in India involves a wide range of perspectives and activities, which can be broadly categorized into support groups, HIV/AIDS related work, and more explicit political activism.

Indian culture also seems to be 'discharge oriented'. Indian men are very troubled by emissions and premature ejaculation, terribly concerned about the size and shape of their genitals and attribute all sexual problems to masturbation and the resultant 'loss' of semen<sup>24</sup>. Sayings such as 'one drop of semen is worth a thousand drops of blood, exacerbate fears about semen loss.

Media's stance on sexuality is confusing and conflicting. On the one hand, media is talking openly about sexuality. There are sexuality and health related columns in English as well as regional language print media. But the flipside is that under the veneer of sophistication and freedom, sexuality is being discussed in ways that are conservative and stereotypical. One Key Informant points out media's double standards on sexuality as follows:

<sup>21</sup> Chandiramani Radhika, (2001) *What's Culture got to do with it? : TARSHI*: Paper presented at the Plenary Session on Culture and Society at the First Asia Pacific Conference on Reproductive Health, Manila, February 15 – 19.

<sup>22</sup> Sharma, Jaya and Nath, Dipika (2005) *Through the Prism of Intersectionality: Same Sex Sexualities in India*, in 'Sexuality, Gender and Rights: Exploring Theory and Practice in South and South East Asia' (ed.) Geetanjali Misra and Radhika Chandiramani, published by Sage, New Delhi.

<sup>23</sup> Op. cit. Sharma and Nath

<sup>24</sup> Op. cit. Chandiramani

*Abstinence till marriage is promoted. Girls reaching puberty are being told that they mustn't talk to boys. Conflicting imagery. The Times of India advertisement on sexual harassment gives a message of 'Protect your women'. Why should the woman not be told to react and other men and women be told to help her? Women talking openly about sexuality are considered loose. Men are being given permission to read Manohar Kahanyian or porn magazines. Women have no access to these magazines.*

(Female, T 2)

Hardening of religious values and stands in the recent years is also impacting on sexual expression in India. The conservative Hindutva forces in the form of Bajrang Dal and Vishwa Hindu Parishad (members of the right wing Sangh Parivar and affiliates of the major opposition political party, the Bharatiya Janta Party) are becoming gatekeepers of morality and sexuality. Dress codes for girls (no sleeveless garments, no jeans etc.) are being enforced in educational institutions in several cities. Celebration of Valentine's Day, largely promoted by market forces, is being banned by the goons of the Bajrang Dal and the Vishwa Hindu Parishad by creating terror (In recent years several cities have seen gangs of men and youth belonging to the two organisations setting shops on fire, and terrorizing students on campuses). Moral policing occurs wherever couples (even married ones) hangout together – in gardens (in Meerut), on seafront promenades (in Mumbai). Police personnel have taken it upon themselves to beat up couples who are seen together in public places.

*Hijras* or transgenders as a social group have cultural sanction in India and their presence is considered auspicious around celebrations of marriages and births. *Hijras* can be in public spaces and visible only in the prescribed cultural role of the *Hijra*. However, as citizens

they find themselves oddly placed – the census does not recognise them as a third sex apart from female or male. They are artificially forced into one or the other category. Their rights to identity are violated in situation after situation – there is no space for them in health care facilities – male ward or female ward? *Hijras* along with other sexual minorities are subjected to exclusion and discrimination.

### Stigma and Discrimination

Stigma and Discrimination (S&D) is a huge problem for marginalised populations such as sex workers, sexual minorities like LGBT groups. S&D often emanates from service providers – medical, non-medical, government and private sectors. It is also manifest in a variety of ways at work places and at community and family levels. Several studies have shown a high level of discrimination – nearly 70 per cent – against People Living with HIV/AIDS (PLHA) and marginalised groups. Nearly 18.3 per cent faced discrimination from their neighbours and 9 per cent from community/educational institutions, etc. Further, PLHA and vulnerable populations themselves are largely unaware of their rights especially in remote and rural areas. There is also evidence that S&D is in many aspects a gender phenomenon<sup>25</sup>.

This section describes how society constructs double standards for male and female sexuality. Markets and media, which overtly promote more liberal and open sexual norms, are offset by religious fundamentalism, which incites intolerance for sexual openness. Sexual minorities are largely invisible. Those who organise and assert themselves are stigmatized and discriminated against.

### 3.2 Existing Laws on Sexuality, Sexual and Reproductive Health and Rights

In this section we discuss how the legal

<sup>25</sup> National AIDS Control Organisation (2006), *National AIDS Control Programme Phase III*, Ministry of Health and Family Welfare, Government of India

framework is also not supportive of sexual rights particularly of women. The repressive legal framework creates a greater need for sexuality counselling services. Knowledge of laws that relate to sexuality is also important for counsellors. The repressive legal framework also creates a threatening atmosphere, which may adversely affect the counselling process and the provisioning of sexuality counselling service.

Section 377 of the Indian Penal Code criminalizes sodomy and prescribes sanctions against 'whoever has voluntary carnal intercourse against the order of nature'. This law appears to hold peno-vaginal intercourse within marriage as the gold standard for all sexual acts. While it is not technically specific to homosexual couples, it acts effectively as an anti-sodomy law. Lesbianism does not come within the purview of this act. The last five years have seen concerted campaigning by gay rights' groups as well as HIV/AIDS organisations against Section 377. 'Voices against 377' is a coalition of groups in Delhi that includes groups working on child rights, queer rights, women's rights, and human rights violations. This is one of the few groups in the country that includes both LGBT – identified and non-identified people working together for queer rights<sup>26</sup>.

Section 375 of the Indian Penal Code is the law on rape. The definition of rape is very problematic, limited to forcible peno-vaginal intercourse. Non-consensual sex within marriage, between husband and wife is not recognized as marital rape. Other forms of sexual assault, for example, insertion of foreign objects into women's vaginas, and so on, are not recognized as rape. Women's groups have been working on the Sexual Assault Bill, a draft legislation to bring about changes in the existing rape law in the country.

The Medical Termination of Pregnancy (MTP) Act was passed in 1971. India is one of the first countries where abortion is legal under the MTP Act. However awareness of the legality of abortion is low amongst women and rates of unsafe abortions at the hands of informal sector abortion providers is unsatisfactorily high. Secrecy around unwanted pregnancies and resultant abortions is high. Adolescents, both married and unmarried obtain abortion services in significant numbers – between 20 and 30% according to a review done under the Abortion Assessment Project – India<sup>27</sup>. Many of the adolescent abortions are second trimester abortions – between 70 and 80% according to the review cited above. Women (and girls) prefer to spend large amounts on transport to access abortion services where there is little danger of them being recognized. The MTP Act is in the process of being amended. Restrictions on second trimester abortions being proposed as a part of the amendment (to prevent sex selective abortions) will further restrict spaces for women to access safe abortion services.

Son preference amongst many communities in India combined with development of new technologies has led to increasing sex selective abortions in many parts of the country. The child sex ratio has dipped alarmingly in many districts. While a healthy population anywhere in the world must have about 950 girls being born per 1000 boys (referred to as 'juvenile sex-ratio' which is the number of girls in 0-6 years age-group for every 1000 boys in 0-6 years age-group), in India, since the 1990s in some places the number of female-births has been recorded to be as low as 500 per 1000 male births, and overall the average juvenile sex-ratio for the country has dropped from 972 in 1901 to 927 in 1991. 2001 Census shows that this trend is continuing<sup>28</sup>. The Pre-Natal Diagnostics

<sup>26</sup> CREA (2006) *Sexual Rights and Social Movements*. CREA: New Delhi

<sup>27</sup> Johnston, Heidi Bart (2002) *Abortion Practice in India: A Review of Literature*, Abortion Assessment Project – India, CEHAT/HEALTHWATCH, Mumbai.

<sup>28</sup> Banthia, J.K. (2001) *Provisional population totals: India, Census of India 2001, Series 1, India, Paper 1 of 2001*. New Delhi, India: Office of the Registrar General.

Technologies (PNDT) Act was passed in 1994 and amended in 2002 to bring in pre-conception technologies into the purview of the Act. Large-scale confusion exists in the minds of most people between the MTP Act and the PCPNDT Act. There is lack of clarity that sex selective abortions are an offence under the PCPNDT Act, but abortions per se are legal under the MTP Act.

The law pertaining to prostitution was enacted in 1956 and was ironically titled 'Suppression of Immoral Traffic Act' (SITA). Its title was subsequently changed to Immoral Traffic Prevention Act (ITPA). The legislation is faithful to the conception of sex work as synonymous with trafficking or criminalized sex trade, and predictably proceeds to stigmatize it. ITPA deals with acts like keeping a brothel, soliciting at a public place and living off the earnings of prostitution. A new bill seeks to amend ITPA<sup>29</sup>. The removal of the section, which made soliciting an offence in the proposed amendments, is a welcome step. However, soliciting is done for the purpose of getting clients. The bill proposes to introduce a provision making clients punishable. The National Network of Sex Workers has sent protest letters to the Ministry of Women and Child Development, describing the provision as a direct attack on their livelihood. The amendments proposed in the bill could drive the profession underground, since punishing clients amounts to outlawing sex work. It disregards the ongoing debate on efforts to decriminalize prostitution and introduce self-regulation in the profession.

### Protection of Women from Domestic Violence Act, 2005

In the Indian context, some aspects of the existing laws can help women facing violence, including sexual violence. For example, when a woman is subjected to cruelty by her husband or his relatives, it is considered an offence under Section 498A of the Indian Penal Code (IPC). Cognizable and non-bailable, it provides for up to three years imprisonment and fine. This, however, is a criminal law and does not address the issue in its entirety. Real life experiences of women pointed to the urgent need for a law that went beyond Section 498A, to ensure other rights, such as the right to matrimonial residence, which could be made available only through a civil legislation.

A new legislation that has been enacted to protect women from domestic violence fulfils a long-pending demand of the women's movement for a civil remedy. The Protection of Women from Domestic Violence Act (PWDVA), 2005 is an important step by the State towards fulfilling its constitutional obligation to ensure equality between the sexes, and its commitment to international (including UN) mandates to address violence and gender discrimination against women through the enactment of effective national laws. It provides protection from violence (physical, sexual, verbal, emotional and economic) and also ensures economic support and shelter. With proper implementation, the Act can arrest the rising incidence of domestic violence in the country and also provide justice to women who face violence<sup>30</sup>.

<sup>29</sup> Shukla, Rajiv (2007) Law on prostitution is full of paradoxes, Indian Express, September 19, Vadodara

<sup>30</sup> Kathuria Poonam (2007) *Towards Violence-free Homes: A Handbook on the Protection of Women from Domestic Violence Act, 2005*, SWATI, Dhrangadhra

### Laws Relating to Sexual Assault

*(Excerpts form 'Revisiting Gender Neutrality in Laws relating to Sexual Assault' by Laxmi Murthy)*

Reform in the rape law is not new to the women's movement in India. In fact, it galvanized women's organisations around the country in the late 1970s. The countrywide campaign launched in 1979 in what came to be known as the 'Mathura Case' brought rape on the public agenda. ...

... The amendment in 1993 following this campaign led to some changes in the Indian Evidence Act (IEA). Prior to this, the burden of proof to establish the commission of rape by accused was wholly on the prosecution, and the definition of 'custody' was restricted to police stations, and did not include hospitals, remand homes or jails. Following the amendment in 1983, in cases of custodial rape, the burden of proof (to prove that rape was not committed) shifted to the accused...

... It was after two decades of sustained campaigning that the Lok Sabha passed the Indian Evidence (Amendment) Bill, 2002 deleting Section 155(4) of the archaic Indian Evidence Act, 1872, which permitted the person accused of rape to prove that 'the victim was of generally immoral character.' ...

... Women's groups, from the early 1990s, have made attempts to broaden the current definition of rape as 'penetration of the vagina by the 'sexual assault', which includes other forms of sexual violence that can be as traumatic. ...

... The 172<sup>nd</sup> report of the Law Commission in March 2000 put forth recommendations for a review of the rape laws... The Bill seeks to amend several laws in the Indian Penal Code related to sexual assault Section 375 and 376 (rape) 354 and 509 (sexual harassment or 'outraging the modesty of a woman'), relevant sections of the Code of Criminal Procedure 1973 and the Indian Evidence Act, 1872, in order to broaden the definition of rape, amend procedures and deal more effectively with child sexual abuse...

... At some point in the process, the draft law was envisaged as gender neutral, in order to bring child sexual assault, and sexual assault of men by other men, and sexual assault of women by other

women, especially in custodial situations, into the ambit of the law. One definition proposed (replacing 'man' and 'woman' with 'person') would apply to forced oral, anal and/or vaginal penetration by a man or a woman, forced penetrative sexual intercourse by an adult man or woman on a child of either sex and forced sexual activity between members of the same sex.

The need to make the law on sexual assault gender neutral was felt because legislation did not recognize any form of sexual assault that did not fit the parameters stated in the current Section 375 IPC i.e. man as perpetrator/woman as victim; peno-vaginal penetration. Simultaneously, there was also a move to repeal Section 377 of the IPC (pertaining to 'unnatural sexual acts) currently the only law that can cover sexual assault on boys and men. The fact that Sec 377 was routinely used by the police to harass consenting adult homosexual men (and in rare cases women), and not to prosecute perpetrators of rape, made it all the more urgent to get the archaic law dropped from the statute books...

... In an ideal society, gender neutrality in laws on sexual violence would imply that any perpetrator of sexual violence must be punished. However, just as there can never be equality between unequal, which frames the logic of affirmative action / reservation, the concept of gender neutrality assumes that all the actors are on the same footing, and treats them all a 'equal before law'. This can have disastrous consequences in a society where patriarchy is not only strong in social, family and community structures, but in the law enforcement and judicial structure as well. While striving for an ideal society, there must be recognition that present society is far from ideal and egalitarian...

... Violence as an expression of power is not limited to unequal gender relations. It spans a whole range of iniquitous relations – from age, caste, religion, race and sexual orientation, to situations of custody, and so on. The thesis that women are 'inherently' peace loving and non-violent cannot be supported by the empirical evidence of the horrors that some women,



especially those in positions of power, are capable of inflicting on other human beings. Yet, a law stripped of the recognized of the systematic patriarchy in Indian society and the widespread violence on women, cannot be an answer to addressing the issue of violence by women...

#### ... Laws on Child Sexual Abuse

Current laws do not deal effectively with child sexual abuse either in definition, or procedural matters. Beginning from the confusion about the age till when a person is a 'child', to restrictive definitions of rape that do not take cognizance of the gamut of sexual violence that a child can be subjected to, to procedural inadequacies that do not take account of the vulnerability of children, their inability to articulate and give evidence, and the long term consequences of sexual abuse.

Introducing gender neutrality in the laws relating to sexual abuse could ensure that boys who were sexually abused by older boys or men could have recourse to legal protection. It would also recognize that women too, are capable of sexually abusing children – both boys and girls.

The challenge for us then is not to criminalize consensual sexual activity of teenagers, but define 'consent' and 'coercion' in a way that would ensure protection against forced sexual acts...

#### ... Gender Neutrality and Same Sex Violence

Another argument in favor of a gender-neutral law is the need to tackle violence of men on men and women on women, in the framework of same sex

relationships. The LGBT community has argued that because the context and realities of same sex interactions are different, it would be preferable to draft a separate law dealing with same sex sexual assault. Most importantly, the initiative needs to come from the LGBT community, particularly because of the non- recognition of same sex relationships in civil law be it marriage, inheritance, or custody of children. When same sex relationship continue to be shorn of legitimacy (and in fact actively criminalized), the first legal recognition in the context of sexual violence is bound to reinforce the perception of same sex relations as 'abnormal'...

.... Any legislation that specially seeks to address same sex violence, must be grounded in the reality of same sex relations in India – the invisibility, lack of societal and legal recognition, as well as the hostility, homophobia and outright violence that is meted out to those daring to challenge the norm of heterosexual monogamous marriage....

The repeal of Section 377 cannot be conditional on the formulation of law penalizing same sex violence. There is an urgent need to strengthen the campaign demanding the deletion of Sec 377 and emphasise that law cannot punish consensual sexual activity between two persons...

... What needs to be emphasized, cutting across all those vulnerable to sexual assault, is that consent should mean the unequivocal voluntary agreement to engage in the sexual activity in question...

<sup>31</sup>(In *Plainspeak*, Issue 3, 2006)

### 3.3 Sexual and Reproductive Health Epidemiological Information

This section refers to three categories of information – first, demographic information on marriage, fertility, contraceptive use, knowledge of HIV/AIDS, women's empowerment from the

National Family Health Survey 3 (2005-06)<sup>32</sup>, second, HIV/AIDS related information from the recent document of NACP 3; and third, information from a large sex survey carried out by Durex on sexual behaviours, perceptions of needs and so on. The annexure 2 contains the tables substantiating the information contained here.

<sup>31</sup> Murthy, Laxmi, (2006) *Revisiting Gender Neutrality in Laws relating to Sexual Assault*, In *Plainspeak: Talking about Sexuality in South and Southeast Asia*, Issue 3, TARSHI, New Delhi

<sup>32</sup> National Family Health Survey 3 (2005– 06. Available from: URL: <http://www.nfhsindia.org/factsheet.html> (Accessed on 21/09/07)

The NFHS 3 data on marriage and fertility shows that while the percentage of girls getting married by 16 years is going down, it is still quite substantial (44.5%). Almost one-third of all men are married by 21 years, which is the legal age for marriage for men in India. Motherhood also comes early for Indian women. Around 16% of women between 15 and 19 years surveyed were either already mothers or pregnant at the time of the survey. Median age at first birth for women between 25 and 49 years is still below 20. Use of modern contraception is increasing – from 40.7% in 1992–93 to 56.3% in 2005-06. Female sterilization continues to be the preferred method (37.3%). Use of condoms by men has increased from 2.4% in 1992–93 to 5.3% in 2005-06. NFHS 3 indicates that women who had heard of HIV/AIDS have increased by 17 percentage points over NFHS 2. However, only 34.7% women knew that consistent condom use could reduce the chances of getting HIV/AIDS as compared to 68.1% men. A total of 65% women and 80% men have regular exposure to media (Rural Women 54% Men 73%, and Urban Women 87% Men 93%). Women's empowerment indicators show that half the currently married women participate in household decisions and as high as 37.2% ever married women reported having experienced spousal violence.

The 2007 Study on Child Sexual Abuse in India commissioned by the Ministry of Women and Child Development, Government of India shows that out of 12,477 child respondents, 53% reported having faced one or more kinds of sexual abuse<sup>33</sup>.

Census 2001 states that overall sex ratio in India is 933 and juvenile sex ratio is 927. Juvenile sex

ratio in Delhi is lower than the national figure– 868. Neighbouring states – TARSHI's 'field area'– have the following

- Haryana – 819
- Rajasthan – 909
- Punjab – 798
- Uttar Pradesh – 916

### HIV/AIDS Epidemiological Situation and Future Projections<sup>34</sup>

Based on the Sentinel Surveillance Data, the estimated number of HIV-infected persons has gone up from 3.5 million in 1998 to over 5.206 million in 2005 accounting for one eighth of all infections in the world. Based on the Sero-Surveillance Data from different sentinel sites in India in ANC clinics and in other HRGs, an expert group in India has estimated the number of PLHA in India to be 5.134 million in 2004. Delhi is a low prevalence and highly vulnerable state (on the basis of vulnerability factors such as migration, size of the population and weak health infrastructure). Sex continues to be the main route (86%) of transmission in most parts of the country. In the general population, women and young people are becoming increasingly more vulnerable to the infection. According to the 2005 Sentinel Surveillance findings, 38.4% of the infected persons in the country were women. In many states, more and more monogamous women are getting infected from their husbands. The male-female ratio of infected persons also shifted from 55/100 males in 2001 to 60/100 males in 2005, indicating increasing feminization of the epidemic. Over 5% of adult population in India suffers from STDs.

<sup>33</sup> Ministry of Women and Child Development, Government of India (2007) Study on Child Abuse: India 2007, Available from: URL: <http://www.crin.org/docs/childabuseindia.pdf> (Accessed on 21/09/07)

<sup>34</sup> National AIDS Control Programme – Phase III, Chapter 2, (2006 – 11), Strategy and Implementation Plan; National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India

### Sexuality Related Data–Durex Global Sex Survey<sup>35</sup>

This Survey was conducted in 2005 in 41 countries. More than 371,000 people responded on sexual attitudes and behaviour. Relevant excerpts from the data for India are presented against the global figures for comparison in Annexure 2.

The data shows that the situation regarding sexuality in India in comparison to other countries is somewhat more conservative. For example, age when respondents first received sex education was reported as 15.6 years as against 13.2 years globally. Indian respondents felt that desired age when sex education should start was 13.9 years as against 11.7 years globally. Age at first sex in India was higher at 19.8 years than the global figure of 17.3 years. Number of sexual partners for Indian respondents was 3 compared to the global figure of 9 partners. Only 21% reported having unsafe sex compared to 47% globally. Indian respondents ranked HIV/AIDS as the foremost area needing greater public awareness, followed by syphilis. Almost half the respondents felt that the government should invest in sex education in schools and they felt that the best way to raise awareness of safer sex was by providing teaching materials for schools and health care providers.

The Durex survey highlights that there is a hunger for information and materials related to sexuality in India.

### 3.4 Sexual and Reproductive Health Services

While the rural health structure is well laid out, health services for the urban poor are a problem. Municipal corporations of bigger cities and Municipal councils of smaller towns are supposed to provide public health facilities at all levels but no clear population norms have

been specified till now. Reproductive health services are located within Obstetrics and Gynaecology departments. It is unclear whether adolescent health care comes in Obstetrics and Gynaecology or Paediatrics department. There is no male equivalent of Obstetrics and Gynaecology services. Men can go to the Skin and Venereal Diseases Department, which provides STI services.

At the sub-centers and the primary health centers, there is no provision of RTI/STI services although under the RCH programmes the package of services has been expanded from MCH to RCH. Lack of women doctors, trained female extension workers, privacy for examinations, supplies and equipment defer provision of SRH services at the primary level. Although there are policy discussions to integrate HIV/AIDS with RH services at the sub district level, this has not happened yet.

Suspect quality services are available through the private sector largely through the informal sector – registered medical practitioners (RMPs), quacks and so on. Few Obstetrics and Gynaecology practitioners who are there in rural areas may provide SRH curative services to women. Men generally go to the local general practitioners, or sometimes the STI Specialists / Dermatologists.

Under the RCH II Programme, the Government is encouraging 'Service NGOs' to provide services in difficult areas and to marginalized populations.

### 3.5 Sexuality Counselling

In India, evidence of provision of comprehensive sexuality counselling services is almost non-existent, although from our interviews we realized that different aspects of sexuality counselling are being handled by many different

<sup>35</sup> Durex Global Sex Survey<sup>35</sup> ([www.durex.com/gss](http://www.durex.com/gss)). Available from: URL: <http://www.durex.com/cm/gss2005result.pdf> (Accessed on 21/09/07)



kinds of organisations and perhaps individuals. We attempt to map below the kinds of sexuality 'counselling' services that we have encountered in our work on Sexual and Reproductive Health in India in the last 15 years.

Some amount of sexuality counselling is given by the public health system of the country. National AIDS Control Organisation (NACO) has established Voluntary Testing and Counselling Centers (VCTC), which provide pre, and post-test HIV/AIDS counselling. Many newly set up NGOs also provide HIV/AIDS counselling. There is some adolescence counselling in schools through school counsellors. Psychotherapists handle psycho-sexual issues of people who can pay for their services.

Specialized sexuality counselling is provided to people of different sexual orientation or preference by LGBT support groups like Sangini, which provides counselling to bisexual and lesbian women. NAZ Foundation provides counselling to men who have sex with men and gays. Some of these organisations also run support groups for their primary members. RAHI in Delhi provides counselling to survivors of Child Sexual Abuse (CSA) exclusively. Some organisations provide counselling to sex workers with an objective of disease prevention. Organisations like SNEHI in Delhi provide counselling to adolescents. Organisations like Pariwar Sewa Sansatha provide counselling on RH issues.

There are websites who claim to provide information and counselling on sexuality. Some NGOs like MAMTA in Delhi have web based question and answer service around sexuality.

Infertility centers, mostly private ones, as well as sexologists provide counselling. A few Gynaecologists may provide counselling around anatomy, physiology and functioning of reproductive and sexual organs.

There are many clinics, which claim to 'cure' sex

related problems – many such clinics have mushroomed in and around cities. They spend huge amounts of money on advertising and use large hoardings and public walls to lure susceptible people. And then there are the traditional *hakims* (traditional healers) who dispense potions and oils for men's sexual problems.

The married men's focused group discussion describes their perceptions of the sexuality counselling services.

*Participant 8: ... All these people who sit in their tents, with boards that read 'khandani dawakhana' (family health centre), many people used to go to them earlier..... when there were fewer options, sources of information were few, ... but now-a-days, the media is doing such good work, there are ads on TV, papers etc., All these people with boards claiming 'Khoiee huee shakti wapas payein' ('reclaim lost (sexual) power')..... they used to fleece Rs.500–600 from the guys and give them pills mixed with horse dung.... but now-a-days these things have really declined.*

*Participant 2: Yes they've declined.*

*Participant 8: Earlier, at every red light there used to be one or the other tentwallah. And many boys went there.*

Sexuality 'counselling' resources, if they can be so termed, are differentiated by their target clientele, their approach or world view, their level of training and expertise, their sense of professional ethics, quality standards.

Key Informants feel that there is lack of adequate and quality referral services in India for issues like CSA, lesbianism and so on. A Key Informant points out that good quality sexuality counselling is not only about skills of counselling, a necessary dimension is non-moralistic, non-prejudicial attitude towards sexuality.

*In India I can probably name about 10 people at the most that I would comfortably refer somebody to, a child sexual survivor to.... On top of that [child sexual abuse] if she is a lesbian and on top of that if she is promiscuous, I really don't know where I would send her... So who actually would run a service like this, who is trained to do it? Not many people. You may be a good therapist or a good counsellor with skills of counselling but if your own issues are not sorted out and your prejudices....*

(Female, K 7)

Sexuality counselling can ideally be anchored in different sectors, like Health, Education, Youth Affairs. However, as pointed out by several Key Informants, in the public health sector there are severe shortages of necessary human resources like doctors, auxiliary nurse midwives and it is unimaginable that the public sector would create a specialised cadre of counsellors. The profession of mental health also suffers from serious shortage of trained personnel like psychiatrists and psychologists. The personnel who are there do not seem to have a facilitative perspective on sexuality. A Key Informant who has done seminal work on adolescent sexual and reproductive health through the public sector, spoke of his frustration.

*A Paediatrician in the city of Chennai gets a client, a young boy who says my facial hair is not enough. And this is a very enlightened Paediatrician and he asked him 'Ok do you masturbate, do you have nocturnal emission?' which is good, because sexual behaviours must be enlisted in history taking. But at the end he says, 'if you reduce masturbation, you are spending so much energy there, and then only your hair will grow.' So therefore even with the qualified people we have such myths.'*

(Male, K 9)

**Training for sexuality counselling.** No formal comprehensive sexuality training exists

anywhere in the country. Some NGOs conduct sexuality training pertaining to their own primary issue of concern, for example, RAHI conducts training on Child Sexual Abuse, Naz on sexual issues of Men who have Sex with Men.

Youth Affairs as a sector appears to offer promise for sexuality counselling and training. MAMTA a non-government organisation in collaboration with a Swedish agency has been conducting annual regional courses on Young People's Sexual and Reproductive health issues since the last five years. MAMTA's national SRIJAN network of organisations working on adolescent reproductive and sexual health, has prepared 75 Adolescent Reproductive and Sexual Health trainers in the country.

No official guidelines or protocols exist in the country on sexuality counselling. TARSHI's 'Common Ground' and 'Guidelines for Good Telephone Counselling' can be considered models.

This then is the context within which TARSHI's sexuality counselling Helpline is situated. The context is complex and confusing. On the one hand there appears to be an increasing openness to sexual matters, in and through the media. On the other, there is closing down of spaces and virulent backlashes as patriarchal structures like religion and law and order clamp down on expressions of sexuality. The Health sector in its policies and programmes is beginning to awaken to the urgency of addressing sexual issues but appears not to know how. There is a paucity of services, which can provide good quality sexuality counselling on the scale that is needed. Sexuality counselling education appears to be practically non-existent, at best it is experimental.

The next chapter describes the sexuality counselling service of TARSHI and the feedback received from the Key Informants.

## Chapter 4

# TARSHI: Helpline Service and Feedback

This chapter describes TARSHI's Helpline service in some detail. After a brief history of TARSHI, we describe the impact of the service, how it is managed and organised, the challenges experienced in running a service like this and finally perceptions of Key Informants as well as their feedback and suggestions.

### 4.1 A Brief History of TARSHI<sup>36</sup>

Based in New Delhi, TARSHI (Talking about Reproductive and Sexual Health Issues) began its telephone Helpline (the core of its activities) in February 1996. TARSHI began as an individual fellowship project supported by the MacArthur Foundation. It grew as an organisation to receive support from the Ford Foundation, The MacArthur Foundation, The Packard Foundation and more recently, HIVOS. Over the past 11 years, TARSHI has expanded its activities beyond the Helpline and is recognized as one of the few Organisations in India that addresses issues of sexuality from a rights' perspective. The organisation continues to be supported primarily by grant funds from donor organisations, with some additional money raised from the sale of its books and other publications, sessions conducted in schools, research, etc.

TARSHI is guided by the vision that all people have the right to sexual wellbeing, based on a self-affirming, and enjoyable sexuality. TARSHI's work currently includes two broad programmatic strands: enhancing the quality of Helpline services on issues relating to sexuality; and making a larger positive impact in the realm of sexuality. Since 2004 TARSHI also hosts a South and Southeast Asia Resource Centre on Sexuality that aims to enhance

knowledge and scholarship on sexuality in the region. TARSHI is part of several national networks, for example Voices Against 377, a broad coalition of groups in Delhi working for sexual rights especially of marginalized sexual communities; a telephone Helplines network, a network that TARSHI helped initiate in 1998-99; and Action Plus, a coalition of 15 NGOs that work on HIV and AIDS.

TARSHI operates one phone line as a Helpline from 10 am to 4 pm, three days a week, and provides confidential services in Hindi and English, with guaranteed anonymity. The Helpline service is free, though the calls to it are not toll-free. It is staffed by two trained counsellors who speak with callers about concerns as wide ranging as body image, masturbation, contraception, abortion, HIV/AIDS/STIs and sexual abuse. There is also a programme associate who looks after the documentation and research related to the Helpline and the calls. All TARSHI staff members are paid a salary.

### 4.2 Impact of the Service

Over 59,000 calls have been logged since February 1996. The amount of time devoted to each is flexible and can range from one minute to an hour. The callers are from diverse socio-economic backgrounds and have ranged in age from 10 to 76 years, though the majority is between 15 and 24 years of age. Over one-third of callers call back. The great majority (75 -80%) are Hindi speakers. (See Table 4.1 Profile of Callers for details). As the Helpline is run in Delhi, most callers are from in and around the city, but there are also many callers who have

<sup>36</sup> Adapted from 'HIV/AIDS counselling just a phone call away' TARSHI: Talking about Reproductive and Sexual Health Issues' UNAIDS 2002

migrated from rural areas to the city, yet still have their roots in rural India.

Approximately 82% of Helpline callers are men, despite the fact that the line is meant to be especially for women. Although in India neither

gender has easy access to information, women are more disadvantaged in that regard, yet they bear the greater burden in terms of sexual and reproductive health problems. Devising ways to increase the number of women callers has been an ongoing challenge.

**Table 4.1 Profile of Callers<sup>37</sup>**

<b>Sex break-up of calls received</b>	No of calls from Men 81.9%	No of calls from Women 17.8%	No of calls from Transsexual Transgender Persons 0.3%
<b>Language Used</b>	Only Hindi 69.4%	Only English 19.2%	Both 10.8%
<b>Age of Callers</b>	10 to 76 years <ul style="list-style-type: none"> <li>• 68% less than 30 years old</li> <li>• 42.6% calls from people between 15 and 24 years</li> </ul>		
<b>Marital Status</b>	<ul style="list-style-type: none"> <li>• Single 38.56%</li> <li>• Married 42.87%</li> <li>• Separated/Widowed/Divorced 0.15%</li> <li>• Unknown Marital Status 18.41%</li> <li>• Separated/Widowed/Divorced 0.15%</li> <li>• Unknown Marital Status 18.41%</li> </ul>		

(NB: Based on analysis of 42,888 calls)

Designed to be interactive, non-judgmental and non-threatening, the Helpline offers information that is relevant to the contexts of people's lives, and counselling that explores with callers the pros and cons of particular choices (while never taking from them their own right of choice), as well as referrals to appropriate agencies. The referral network includes private practitioners, government hospitals, therapists and lawyers, as well as HIV counselling,

testing, care and support services, etc. The service organisations are researched to the best of TARSHI's abilities, and site visits are made in an attempt to ensure good-quality service – or at least to know first hand what callers will encounter at a facility. In the case of private doctors and therapists, the organisation tries to select sensitive and non-judgmental professionals, and asks them to reduce their fee for TARSHI clients.

<sup>37</sup> Talking about Sexuality: A report of Preliminary Findings from the TARSHI Helpline, 2007, New Delhi

**Table 4.2: Number of Calls and Counsellors in Each Year on the TARSHI Helpline**

<i>Year</i>	<i>No. of counsellors</i>	<i>No. of calls: Line A</i>	<i>No. of calls: Line B</i>	<i>Total calls</i>
1996	6	8489		8489
1997	3	8752	897	9649
1998	5	5139	6042	11181
1999	7 (transition – old counsellors left and new joined)	1727	3919	5646
2000	4	7599	1736 (transferred calls to Line A)	9335
2001	4	5772	4 (transferred calls to Line A)	5776
2002	5	2941		2941
2003	6	1706		1706
2004	2	790		790
2005	2	1109		1109
2006	2	1033		1033
2007	2	385*		
<b>Total</b>				<b>56,564</b> (as of 26/4/07)

(\* The Helpline had 2 phone lines between 1997 and 2001 and were referred to as Line A and B respectively)

TARSHI has found that people often do not consult experts about a problem because they are unclear about the procedures or techniques that will be used and the cost of the services. Based on the site visits, TARSHI's counsellors offer simple, comprehensive information on what callers can expect if they follow through on a referral. TARSHI's philosophy is that all people are able to make choices, and Helpline information, counselling and referrals can enable them to discover what they want to do. In TARSHI's experience, once callers make a decision, they want to act on it.

Every effort is made to create and preserve a sense of safety for callers. No personal identifying information is requested and care is taken to avoid asking questions that might seem intrusive. No one other than the Helpline staff is allowed into the Helpline room while calls are in progress.

### 4.3 Management and Organisation of the Service

Although no personal identifying information is gathered, the Helpline does document each call and tracks repeat callers using code numbers. The information gathered is used for a variety of purposes. The primary purpose is to provide high quality service and continuity to repeat callers. In addition, callers' concerns and queries have formed the basis of TARSHI's print materials and presentations. Logging the time, day and nature of calls lets staff know when to expect a higher number of certain kinds of calls, and this has helped to set the Helpline hours. For instance, TARSHI does not operate the Helpline on government holidays because very few people call on these days due to the lack of privacy at home. During other periods of infrequent calls (vacation time, school holidays, periods when there is little publicity of the



service), the Helpline remains staffed and counsellors do off-phone tasks while being available to take calls as they come in so as to maximally utilize their time. The documentation also reveals what advertising is effective and how to time promotional campaigns for phased results. The Helpline records are confidential and are kept in a safe place.

The Helpline room is a dedicated room only for receiving calls. Apart from the counsellors, entry to the room is barred to others.

### **Recruitment, Training and Support of Counsellors**

TARSHI counsellors are women with post-graduate degrees in the social sciences; they range in age from 25 to 40 years. The Helpline team and the administrative staff assess new candidates on a number of criteria including sensitivity, openness, awareness of, and comfort in dealing with, issues of sexuality, and fluency in Hindi and English. The hiring of a new counsellor is done collectively by the current counsellors because it is important that the Helpline staff feel comfortable with the new person.

New counsellors undergo 12-14 weeks of intensive training that focuses on imparting factual information and building counselling skills as well as a perspective that is feminist and affirming of sexuality. Counsellors are trained on basic sexual and reproductive anatomy and physiology, pubertal changes, conception, contraception, sexual practices, sexual problems, infertility, STIs, HIV/AIDS and other topics. Gynaecologists, sex therapists, STI specialists and other resource persons with relevant skills conduct this training. Additional training addresses issues relating to sexual and reproductive rights, gender, patriarchy, violence against women, the socio-economic impact of HIV/AIDS, stigma and discrimination, and the rights of people with HIV/AIDS and of other marginalized communities, such as people with disabilities. As a part of their ongoing work,

and continuing even after the formal training period ends, counsellors are encouraged to read about, and analytically discuss, different perspectives on these issues. Because people engage in a wide range of diverse sexual acts, the counsellors must also be familiar with the repertoire of human sexual behaviour and know the terms (including slang) that people use to refer to sexual practices.

The counselling skills' training is done through experiential and interactive role-plays and mock counselling sessions. Counsellors learn to communicate effectively in jargon-free language without preaching or assuming responsibility for callers' decisions. They develop the ability to make referrals in a manner that does not make a caller feel rejected by the Helpline. They also learn to identify and deal with 'crank' and abusive calls politely and firmly, while also making the purpose of the Helpline clear to these callers in case they have a genuine problem that they might wish to discuss.

Because issues of sexuality are complex and intimate, these training sessions often trigger strong reactions, and it is important that counsellors become aware of how they feel about charged issues such as sexual violence, for example. Training exercises are conducted for the counsellors to clarify their personal values so they do not unwittingly impose them on a caller. Counsellors can influence callers not only by what is said but also by how it is said, and they have to be particular in terms of the words and phrases they use. For example, counsellors learn to use the term 'partner' rather than boyfriend, girlfriend, husband or wife. This makes callers feel more comfortable discussing homosexual, premarital or extramarital relationships. Counsellors also receive voice training, recording themselves in mock counselling sessions until they can speak in well-modulated tones.

After trainees become proficient at professionally and sensitively handling mock

calls, they take calls on the Helpline under supervision and are given regular feedback on their skills. After about four weeks, a new counsellor is usually able to respond to calls without supervision. But even when supervision may no longer be needed, support is always available. There are always two counsellors in the Helpline room, and if one is free she is available to assist the other – especially with ‘difficult’ calls such as those about sexual abuse or suicide.

Till 2003 counsellors’ skills and performance were formally evaluated bi-annually by their peers and their supervisor. Informal evaluation (e.g., discussing the day’s calls) is ongoing. After 2003 since there are only two part time counsellors who are experienced, the system of evaluation is more informal and need based.

### Development of Material

TARSHI documents each Helpline call and studies the language callers use to describe their bodies, their sexual experience and partners. This gives the counsellors a unique insight into urban Indian men’s and women’s understanding of sexual behaviour, and the organisation uses this information to support its other services to clients and the larger community. TARSHI also receives calls from transgender people.

From the Helpline experience, it has become clear that, although people need to be able to speak openly about issues related to sexuality, there is also a great need for written material that provides accurate information. The TARSHI books and pamphlets on sexuality have been written in an easy-to-understand and friendly style. Based on analysis of young people’s calls, TARSHI has produced a set of informational books on sexuality in English and Hindi (the Red Book and the Blue Book) that address their specific concerns in an affirmative manner. The books are widely circulated and are being translated into regional languages by

organisations that have found them useful. Other notable publications produced by TARSHI are ‘Common Ground: Principles for Working on Sexuality’, ‘Guidelines for Good Helpline Practice’ and ‘Basics and Beyond: Integrating Sexuality, Sexual and Reproductive Health, a Manual for Trainers’. These and TARSHI’s other publications are developed for specific audiences based on their concerns as revealed on the Helpline. All TARSHI publications affirm people’s right to sexual wellbeing.

TARSHI also makes oral and written presentations on issues of sexuality, reproductive health and HIV/AIDS to professional audiences nationally and internationally. For example, on the basis of the concerns voiced by young people on the Helpline, TARSHI makes a case with schools, other NGOs and the media for providing adolescents with sensitive and accurate information on sexuality and HIV/AIDS.

TARSHI also facilitates the development of training materials for Helpline staff that are specific to the Indian context. Most of the available training curriculum for Helpline counsellors was developed for use in industrialized countries, and they do not necessarily provide responses appropriate for a counsellor to offer to an Indian Caller.

According to the counsellors’ own assessment, strong elements of their counselling are:

- A focus on professionalism, ethics and boundaries
- Counsellors are able to speak on difficult issues in a non-judgmental manner

The results of the good service provided by the Helpline is that TARSHI’s credibility has increased and this is reflected in increasing demand from schools as well as increasing training demands for sexuality training as well as training in counselling skills.

## 4.4 Challenges and Self-reported Problems

### Limitations of Telephone Technology

Due to India's restricted telephone access, the Helpline has timed its hours of operation to correspond with most people's office hours; they find it convenient to call from their workplace if they do not have a phone at home. Restricted access to telephones and/or privacy when making a call can be a challenge to people who need to call the Helpline. In TARSHI's early days, many people in India were still unfamiliar with telephone technology (some callers had to ask someone else to dial the number), and would hesitate to speak to an unfamiliar, faceless person about intimate and important issues. Also, many women cannot call because there may be no telephone in their homes and a public telephone booth may be inaccessible and/or considered an uncomfortable place from which to call a sexuality Helpline. Indeed, long queues at public telephone booths can not only diminish privacy, but can also lead callers to rush through their call instead of asking questions at their leisure. These issues were more pronounced in the early years of the Helpline. With the advent of mobile telephony, access to the Helpline has become a little easier though the social/attitudinal barriers still exist.

If the timing of promotion campaigns is not properly optimized, the Helpline can become flooded with calls in response to ads. Not only are callers who get a busy signal discouraged from calling back, but also those who do get through complain about how difficult it was. Many people have wondered why TARSHI does not use a system of pre-recorded messages to provide accurate and understandable information to individual callers. This would save on human resources and make it possible to respond to a larger number of calls, but speaking one-to-one about sensitive topics and addressing callers' doubts as they arise is far more effective than having them repeatedly

punch buttons and still not find information that is relevant to their concerns.

Another telephone technology that TARSHI has considered and rejected is adoption of a toll-free call-in line. The bureaucratic procedures involved in setting up such a line have deterred TARSHI from seriously considering it. In addition, the cost of making a local call is not very high and is affordable for most of those women who are able to access telephones.

### Increasing the Number of Female Callers

TARSHI's policies are formulated with women in mind, yet less than 20% of the calls are from women, and increasing the number of calls from women remains the greatest challenge. In the first year of operation, the Helpline had men as well as women working as counsellors. However, many female callers would terminate the call upon hearing a male voice. This was probably related to cultural taboos that make it difficult for women to speak to men about intimate issues, especially those relating to sexuality. Men have no comparable problems speaking to female counsellors. Helpline promotion strategies have been specifically geared to reach out to women. Advertisements have been placed in women's magazines, and the text of radio and TV advertising uses the feminine gender (in the Hindi language) and is recorded by women.

Women working at home can learn about the Helpline's existence only if they have access to radio or TV and are tuned in when TARSHI's advertising is on the air. Many women do not have a telephone at home and may not have the freedom to call from an outside box. Indeed, women may find it difficult to decide to call at all, even if a telephone is readily available, for they are socialized to remain silent about their sexuality and to leave all such matters to men.

### Promoting the Helpline

Documenting how callers heard about the



Helpline allows TARSHI to analyse its advertising so it can be done in a phased manner that results in an optimal number of calls over a sustained period, rather than a barrage of calls intermittently. The Helpline has been advertised on a popular FM radio channel, on a local cable TV channel, in a newspaper and in a women's magazine. The phased campaigns on FM radio, in which the advertisement spots were spread out over a period of several weeks, have proven to be the most successful. The time slots were carefully chosen (in the afternoons) to reach as many women and young people as possible. For example, one year, the campaign began with a regular airing of 30-second spots for a week, followed by 10-second spots the following week, and so on. Another year, the spots were gradually decreased over a period of several weeks, which helped get maximum mileage from a limited budget. Interestingly, just learning about the Helpline through advertising may not be a strong enough incentive for many people. Early data indicated that more than one-third callers said that, though they heard about the Helpline through an advertisement, they were motivated to call when a friend recommended that they do so.

### 'Crank'/Abusive Calls

While often rewarding, Helpline counselling can also be stressful. 'Crank' and abusive calls can increase counsellors' stress and lead to burnout. Such calls are an occupational hazard on any Helpline, but are all the more so when issues of sexuality is the topic. Because Indian men are not used to open discussion on these topics, some of them assume that a woman who talks about them is sexually available. Counsellors are trained to handle such calls by describing the Helpline's purpose and emphasizing that it is not a chat line, sex line or a party line offering sexual services.

Some 10-15% of calls fall into the 'crank' / abusive category, and counsellors give Callers the benefit of the doubt (though at the cost of feeling abused by 'borderliners' when they are

not sure if the call is genuine). These are callers who seem 'genuine' at first and appear to want information and counselling for their problems, but who, well into the conversation, begin to get sexually aroused and/or ask for details of the counsellor's sex life or make her sexual propositions. The counsellors are trained to judge when to terminate the call. On terminating, they suggest that the caller call back when able to concentrate on the conversation and not misuse the Helpline. These calls take a toll. As one counsellor put it, *'Cranks and the out and out abusive calls are easy to handle; it's the 'borderliners' that are the worst'*.

### Minimizing Staff Turnover

Helpline work is emotionally taxing, and stress builds up from difficult-to-handle calls as well as from the boredom of dealing with monotonously repetitive calls. Stress can lead to burnout, which can have a negative impact on service quality and can lead to high rates of staff turnover. Keeping the lines of communication open, building strong staff relationships and encouraging counsellors to participate in activities such as workshops and conferences that involve meeting others in related fields and sharing experiences can all help prevent burnout. Counsellors and their supervisor discuss calls (including their emotional responses) and give feedback on an ongoing basis. This interchange helps both to evaluate the service and to prevent burnout.

Even though TARSHI was aware of the dangers of burnout and has had some of these prevention activities in place from the beginning, it has lost a couple of counsellors to burnout over the past 11 years. But burnout-related turnover has not been very high, and this is an encouraging indication that TARSHI's activities to prevent it have been successful.

### Data Collection

Empowered decisions about sexual and reproductive health do not happen in a vacuum

but within the complex context of people's lives. For this reason, information alone, no matter how good, is not sufficient to empower wise choices. Those who look to provide accurate information and to influence people's sexual practices need to know not only who does/uses what, but also why, how, when, for what purpose and to what effect.

Unfortunately, there is a lack of systematic research and documentation on sexual practices and preferences. This stems largely from methodological constraints on eliciting deeply personal and intimate details while, at the same time, ensuring confidentiality and maintaining the dignity of the respondents. Nonetheless, qualitative data that may be meaningfully interpreted and, most importantly, applied in the designing and implementing of programmes are essential.

#### Evaluating the Programme's Effectiveness

It is very difficult to directly track the effectiveness of a Helpline service. Numbers of incoming calls can be purely a function of effective advertising and are not an indicator of the quality of the Helpline service. The fact that it is difficult for Helplines to directly follow up on callers is a consequence of ensuring that callers remain anonymous; thus there is no way to call them up and follow up with them. There is no way to assess the impact of the Helpline on callers' risk-taking/health seeking behaviour or to determine if referrals were followed up on and if callers received satisfying, good-quality service. The lack of direct follow-up also prevents counsellors from knowing the results of their work.

Evaluating the impact of the Helpline is therefore based on indirect inferences from the calls, especially those from repeat callers. Reliable indicators of good Helpline service can be found in the number of repeat callers, whether their current concerns or questions indicate that they understood the information

they received during previous calls, whether their sexual behaviour or their feelings about it have changed, and whether new callers were urged by their (satisfied) friends to call in.

For example, frequent callers often move from wanting basic information on sexuality to discussing more complex issues. Over a number of calls, they may move from wanting to know about the sexual transmission of HIV to asking questions about safer sex and how they can have safe, yet pleasurable sex. From the documentation of their calls, TARSHI has been able to track the positive changes they make in the lives of callers. For example, young men report delaying penetrative sex, masturbating instead of visiting sex workers and adopting other less risky sexual practices.

Another challenge facing TARSHI is lack of funding available for running the service. Counsellors have had to be reduced and therefore number of days and hours of the service have been reduced.

#### 4.5 Feedback from Respondents

TARSHI enjoys tremendous goodwill and respect amongst many of the respondents interviewed. People who know TARSHI closely i.e. past counsellors, donors, organisations, specialists and service providers to whom TARSHI refers callers, and organisations who refer their clients to TARSHI, perceive TARSHI as a resource organisation, an organisation that has brought visibility to sexuality issues. TARSHI is perceived to be the best in the field and TARSHI's counsellors have the reputation of being experts.

*It is one of the finest and effective institutions working on sexuality and has contributed so significantly to putting sexuality on the agenda.*

(Female, K 4)

*...overall feeling about TARSHI counsellors is that they are very professional and they are good at what they do.*

(Female, K 3)

*In the 80s and 90s there was such a dearth of unbiased space where you could call up, for any kind of information on sexuality. TARSHI is a fabulous space.*

(Female, K 1)

*Usually if I were to need that [sexuality related] information, I would call up TARSHI and ask them. For me they are my resource in such matters. When I run in to such things or when I read an article, and I think oh wow! How does that come about or where is that coming from then I expect TARSHI to be the expert in this and for them to be able to give me information.*

(Female, T 3)

## Strengths of TARSHI

TARSHI's strengths as perceived by the respondents are:

- Conceptual understanding of sexuality, its multi-dimensional and cross-cutting nature
- Experience in sexuality counselling
- High standards adhered to for quality sexuality counselling
- Meticulous documentation of all calls
- A good referral system highlighting costs, timings and contact details
- Wealth of rich data on sexuality issues in India
- Excellent burnout prevention systems
- Excellent training on sexuality and sexuality counselling
- Useful publications

The quotes given below highlight the points listed above:

*TARSHI covers much broader issues on sexuality like homosexuality. Our organisation's counsellors refer callers when they find the call intimidating and feel that TARSHI counsellors will be more comfortable in handling it. Questions like, 'how to do sex?'*

(Female, K 2)

*They have been providing sexuality counselling since a long time, they have become experts. They know what they are doing, this is strength.*

(Female, K 3)

*TARSHI does not have casual approach towards training. P and G have lots of experience and ability and they have a good perspective. ... Counsellors must have certain expertise, Helpline also needs certain level of skill building and I respect TARSHI for that. They have G on board and she is very good. They are not casual in their approach, is what I want to say.*

(Female, K 6)

*TARSHI has a very good capacity building and growth mechanism in place so training was excellent, I had one and half months of training, R is an excellent trainer, fortunately, I had a lot of chance to interact with her. They had put a mechanism in place where after the calls, we used to discuss about the calls, so it enhanced our understanding of taking calls or any follow up mechanism on a particular call. It actually helped me because I could link those calls to larger issues. It helped me grow. I have grown tremendously in TARSHI. Their training on conceptual issues is great which is not the case with other organisations. I have worked with many organisations, I think that I am very fortunate that I worked in TARSHI, my training was very good and it is helping me till now.*

(Female, PC 2)

*They would be somebody I would tap for training on how to run a Helpline in general and perhaps what are some of the issues that come up in a sexuality related Helpline... what would be the issues that come up in terms of crank calls and how do they handle it.*

(Female, K 7)

*I have worked for a few organisations and I have not seen as good burnout prevention mechanisms as TARSHI'S.*

(Female, PC 2)

*I would hand out TARSHI's booklet which people have been able to use very effectively, in different ways because this is one of the sensitive areas.*

(Female, T 3)

### Some Concerns and Expectations

Major concerns expressed by a few respondents are that TARSHI limits itself by not reaching out to different constituencies. This was echoed by the persons in the government whom we interviewed. They were either not aware of TARSHI and its contribution to the field of sexuality or they had very vague and unclear idea of their activities.

*TARSHI works within a small network of 'known' people thus limits itself... they don't interact very much with people beyond their small close networks, that also with people who have a same type of attitude... They are good enough [to hold their own amongst diverse constituencies] and don't need to do it ['it' referring to the small close networks]. I respect their work.*

(Female, K 5)

Respondents expressed that TARSHI could play a more strategic role in the future.

*TARSHI should take advantage of putting counselling on the agenda, training a greater number, training school teachers.*

*I think just putting up those books is not enough. ... keep telling them that they have to do books that are sold in the market, sold in bookshops. It cannot be exclusively for the NGO community. You have to mainstream sexuality and work on sexuality, and that's the broader agenda.*

*I think the amount of resources and time that is going in to investing in a few elite middle-class young women is not... I mean I'm not seeing the impact on the grassroots... even on NGOs I am not seeing a multiplying effect. ... I think they should straightaway train trainers in doing counselling, rather than train people to have better perception and perspective on sexuality.*

(Female, K 5)

*I think they must advertise more because the need is definitely there and I don't see very much... I suppose advertising also costs money but I don't know how you can do that, I don't know if they do it in colleges and schools or anything. Even a small visiting card like thing, and.... can be distributed because children do want to know. I have two adolescents at home and I know they think that I know everything and more than my children their friends come to me and I also don't have all the time all the answers but I am always able to put them in touch or try to refer them to material or websites or people or something. And stress.... I don't know if that's too much for asking to integrate...*

(Female, K 15)

A government officer highlighted what could be an opportunity for TARSHI,

*There is a need to integrate sexuality counselling in to policy. The NGOs who are running these Helplines should try to work with government. They should become technical resource agency.*

(Male, K 11)

Yet another old friend and supporter of TARSHI suggested possible strategic interventions by TARSHI like the following:

*.... [there is such a] lack of trained professionals in India. They should work with the Pune University, [or other] Universities, which have social work courses, and develop the curriculum and develop the module and first train the teachers.*

(Female, K 4)

*There can be ways in which that data can actually feed in to advocating the policy changes and broad basing the outreach.*

(Female, K 6)

There was concern expressed about the sustainability of the Helpline, a concern that TARSHI is very preoccupied with too.

*It is an important service and to sustain it, TARSHI should look out for another ways of supporting it. The data should be analysed in a strategic way. One has to be strategic in how to bring out a publication. If one is targeting the government then one has to put*

*it in to HIV jacket. Lack of strategic thinking to sustain the Helpline is the biggest challenge of TARSHI. This is my big concern.*

(Female, K 5)

And then there were other suggestions for TARSHI to increase advertising about the Helpline service, to use its rich data more to disseminate lessons learnt, generally to share their insights and experiences more frequently and more widely. A universal and unanimous demand was that they should increase the hours and days of the telephone Helpline.

In conclusion, TARSHI is widely appreciated and recognised for its contribution to the field of sexuality in India. There are expectations that it play a more strategic leadership role, get into policy advocacy on sexuality issues and become a resource organisation for government ministries having even an indirect sexuality agenda, for example, the Ministry of Youth Affairs, which should address young peoples' sexuality related issues through its programmes, or the Education Ministry which is being affected by the right wing conservative forces to stall attempts at introducing sexuality education.



## Chapter 5

# Contents of Sexuality Counselling

This chapter draws from TARSHI's own internal documentation as well as interviews with the past counsellors, current counsellors, managers as well as feedback received from the repeat callers (both internet as well as telephone interviews).

### TARSHI's Documentation

Over the years TARSHI has analysed the calls received. The categories of issues presented by the callers are as follows:

- General information related to sexuality
- Sexual problems
- Conception and contraception
- Infections including HIV
- Menstrual problems
- Relationship problems
- Infertility
- Emotional problems
- General health
- Abuse

*General information related to sexuality* refers to callers' questions on the body, anatomy, physiology, size and shape of genitals, and so on. *Infection* includes concerns about sores, rash, unusual discharge, symptoms of and fear of infections involving the genitals, and concerns about HIV/AIDS. *Sexual Problems* have to do with impairment in sexual functioning (lack of desire, 'performance', orgasm) and include erectile and ejaculatory problems. *Conception and*

*contraception* include questions about how to conceive and how to prevent conception, as well as concerns about emergency contraception and abortion. *Abuse* refers to concerns about any coercive sexual activity. Here it must be clarified that callers do not always conceptualize their concerns in terms of abuse; the conceptualization is TARSHI's based on an understanding of coercion as being central to abuse. *Relationship* problems most commonly include concerns about callers' intimate relationships (wife doesn't love me any more, parents opposing marriage, and so on). *Menstrual problems* have to do with irregular periods, pain during menstruation, etc. *Emotional problems* are categorized separately from relationship problems because these focus more on the callers own feelings of depression or loneliness for example, rather than on the issue of a troubled relationship/s.

The table below gives an analysis of the **first concern** presented by callers. These may not be their only concern and frequently it is also not their most pressing concern. It is only as the call progresses that they go on to talk of what may be troubling them the most. This is also borne out by the range of issues presented by the callers who gave their feedback in the course of this study, as well as the analysis of the records described elsewhere in the report.

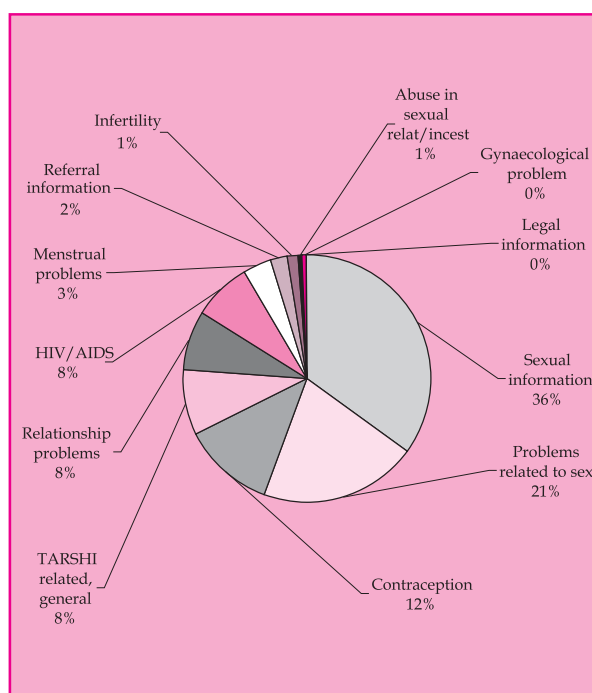
The table shows that more than a third of the callers called with the first question related to information about sex, and one fifth of the callers called about a problem related to sex and sexuality.



**Table 5.1: Analysis of First Concern Presented**

The major category of the query	Frequency	Percent
General sexuality information	15371	35.02%
Problems related to sex	9028	20.57%
Contraception	5276	12.02%
About the TARSHI service	3668	8.36%
Relationship problems	3485	7.94%
HIV / AIDS	3440	7.84%
Menstrual problems	1517	3.46%
Referral information	1047	2.39%
Infertility	562	1.28%
Abuse in sexual relations / incest	275	0.63%
Gynaecological problem	184	0.42%
Legal information	35	0.08%
<b>Total</b>	<b>43888</b>	<b>100</b>

**Diagram 5.1: First Questions asked by Callers on the TARSHI Helpline**



**Table 5.2 Sex Differentials in First Concerns of Callers**

	Sex of Caller		Sex Unknown	Total		
	Male No.	Female (%)				
General sexuality information	13924	(38.76)	1400	(17.95)	47	15371
Problems related to sex	8487	(23.62)	515	(6.60)	26	9028
Contraception	3466	(9.65)	1792	(22.98)	18	5276
About the TARSHI service	3039	(8.46)	603	(7.73)	26	3668
Relationship problems	1789	(4.98)	1672	(21.44)	24	3485
HIV / AIDS	2937	(8.18)	493	(6.32)	10	3440
Menstrual problems	717	(1.99)	796	(10.21)	4	1517
Referral information	827	(2.30)	214	(2.74)	6	1047
Infertility	420	(1.17)	141	(1.81)	1	562
Abuse in sexual relationship / incest	215	(0.60)	57	(0.73)	3	275
Gynaecological problem	87	(0.24)	95	(1.22)	2	184
Legal information	15	(0.04)	20	(0.26)	0	35
<b>Total</b>	<b>35923</b>	<b>(100)</b>	<b>7798</b>	<b>(100)</b>	<b>167</b>	<b>43888</b>

It is interesting to note that there are differences in the issues of men and women. While men's questions are related to General Sexuality

Information and Problems related to Sex, women's questions are around Contraception and Relationship Problems.

A recent analysis done by TARSHI<sup>38</sup> shows the following:

- The maximum number of calls is received from people between 20 and 24 years and has to do with General Sexuality Related Information. (35.4% calls received from this age group for sexuality related information). This reflects a lack of knowledge and a curiosity for sexuality information in this age group.
- People younger (15-19 year olds – 20%) and older than this age group (25-29 year olds – 20.8%) are also asking for Sexuality Related Information.
- People who are between the ages of 25 and 29 years are the second highest age group of Callers (25.3%) overall.
- Sexual Problems top the list for those between 25-29 years (36.2% calls received for Sexual Problems are from 25-29 year old people).
- People younger and older than this age group also have concerns related to Sexual Problems. (27% of calls on sexual problems are from 20-24 year olds and 11.5% are from 30-34 year olds).
- Contraception related information is also one of the highest concerns for people between 20-24 years (35.1%) and 25-29 year old (32%).

### Issues of Four Repeat Callers Interviewed

The issues and problems which motivated the respondents to seek the help of TARSHI's Helpline were diverse. Some were immediate concerns. For example, a respondent called the Helpline in a state of panic when he had sex with a sex worker and was very confused about whether he had contracted HIV. Sexual dysfunctions like lack of erection and reduction

in the quantum of discharge and subsequent lack of satisfaction were other issues, which prompted respondents to seek help.

Callers approach TARSHI's Helpline for those sexuality issues for which they feel there are no formal spaces. To quote a respondent:

*'I wasn't sure of my sexual identity. But this I think was only a part of it. I didn't know who I was, what I was. I didn't know who to go to. I am not afraid of the larger society, I was afraid that my close friends would shun me. I was afraid of losing my loved ones. I was very unsure of myself.'*

(Female, RK 5)

Callers approach the Helpline at different stages of their lives and for issues that emerged in these stages. A male respondent stated that he had used the Helpline twice. He made his first call to know about the precautions that need to be taken while engaging in sex during pregnancy. He approached the Helpline again when the baby was delivered and the couple needed to know about the precautions while engaging in sex in the post-partum period.

### Internet Feedback from Three Callers

Specific concerns like conception and general information about sex were the issues for which respondents sought the services of Helpline. In response to a question on what made him/her call the Helpline a caller wrote:

*'The curiosity about sex and related problems and some myths about sex.'*

(TR 9)

### Counselling Needs Emerging from Callers' Cards

As mentioned in Chapter 2, 11 callers' records were retrieved based on certain inclusion

<sup>38</sup> *Talking about Sexuality: A report of Preliminary Findings from the TARSHI Helpline, 2007, New Delhi*

criteria described in that chapter. Issues that each caller spoke about over the multiple calls are summarised below to give an idea of the information and counselling needs of a group of frequent callers. The counselling provided by TARSHI counsellors is discussed in Chapter 6.

*Caller 1, Female, 27 years, more than 13 calls over two years.*

Does not enjoy sex, asked where exactly penetration took place, does not experience pleasure, does not want pregnancy, and does not like children, wanted information about infertility tests, had a leg pain, wanted information on aromatherapy, reported blood in husband's semen, felt bad that at her age did not experience pleasure in sex.

*Caller 2, Female, 25 years, more than 27 calls over three years.*

Relationships with husband and boyfriend, wanted child from both, felt suicidal, experience of child sexual abuse, fight with the boyfriend and depressed about it, wanted to make a film on children and HIV/AIDS and wanted information which could help, missed boyfriend and still wanted a child by him, 'casual' sex and self-loathing, 'overpowering sexual needs', not sure whether she 'loves' her husband, likes a 22 year old man but feels that it is 'child molestation' and she is his boss, had sex with boyfriend and second orgasm in six years, cannot relate with mother, abortion after sex with a third person and grief, 'respects' husband but does not enjoy sex with him.

*Caller 3, Female, 18 years, 15 calls over four months.*

Feelings around lesbianism, relationship with older woman, wants to be with girlfriend all the time, 'wrong to feel sexual?' She feels that 'the counsellor is the only person that she can talk to.'

*Caller 4, Female/Male 30 years, ten calls.*

Wanted a sex change surgery from female to male, looks and feels like a man, has a girlfriend

who does not know that he does not have a penis, told girlfriend the truth and she was angry that he deceived her for two years. Information was given by the counsellor about doctor for phalloplasty. There is a family problem and he wants to support brother but doesn't know how. After a break-up with girlfriend, he got back with her again, told her that surgeries were done when they actually would be done next week. He did not want to tell her the truth because he wanted to 'protect her'. Later, s/he told girlfriend the truth. The girlfriend wants them to marry soon, but he wants to wait, because he is not yet ready for sex. In a later call, he says that he got engaged to another 'trans' and inquired about legality of marriage between transsexuals. He wants his fiancée to undergo facial surgery to look feminine, also wanted information on prosthetics for wife.

*Caller 5, Male, 44 years, seven calls in one month.*

Called about erectile problems that he has been having since the last two years. Earlier information provided by the Helpline had not helped. His wife suggested that he have sex with someone else since he got aroused by a woman in the bus. He wanted to know whether to have paid sex. He also wanted information of a doctor. The doctor that he was referred to did not respond well. The counsellor apologized for the inconvenience caused.

*Caller 6, Male with disability, 28 years, seven calls in two months.*

He hasn't been able to find a partner / get married because of his disability. Is frustrated. Wants to know where he could meet women with disabilities. Cannot focus on anything other than sex. Information on masturbation given. Friend suggested sex with a call girl. He wants to know how to use a condom. He had sex with a call girl six times and wants to know whether that is okay.

*Caller 7, Male, 19 years, ten calls in three months.*

He called in November 2002 because of ragging

in college. He looks feminine, is treated like a girl, and feels bad. He also likes dressing like a girl. He is developing fat on thighs, went for a check up. Estrogen is 39% and the doctor said that if it increases to 49%, he would need a sex change operation. Ragging continues in college. He was sent to the girls' hostel again. His mother gets him girls' clothes. The counsellor explored options of sex change, what would it be like to live as a girl. He wanted to know about the legal formalities around name change. He called again in 2003 and reported on breast implantation and jaw surgery.

*Caller 8, Male, 33 years, called five times in three months about premature ejaculation.*

Information given on erectile dysfunction, after play so that wife gets satisfied and he feels less pressure to perform. 'No Indian wife will allow all these things' referring to oral sex, mutual masturbation, and sexual pleasure without penetration that the counsellor was informing him about. Disagreed with every suggestion. Two weeks' yoga has given some improvement. Reported '5 – 7%' improvement.

*Caller 9, Male, 32 years, 12 calls in five months.*

Called because married for 15 days but his marriage was not yet consummated – wife was not allowing penetration. Was given information on foreplay. Called again to say did it, we were successful with foreplay. Wife was bleeding and in pain. Next few calls were also on problems in penetration, pain in erection. Called about contraception. Rejected condoms, information on pills given. Condoms burst; will it lead to any problems? Later calls asked for information on MTP. Asked about wife's growing / changing breast size. Wife pregnant, he is panicking, wants information on capsules and medicines. Asks if he should see a local doctor who also does 'Kaam', MTP. Asks if it's okay to have sex now.

*Caller 10, Male, 26 years, six calls in one year.*

Premature ejaculation in spite of trying

masturbation before intercourse for a month. In the next call wants to know how to recognize female orgasm. Wife is not satisfied, he has premature ejaculation. Next call he has a different question – a few days ago he had sex three times after three and a half years, third time he had neither proper erection, nor ejaculation and no erection since then. He went to a 'local sex specialist-type doctor' who advised potions worth Rs. 1500 for three months and told him he is 'not man enough'. Asked if conception could occur with woman in top position and with withdrawal method. Is oral sex and anal sex with female partner okay? Wanted information on temporary and permanent methods of contraception?

*Caller 11, Female 38 years, called five times in one year and had called in the previous year also.*

She is a woman with multiple partners. She uses emergency contraceptives every time after sex because partner does not use condoms. She is in a relationship with a 28 year old man for two years, the relationship is strained since six months. Now a surgeon is 'very keen' on her. She does not want pregnancy. She wants to stay with boyfriend but knows that the relationship is not going anywhere. She wants to marry him only, because he is the only 'non-alcoholic' that she knows. Describes symptoms – her own and her partner's – wants to know whether these could be STIs? What tests are required? What precautions are necessary while having sex? Bleeding and spotting on a weekly basis, what should she do?

### Issues and Needs Emerging from the Focused Group Discussions

The five FGDs with proxy users brought out that the participants had the following issues:

- Curiosity about sex, information related to sex
- Menstruation related concerns
- Problems of inter spousal communication related to sex

- Reproductive health problems: white discharge, abortion
- Sexual abuse/unwanted pregnancy
- Sexual problems: premature ejaculation, erectile problems
- Bodily changes while growing up
- Gender identity, unhappiness at being a girl
- 'First night' related problems
- Contraception
- 'While men have spaces for asking sexuality related questions, women have none'

Excerpts from women's FGD show that women wanted information on the body, sexual relationships, desire. They also pointed to the need for safe spaces for women to access such information. Given below some quotes from the women's FGD.

*Facilitator* – Do you have other questions in your mind, which you think you want to take more information and want to know more about, for which you are not getting the space to talk about?

*G* – We would like to know about a lot of things.

*K* – We also would want to know about husband wife relationship.

*AN* – How our body functions?

*RA* – Yes what is good for our body and what is not good.

*G* – Now we have half-baked information that is not proper.

*K* – When husband and wife have sex, husband gets satisfied (orgasm) and wife does not get satisfied then we ...

*RA* – We need information on it.  
(Some participants laughed)

*K* – It is not discussed even between husband and wife.

*W* – No we never discuss this with our husbands.

*AN* – Yes things related to white discharge. In some people there is a lot of discharge. Some people think that discharge never stops and it always stays wet.

(Some participants laughed)

*AN* – If we ask someone they will say that white discharge is normal. As the tongue stays wet, similarly that place also stays wet.

*Facilitator* – Anything else you can think off, you want information about, and the information that you did not get from other places?

*D* – From the time I got married I never felt like.... I used to think that I could live without my husband. But from now, since a week and a month I am feeling like....

(Some participants laughed)

*D* – I want more information on it.

*Facilitator* – I could not get you? Please don't laugh.

*D* – From the time I got married, I have got two children, and I have never felt the need to be with my husband ...whether I stayed at my mother's place or elsewhere.

*D* – But for now, since one month I felt strange sensations in my body.

*AN* – Now that (sex) thing should happen. So you need your husband now (laughed). It happens with age.

*Facilitator* – All right. So these things you can't discuss with others... did you ever discuss it with your husband?

*D* – I can discuss it with my sister-in-law.

The married men expressed their need for sexuality counselling as follows:

*Participant 7*: Sir the biggest reason for this is that in our country they've made a 'big deal' out of sex. People are not properly given knowledge about sex.



People are shy to talk about it. Be it ladies, men, teenagers, everyone. But now things are changing..... Like we see in the European societies, there sex is no big deal. We have not seen any such cases there.

**Participant 2:** In the west there are abortion centres in front of every school because girls as young as 14 years get pregnant.

**Participant 2:** ... that [sexuality counselling] is most definitely needed. And we should be able to talk about sex openly. So there should be counselling and advice without any hesitation. Here, many people don't even share with their friends. They are even more tense. Therefore there should be open counselling on this.

The adolescent boys had the following questions:

RS: we would like to get more and more information. I would like to know how can I satisfy my woman and how can I myself perform better....

... There are this young boy and a girl they were having physical relationship. The girl is only 17 years old. They used to meet every now and then but the sex was so much on their mind that they had to do it every time they met. But they didn't have proper information. The boy thought that if ejaculated outside vagina then she will be safe but they were having sex frequently and now the girl is five months pregnant and her parents are filing a case against the boy. Now this is legally also wrong. So the point is that they didn't have proper information on how to have sex.

So I mean to say that they don't have proper information. There is lack of information. Now this girl doesn't know that this pregnancy can cause her many problems as her body is not ready for this as yet. It can cause weakness; anemia or she can even die. Sex is not bad but it's important to see that lack of information can lead where.

R: Can one have sex during menstruation?

RS: You said earlier that women get discharged (have orgasms) four times; tell me how I can make her discharge four times.

RS: There is another question sir. There are many people who have sex without thinking through properly. So they should be told about emergency contraceptives. Because young boys and girls have sex, of course with consent, but don't know about contraception and then girl becomes pregnant. There are some emergency contraception pills that are taken before sex, this information should be provided.

RS: Whether too much sex is good or bad for body?

R6: What is premature ejaculation? What effects do medicines have on premature ejaculation?

## Conclusion

The nature of issues that people want information on or counselling for, emerging from this study indicates that most of the questions arise from a lack of a very basic information about one's bodies, sex and sexuality, reproductive and sexual health (including menstruation and contraception). People do not have access to basic accurate information about sexuality and their bodies even though these are issues that all human beings grapple with at different points in their lives. Some other questions are related to misconceptions and beliefs related to sexuality, many of which are related to the social construction of male sexuality. The information that they have is usually incomplete or inaccurate as the sources of information appear to be 'blue films', misinformed friends, or Internet sites. And finally there are issues related to relationships, including sexual relationships and lack of communication between partners.



## Chapter 6

# Quality of Sexuality Counselling

This chapter contains an assessment of the quality of sexuality counselling provided by TARSHI's telephone Helpline. Different sets of data were examined to make an assessment of the quality. This chapter draws from:

- A study of selected records of repeat callers
- Feedback received from callers
- Interviews with counsellors and manager
- Analysis of the Peer Assessment system followed by TARSHI

### 6.1 Analysis of Records of Selected Repeat Callers

The purpose of this study was to assess quality of sexuality counselling provided by the TARSHI Helpline.

#### Methodology

- Records of those callers who had called for at least 5 times in the span of one calendar year, about sexual health concerns are analysed for this study. We decided on at least 5 calls in one calendar year per caller, as an inclusion criteria because this would give us a long enough caller-counsellor interaction to assess the quality of counselling provided.
- Two calendar years were selected to retrieve the records. Year 2002 was selected because the TARSHI Helpline had a maximum number of counsellors (6) in this year. Calls from 2005 and 2006 were chosen to look at most recent records. 11 callers fulfilled the inclusion criteria. Their records show that these callers can be termed as 'special' callers, needing a higher level of counselling skills. Documentation of each call contained in the 'Long Register' and the 'cards' as mentioned in

Chapter 4 on TARSHI, for each of the selected callers was compiled.

- Quality of sexuality counselling provided was assessed according to the framework specified for the present study, viz.

#### WHO – KIT Framework on Quality of Sexuality Counselling

- Confidentiality
- Privacy
- Choice
- Time / Duration
- Language
- Attitude of Provider
- Sex of Provider
- Age of Provider
- Information
- Interpersonal Communication
- Referral

Additional criteria that reflected quality of Sexuality Counselling were also noted:

#### Adapted Framework to Assess Quality of Sexuality Counselling

- Specific sexuality issues addressed
- Evidence of privacy and confidentiality
- Details of Information provided
- Details of Referrals made
- Validation: giving permission,
- Exploring and Probing
- Listening
- Woman centeredness
- Other aspects of quality counselling: not making decisions for client, managing dependence, evaluating own counselling etc.

### Introductory Observations

Four of the repeat callers were women 18 to 25 years; seven were men 19 to 44 years old. Sources of information about the TARSHI Helpline were not recorded consistently. The callers whose records mentioned the source had received information or referrals from:

- Referrals by another Helpline, psychologist or an unnamed friend
- Yellow Pages
- Justdial.com

Number of calls made by each caller range from 7 to 27. Interval between calls for each Caller ranges from same day to 11 days (Caller 9) to one day to eight months (Caller 2).

### Issues of Each Caller

The issues that each caller spoke about over the multiple calls are given in Chapter 5. They are summarised here with the counsellors' responses in brief.

*Caller 1, Female 27 years, more than 13 calls over two years.*

Does not enjoy sex, asked where exactly penetration took place, does not experience pleasure, does not want pregnancy, and does not like children, wanted information about infertility tests, had a leg pain, wanted information on aromatherapy, reported blood in husband's semen, felt bad that at her age did not experience pleasure in sex.

The counsellor explores with her reasons for not enjoying sex, gives information on the genitals, infertility tests, reasons for pain in the vagina. She refers her to a gynaecologist and a doctor for osteoporosis.

*Caller 2, Female, 25 years, more than 27 calls over three years.*

Relationships with husband and boyfriend, wanted child from both, felt suicidal, experience of child sexual abuse, fight with the boyfriend

and depressed about it, wanted to make a film on children and HIV/AIDS and wanted information which could help, missed boyfriend and still wanted a child by him, 'casual' sex and self loathing, 'overpowering sexual needs', not sure whether she 'loves' her husband, likes a 22 year old man but feels that it is 'child molestation' and she is his boss, had sex with boyfriend and second orgasm in six years, cannot relate with mother, abortion after sex with a third person and grief, 'respects' husband but does not enjoy sex with him.

Counsellor gives information on ways to avoid infection, on possible collaborators for the film that she wants to make, she reassures her on several occasions, validates her feelings.

*Caller 3, Female, 18 years, 15 calls over four months.*

Feelings around lesbianism, relationship with older woman, wants to be with girlfriend all the time, 'wrong to feel sexual?' She feels that 'the counsellor is the only person that she can talk to.'

Counsellor has to manage the boundaries of this relationship. Caller appears to get dependent on the counsellor.

*Caller 4, Female/Male, 30 years, ten calls.*

Wanted a sex change surgery from female to male, looks and feels like a man, has a girlfriend who does not know that s/he does not have a penis, told girlfriend the truth and she was angry that s/he deceived her for two years. Information was given by the counsellor about doctor for phalloplasty. There is a family problem and s/he wants to support brother but doesn't know how. After a break with girlfriend, he got back with her again, told her that surgeries were done when they actually would be done next week. He did not want to tell her the truth because he wanted to 'protect her'. Later, s/he told girlfriend the truth. The girlfriend wants them to marry soon, but he wants to wait, because he is not yet ready for

sex. In a later call, he says that he got engaged to another 'trans' and inquired about legality of marriage between transsexuals. He wants his fiancée to undergo facial surgery to look feminine, also wanted information on prosthetics for wife.

Counsellor has to do woman-centered counselling.

*Caller 5, Male 44 years seven calls in one month.*

Called about erectile problems that he has been having since the last two years. Earlier information provided by the Helpline had not helped. His wife suggested that he have sex with someone else since he got aroused by a woman in the bus. He wanted to know whether to have paid sex. He also wanted information of a doctor. The doctor that he was referred to did not respond well. The counsellor apologized for the inconvenience caused.

Counsellor has to let him decide whether to have paid sex or not. Most of the remarks by counsellor are regarding validation, information given and referral. The counsellor also refers him to a book *Joy of Sex* by Alex Comfort that can help him to have more pleasurable sex.

*Caller 6, Male with disability 28 years seven calls in two months.*

He hasn't been able to find a partner/get married because of his disability. Is frustrated. Wants to know where he could meet women with disabilities. Cannot focus on anything other than sex. Information on masturbation given. Friend suggested sex with a call girl. He wants to know how to use a condom. He had sex with a call girl six times and wants to know whether that is okay.

Counsellor gives him information on marriage related/matchmaking websites. The caller was suggested to try masturbation and fantasy and referred to a website for networking with other disabled people, on masturbation and how to have safe sex.

*Caller 7, Male 19 years. Ten calls in three months.*

He called because of ragging in college. He looks feminine, is treated like a girl, and feels bad. He also likes dressing like a girl. He is developing fat on thighs, went for a check up. Estrogen is 39% and the doctor said that if it increases to 49%, he would need a sex change operation. Ragging continues in college. He was sent to the girls' hostel again. His mother gets him girls' clothes. The counsellor explored options of sex change, what would it be like to live as a girl. He wanted to know about the legal formalities around name change. He called again in 2003 and reported on breast implantation and jaw surgery.

Counsellor does a lot of validating around cross-dressing.

*Caller 8, Male 33 years. Called five times in three months about premature ejaculation.*

Information given on erectile dysfunction, after play so that wife gets satisfied and he feels less pressure to perform. 'No Indian wife will allow all these things' referring to oral sex, mutual masturbation, and sexual pleasure without penetration that the counsellor was informing him about. Disagreed with every suggestion. Two weeks' yoga has given. Reported '5 – 7%' improvement.

Counsellor warns against 'desi ilaaj' (traditional remedies), dependency and other scams.

*Caller 9, Male 32 years. 12 calls in five months.*

Called because married for 15 days but his marriage was not yet consummated – wife was not allowing penetration. Was given information on foreplay. Called again to say did it, we were successful with foreplay. Wife was bleeding and in pain. Next few calls were also on problems in penetration, pain in erection. Called about contraception. Rejected condoms, information on pills given. Condoms burst; will it lead to any problems? Later calls asked for information on MTP. Asked about wife's

growing / changing breast size. Wife pregnant, he is panicking, wants information on capsules and medicines'. Asks if he should see a local doctor who also does 'Kaam', MTP. Asks if it's okay to have sex now.

Counsellor does a lot of confronting because the caller hears only what he wants to!

*Caller 10, Male 26 years. Six calls in one year.*

Premature ejaculation in spite of trying masturbation before intercourse for a month. In the next call wants to know how to recognize female orgasm. Wife is not satisfied, he has premature ejaculation. Next call he has a different question – a few days ago he had sex three times after three and a half years, third time he had neither proper erection, nor ejaculation and no erection since then. He went to a 'local sex-specialist type doctor' who advised potions worth Rs. 1500 for three months and told him he is 'not man enough'. Asked if conception could occur with a woman-on-top position and with withdrawal method. Is oral sex and anal sex with female partner okay? Wanted information on temporary and permanent methods of contraception?

Counsellor gives information on masturbation before intercourse. Same advice is repeated in subsequent calls because the Caller keeps saying the same things. Information is given on oral and anal sex and on contraception. He is referred to a doctor if he has no erection for four or five days.

*Caller 11, Female 38 years. Called five times in one year and had called in the previous year also.*

She is a woman with multiple partners. She uses emergency contraceptives every time after sex because partner does not use condoms. She is in a relationship with a 28 year old man for two years, the relationship is strained since six months. Now a surgeon is 'very keen' on her. She does not want pregnancy. She wants to stay with boyfriend but knows that the relationship

is not going anywhere. She wants to marry him only, because he is the only 'non-alcoholic' that she knows. Describes symptoms – her own and her partner's – wants to know whether these could be STIs? What tests are required? What precautions are necessary while having sex? Bleeding and spotting on a weekly basis, what should she do?

Counsellor gives her information, probes at several points and refers her to a gynaecologist.

### Analysis of Quality of Sexuality Counselling

**Evidence of privacy and confidentiality:** Privacy and confidentiality of the client is maintained. All references to any identifying information were deleted before these records were handed to the researchers (E.g. Therapist's name, NGO activist's name, Counsellors' names, Hospitals' names, clients' friends' names). Callers are either given code numbers or references like 'Man from a South Delhi Colony', then the serial number from the registers are used.

**Information given:** The notes show evidence of information being given to the Callers on their needs. Callers are asked to call back if the counsellor does not have ready information.

The information provided ranges from:

- Infertility tests, anatomy of genitals reasons of pain in vagina, contraception and condom usage, and fertility (Caller mentioned it but counsellor/s do not have expertise to give information on these)
- Risk of condom usage just before ejaculation
- Masturbation, relevance of social-networking websites, consent and safety
- Foreplay, digital penetration
- Various choices / preference at different times, sex change operation would mean hormonal changes leading to emotional and psychological changes

- Erectile dysfunction and side effect of BP medicine, after play
- Pain on penetration, foreplay and negotiation, contraceptive pills, the fact that MTP is not a contraceptive
- Emergency contraceptive pills
- Symptoms of STIs

Callers were also asked to call back later for information that the counsellors did not have the information at that time. The commitment of the counsellors to follow up and seek the information can be taken as a marker of a high quality of the counselling service,

*(A 27-year-old married woman) (25/04/02): Went to gynaecologist and has been asked to get some tests done for infertility. Caller wants to know about the tests. Said that all gynaecologists she has been to are insensitive. Pressure to have a child is increasing. Situations for her either ways is bad. Wants to avoid going to doctors for tests.*

*(25/04/02): Called back to give names of tests – Hyftro, DFM, FHF, LH.*

**Remark:** Suggest she call on Monday for more information.

*(30/04/02): Wanted to know about the tests. Will call tomorrow. Told her to check on net.*

*(06/05/02): About tests? Information given. Will it be painful? Information given.*

The Key Informant interviews reinforce that TARSHI counsellors aspire to give correct information, repeat the information to make sure that the client has heard it and then check back with the caller to assess whether the caller will act on the information provided. Additionally, as a past counsellor pointed out that information provided was not value free. The counsellors interwove gender and rights' perspectives into the information provided.

*Information related to body, anatomy, functioning, information on whole range of issues related to sex, positions, things related to relationship, sexual orientation, general feelings and thoughts about sex, fantasies, actual act. Some of the information was plain some of it was interlinked with gender, relationships, mental health and so on. Lots of rights (not those given in Conventions) and legal issues also used to come up.*

(Female, PC 1)

This past counsellor also states that while respecting the right of the male caller to information, they also had to bring to his attention the human rights of his partner.

*To decide how much, of what information to give and to whom was particularly difficult for us. Especially with male callers who kept asking on behalf of their female partners. We used to give them the information and also invariably used to bring in the issue of consent but we never knew what happened after that.*

(Female, PC 1)

**Referrals made:** The notes also reveal evidence about referrals being made. In one instance, the caller had complaints about the referral service and the counsellor apologised for the inconvenience caused. The referrals made were to: Gynaecologist; doctor; internet for various issues like sites for disabled people, prosthetics for penile implants and so on; organisations for CSA, HIV/AIDS etc.

### Counselling Process and Skills

The 11 callers' records indicate that the same caller was handled by two or more counsellors and efforts were made to ensure the continuity of the counselling. Counsellors referred to the notes on the previous calls to carry forward the process.

*(A 32-year old married man) (9/8/06)*

*Caller is unsure about who he spoke to last.*



*Information on our system given. Once again reminded to give appropriate information to find records or last call.*

**Caller 9 (A 32-year-old married man) (4/9/06)**

Caller giving reference of last calls. Found first call (caller remembers only this date) and subsequent discussion thereof.

**Remark:** *Caller most impressed with our detailed notes, says, 'kamaal kar deeya aapney (what a great thing you do!) Do you really keep so many things in notes?'*

The documentation on these 11 callers mentions at several places 'Discussed' and 'Counselled' Clarifying the use of these different terminologies, counsellors of TARSHI Helpline said that they use 'discussed' to denote exchanges with callers that do not include dealing with feelings.

**(A 27-year-old married woman)**

*Caller started talking about her past – parents, relationship with husband, boyfriend. Talked of how her mother nags her etc. Said over a week ago, she has developed indifference, a space she needs for herself, where no one bothers her. **Discussed.** Asked if she is feeling better having taken a stand, having developed an attitude of 'who cares, after always succumbing to her need for acceptance. Caller said yes. **Discussed.** Explored attitudinal differences and coping patterns.*

'**Counselled**' is used as a short form in the documentation for exploring feelings and options, help the caller to ventilate feelings, and come to a decision. For example, Caller 2, a 25 year old woman, was counselled as follows on 2.8.2002 and then again on 6.8.2002.

*Very depressed. Misses boyfriend. Called him 3 days ago but is not ready to meet him. Has a severe backache. Feels that her life is 'hopeless'. Ayurvedic doctor has said she has*

*thyroid and allopathic doctor said it was normal. Believes that her weight gain is related to thyroid. Information given. Is very lonely and unable to do anything. Cancelled appointment with therapist because of back problem. Wants to stop feeling low but unable to do so. **Counselled.***

*Met a senior professional and there was a lot of sexual chemistry between them. The business meeting got extended and they spent an evening talking. Caller feels aroused and wants to have sex. However feels that casual sex is becoming a habit. Blames it on sexual dissatisfaction with husband and boyfriend. Not attracted to husband and with boyfriend is too stressed to enjoy sex. Never gets an orgasm. In casual relationships, she loses interest and there is self-loathing. Would like to have a consistent, sexually gratifying relationship with husband or outside marriage. Guilty that she is not turned on by her husband. Feels sexually frustrated. **Counselled.***

'**Validation**' is a term used by the counsellors for acknowledging that the caller's feelings and thoughts are valid. There is evidence of validation of the callers by the counsellors in the notes. In a couple of cases, the callers have actually remarked that speaking to the counsellor makes them feel validated.

**Caller 1, Female, 27-year-old.**

*Married for 2 months. Sex not enjoyable. Had heard a lot about sex being very exciting but it has turned out to be a damp squib. She has no complaints about husband and mother-in-law (family now). But has a lot of anxiety regarding getting pregnant. Does not want to have a child. Said if she becomes pregnant, she is going to get an abortion done for which she will probably have to fight with her family. Husband uses condom now. But it has burst 4 times. Wanted to know where exactly penetration takes place. Information given on genitals. Suggested place mirror between legs*



*and try observing various parts. Also told that many women not familiar with their bodies. Validated fear of pregnancy.*

For example Caller 2, a 25-year-old woman had been calling the Helpline since 2000. She had a complex relationship with her loving husband and a boyfriend after a history of 'numerous extramarital affairs'. At one point in her 22<sup>nd</sup> call, the record states:

*'Has visited her mother in the morning and is feeling disturbed. Cannot relate to her mother and has started ill-treating her by ignoring her. Mother is in a pitiful situation but Caller is unable to feel sympathy because mother played a major role in spoiling her life, her sister's and brother's lives. Sister had a love marriage that is unsatisfying. Both of them got married to escape from their home. Both were not 'happy kids' and in their adult lives are depressed and restless. Caller feels hollow and gets depressed about her future. She thinks a lot and wonders if others think too – **validated feelings**. Said she feels validated when she speaks to counsellor.'*

The 24<sup>th</sup> call three weeks later states:

*'Wants to get out of the 'search mode' that is stop looking for someone she can love. Wants to control and restrict herself to her husband. Her sexual needs are overpowering. Are other people like that? Has a friend who doesn't want to have sex. **Validated feelings and counselled.***

Caller 3, an 18 year old, woman who was calling the Helpline around her feelings around lesbianism in her 11<sup>th</sup> call states:

*'Counsellor is the only person she can talk to. Cannot speak to partner about her feelings.'*

Caller 4, a 19-year-old male called 10 times in three months about issues around identity; he liked to cross dress but stated that he was not gay and was attracted to girls.

*'Used to dress like a girl in 5/6<sup>th</sup> Std. and looked cute then. Is able to understand how girls feel in the society. Said that he 'is not firm' in his mind. Sometimes feel comfortable when in girl's clothes, gets due attention. **Validated.***

**Helping Callers explore their issues.** There is evidence of helping callers explore their issues:

Caller 9, a 32-year-old man called first time after his 15-day-old marriage, which was not consummated. His wife was not allowing penetration.

***On probing** found wife is young (24) and seemingly scared – very resistant to penetration. Detailed information on pain discomfort and also gave information on taking it easy, slower in the beginning. Caller agitated; so much as saying, 'ek baar bas ho jaye' (let it happen just once). Much information shared and examples given. Validated frustration of caller and fears of wife. Introduced to foreplay and negotiation. Repeatedly gave 'no force' messages. Caller seems to calm down, now asking questions on foreplay, (calling it 'phone play') Gave information on how to encourage sex and initiatives in sex etc.*

Another example is from Caller 4's record.

*'During ragging socks were stuffed in his chest to appear like breasts. Found it 'ok' said he likes girls. **Explored.** Said would like to marry a girl but it would be difficult if he starts dressing like a girl himself. Validated.'*

Caller 1 was married for two months and did not enjoy sex. The counsellor:

*'Went over all possible causes of her not enjoying sex. Fear of pregnancy seemed to be the overwhelming factor. Said she enjoys hugging and kissing. Doesn't like smooching and intercourse.'*

### Other Evidence of Good Quality Sexuality Counselling

**Woman-centered counselling:** By woman-centered we mean counselling even to men that promotes a respect for his woman partner, for sensitivity to her needs and desires. Several instances of woman-centeredness are revealed in the documentation. These can also be considered as examples of sexuality counselling based on a rights' framework.

Caller 6, a 30-year-old, female to male transgender person who was considering sex change surgery. An example of woman-centered counselling is reflected in his records.

*'We discussed at length the reasons for not being able to tell girlfriend the truth. He is not sure of the relationship – wants to tread cautiously. Though he first said he wants to protect girlfriend from anxiety. He also agreed he is protecting himself too by not telling her the truth. He is confident that he will be able to mollify her later when he tells her (after surgery).....'*

**... Remark:** *Very focussed about surgery. Up-beat about career and girlfriend. Not able to look at things from girlfriend's point of view – that she has the right to know the truth and not be 'protected' for example.'*

*(Caller 6) (9/9/03): Going in for surgery tomorrow. Has told his girlfriend the 'truth' – i.e. he is undergoing surgery (not Bangalore as he had planned to tell her earlier). He was depressed for a while and felt he shouldn't hide anything from her so 'gathered courage' and told her that his surgery is to 'remove female parts' which are of no use and could become cancerous. She was upset and told him he shouldn't hide anything from her and he said to her that he had 'overestimated your reactions and underestimated our love'. He feels R is 'very broadminded'. She tells him 'I've loved you not your flesh'.*

*He took girlfriend to meet [gynaecologist] who*

*used words like hysterectomy and vagina, which embarrassed the caller, but girlfriend was ok. 'She took it very positively'. Caller sounded happy...*

3 years after the above call, this caller also wanted his fiancée to look more 'feminine' and was persuading her to undergo facial surgery. The counsellor pointed out to her/him the controlling and coercive aspect of this demand. He was objectifying his fiancée and not allowing her to be the person she is.

*...Spoke of fiancée. Wants her to undergo facial surgery to look more feminine. Discussed importance of letting her decide and accepting her for herself. Counselling.*

Another caller named Caller 8 (Male, 33 years) called about erectile problems. Once again while addressing his right to sexual pleasure, the wife's sexual pleasure was also taken into consideration. He was:

*'Given information on afterplay so that wife gets satisfied and he feels less pressure to perform'.*

By focusing on 'he feels less pressure to perform'. Social construction of masculinity and male sexuality was also addressed.

Caller 9 was told not to regard MTP as a contraceptive and not to take his wife to any backstreet abortionist. Information was given about safe abortion services where quality of care was assured. Records of Caller 9 (Male, 32 years) state:

*'...Then caller asking for information on MTP reminded MTP is not a contraceptive'*

A month later he calls again. The record states:

*'Seems wife probably pregnant. LMP [should actually be 'next period'] due on 11th Nov. Caller panicking. Information on MTP given a number of times...Now asking if should see*

*a local doctor who also does 'kaam' i.e. MTP. Urged Caller to access only reliable service and not any 'quack'. Well known abortion centre and reproductive health Helpline recommended'*

**(21/11//06)**

*Wife's MTP done. Caller again repeats that he is working on our 'salaah', [advice] including the force he has used on his wife initially – confronted and clarified that this has never been our advice. Caller now clarifying and defending. Now clarified information on contraception, positive and negatives of both given. Caller full of remorse and says will use a condom. Sounding low, reason as no sex for 8 – 10 days, he says. Information given and closed call.*

**Confronting.** In the interest of women, the Helpline counsellors also confront the male Callers appropriately. The records of Man from a South Delhi colony provide one such example of appropriate confrontation.

*'Caller seems agitated. Very angry and agitated. Married 15 days and not consummated. Wife not allowing penetration. On probing found wife is young (24) and seemingly scared – very resistant to penetration. Detailed information on pain discomfort and also gave information on taking it easy, slower in the beginning. Caller agitated; so much as saying, 'ek baar bas ho jaye' ('If only once it can happen'). Much information shared and examples given. Validated frustration of caller and fears of wife. Introduced to foreplay and negotiation. Repeatedly gave 'no force' messages. Caller seems to calm down, now asking questions on foreplay, (calling it 'phone play') Gave information on how to encourage sex and initiatives in sex etc.*

**Caller 9 (1/08/06)**

*Yesterday's caller. Full of happiness. 'Did it, we were successful'. Says spent a lot of time*

*on foreplay. And when she was very relaxed – penetrated. Wife bleeding and in pain.*

**Remark:** *Caller seems so happy, is not listening to anything. She was almost 'unconscious', for about half an hour or so. Second time spent a lot of time on her and she too, 'enjoyed'. Caller not ready to hear a word about pain for her. Tried innumerable times, too happy with, 'I really enjoyed'. Also convinced that she must have also liked it. Ultimately had to confront. Pushing in was and is **not** our advice, ever. This one sided pleasure also not equal or fair. Caller to ensure her consent, Caller not listening.*

*Recommend taking a step back if she is in pain or discomfort – says, 'Please don't say this'.*

**No decisions taken.** At several places in the records, it appears as though the callers desperately want the counsellor to decide for them. There is evidence of the counsellors not taking decisions for the clients. For example Caller 9, (Male, 44 years) called about erectile problems.

*... Said a few days back while getting down from a bus, a woman pressed herself against him, which gave him an instant thrill and an erection that lasted only a minute. He felt good about erection. Validated.*

*... (2/1/03): told his wife about his reaction to woman in the bus. Wife then said maybe he should go and have sex with someone else. This got the Caller thinking. He wanted our advice on whether or not to go and have paid sex. Asked him to think of pros and cons. He said the only 'negative' he can think of is infection. The 'positive' he would know only after having had sex as to whether he was successful or not. Helped him think of other pros and cons. Also suggested he take time before deciding. Finally said, 'main nahi jaoonga' ('I won't go') in a dejected way.*

Caller 5 (Male, 28 years) is a person living with

disability. He too wanted the counsellor to give him permission to go to a sex worker. The records indicate that the counsellor gives information on consent and safety and leaves decision making to him.

*(Caller 5) (21/3/05): Has a disability because of which he hasn't been able to find a partner/get married. Is frustrated and unable to concentrate on work.*

*(25/4/05): Is sexually frustrated. When he gets aroused, he pours cold water over himself. Is this OK? Information on masturbation given.*

*(26/4/05): Said friend has suggested solution to his sexual frustration – sex with a call girl. Is this OK? Information on condom use given. He asked if it was right to do this. Information on importance of consent and safety given.*

**Managing dependence and establishing boundaries.** Counsellors find themselves in tricky situations at times. There are signs of the callers becoming dependent on the counsellors or showing too much personal interest in them. The counsellors are challenged to find ways of keeping the relationship professional.

*Caller 2: Said she loves talking to counsellor and wants to see her. Wants to look at her once. And then seven months later, Remark: Asked if counsellor got bored with her call or if counsellor thought about the caller after disconnecting. Explained.*

*Caller 3's fifth call had the following note: Remark: Call was not going in any direction. Caller was using 'counsellor' as a friend – suggested she call back after reflection.*

Caller 4 calling about sex change information and process in one of the later calls:

*Asked if the counsellor would be his friend later as well and whether the organisation*

*would be there. Counsellor told him that he could call whenever he had any concerns to talk about, and suggested that he could think about the conversation and call later.*

Caller 10, Male, 26 years old called repeatedly about premature ejaculation. His third call had the following notation. The counsellor repeats the earlier advice, explains that perhaps she has helped all that she can.

*Same query, wife not satisfied, premature ejaculation. Rejects all counsel. 'No, but' for any information. Masturbation is forced, no erection thereafter. Wife seems progressive – is agreeable to take initiative. What about sharing this information (masturbation etc) with her to 'reduce annoyance'. Relationship issue important. Explained. Same advice repeated. Caller keeps saying the same thing. Says will call us, explained only if need be; reminded perhaps we have helped all we could.*

**Communication:** There are mentions of 'listened to Caller' or 'reassured'.

The counsellor listens to Caller 1 who hates children and refers her to a gynaecologist.

*Caller spoke of her dislike of sex, which she sees as a 'baby-producing' activity. Finds it very painful. Hates children whom she sees as an unnecessary responsibility. Never wanted children. Couldn't say why. Had earlier thought that if after marriage she is forced to consider having children, she will commit suicide, as there didn't seem any other option. Appears to have changed her mind about suicide, not about children. Listened and Ref: Gynaecologist for contraceptive advice also.*

The communication with Caller 7 combines various aspects of listening and reassuring, exploring, validating, giving information and counselling.

*While growing up, in school was made to play the roles of girls in functions, did not feel bad*



*about it then, was fine, some other boys were also doing that. But now he feels very odd. Did not go out much at that time, was too busy in studies and said that perhaps Oestrogen was being produced in the body at that time and so did not feel like going out. Went to doctor last year when he told his parents that he did not have body hair. Repeatedly said had problems of his own and then ragging in hostel added to them. Tensed about medication also, should not develop breasts, with medication it will take six years for hormone level to stabilize. Counsellor **validated** caller's feelings, gave **Information** on cross dressing, abusive and coercive activities not acceptable, reassured that in adolescence many people do not feel like socialising. **Explored options** of informing professors/sympathetic seniors at the university. Had to terminate the call as went beyond Helpline time, gave him Information that he could call later.*

### Evidence of Value of the Helpline for the Caller

The records mention at several places that callers feel validated or satisfied with the services offered by the TARSHI Helpline. Caller 2's record states:

*'Said she feels validated when she speaks to counsellor.'*

Caller 3's record demonstrates the value of the Helpline for her:

***Inference:** Caller used the Helpline as a space where she could share experiences and feel happy. Unable to express fears, desires, thrills, excitement with anyone else*

- *Counsellor will give TARSHI information (that it is not a chat line) to caller if she calls repeatedly with the same concerns*
- *Said she liked speaking to counsellor*

*(22/10/02): Wanted to talk. Has never spoken to anybody about her relationship.*

### Self-Evaluation of the Quality of Counselling Provided

There is evidence that the TARSHI counsellors reflected on their interactions with the callers. This kind of self-evaluation is seen in the following record when the counsellor writes '*not handled very well, could have terminated earlier*'.

#### **Caller 11 (Female, 38 years (12/04/06))**

*Caller talks non-stop. Huge Emotional issues. Loss from all sides. Repeated earlier conversation and found back to (S.No \_\_\_\_\_) and subsequently (S.Nos. \_\_\_\_\_).*

***Remark:** Caller goes on and on. Tried hard to refer on, caller not interested. Keeps changing her stand. Finally confronted with TARSHI's role and caller immediately changes track to contraception issues. Reminded our first conversation also on same issues. Rapidly made references, caller rejects all. Re-stressed and then terminated call.*

*Not handled call very well, could have terminated earlier.*

## 6.2 Feedback from Callers

This section summarises what the callers interviewed (4) as well as those who responded to the Internet questionnaire had to say about the quality of counselling received on the TARSHI Helpline.

### Experience of Calling the Helpline

The experience of all telephone callers who responded to the invitation to give telephonic feedback was good and this was clearly reflected in their responses. Given the fact that there is an absolute dearth of experts on sexuality counselling, perhaps one of the important reasons of callers' positive experience could be the space that was being made available to them to discuss their sexual problems and the anonymity the Helpline offered. To quote a respondent:

*'The experience of calling TARSHI was good. It is not possible to discuss sexual problems*

*openly. The anonymity offered by the Helpline is excellent. In our society there is a drawback that we cannot go for consultation to any consultant. Especially in small towns this is very difficult'.*

(Male, RK 1)

For a female caller the good experience has manifested in her desire 'to give back to the Helpline.'

### Usefulness

It was evident from the replies of all the respondents that calling the Helpline proved very useful to them. All the respondents got the information and counselling on issues for which they approached the Helpline. The callers also judge the usefulness of calling the Helpline by the immediate gains they have from talking to the counsellor. To quote a respondent:

*'The call helped me to sort out my confusion. I was very tense the past 2-3 days. Talking on the Helpline has helped me to be calm; I am now happy and relaxed. I can now work better. I just want to tell you that this is a very good Organisation'.*

(Male, RK 3)

It is also evident from the Internet responses that the issues with which the callers call the Helpline correspond to the information, which they eventually get from the counsellor. A respondent sought the Helpline service to get information on 'most appropriate time to conceive'. And later he indicated that he got information on conception/contraception/infertility and marriage.

A respondent had general concerns i.e. curiosity about sex, sexual problems and myths related to sex, got information on sexual relationship, marriage, sexual pleasure, unwanted pregnancy/abortion and general counselling.

One Internet respondent stated that he was referred to another Helpline and was given its

contact and other details (timing) etc. Out of the other two respondents, one indicated that he was not referred – he pointed out he did not think that he needed to be referred – and other said that he didn't remember if he was referred.

One Internet respondent indicated that the counsellor did review with him his immediate plans and intentions. Out of the other two one didn't respond to the question and other one said he didn't remember if it was done.

### Getting Answers

It is apparent from the responses that callers received answers to their queries from the counsellors or if not, they were referred to some specialist who satisfactorily answered their queries. And this fact has resulted in an increased level of information and conscious efforts to solve the problem on the part of respondent. To quote a respondent:

*'I was told that semen discharge decreases with age. Reduced satisfaction or lack of erection could be due to a lack of novelty. We could do different things to break the monotony, change the position, change the room and use pornography'.*

(Male, RK 1, 53 years)

### Counsellor's Ability to Understand

Two of the four respondents clearly stated that the counsellors who attended them were able to understand their problems and based on this knowledge; one caller stated that she was referred to a suitable specialist.

*'The counsellor had a grasp of the subject. I felt that she had thorough knowledge of my issues'.*

(Male, RK 1)

### Non-judgmental Attitude

All the callers felt that they were treated in a non-judgmental way by the counsellor and this according to some of them gave them courage to come out of their circumstances and be



confident to call back again for new queries. To quote a respondent:

*'No, I did not feel that she was judging me at all. Actually she was helping me to resolve my confusion'.*

(Male, RK 3)

### Comfort Level

Respondents gave some very positive reactions on being asked if they felt comfortable while talking to the counsellor. They also mentioned some probable reasons on why they were comfortable. Talking on the phone was one of the reasons that was mentioned. Other was the fact that no personal details were asked during the counselling. It was also due to counsellor's conscious effort to make the caller comfortable. One respondent stated that:

*'Since I was talking to a lady, initially I was not comfortable. But she helped me to open up. And soon I was quite comfortable. She helped me a lot. If you ask me on a scale of 1 to 10 how comfortable I felt, I would rate it at 10 on 10'.*

(Male, RK 3)

The Internet respondents indicated that the counsellor to whom they spoke to, encouraged them to express their feelings and concerns during the conversation. The counsellor listened to them attentively during the call. All the respondents felt that the counsellor, whom they spoke to, completely understood their dilemmas and needs and made them feel highly validated. All the respondents said that the counsellor used words that they easily understood. The respondents were of the opinion that the counsellor used a very kind and warm tone during the calls and they were able to discuss the issues, which were troubling them. They indicated that they were given time by the counsellor to process the information and respond to it. Out of the three responses received, two respondents indicated that the counsellor allowed them to ask for clarification

about information given. One respondent said that he did not remember whether he was given such a chance or not. One respondent pointed that the counsellor did not repeat and reinforce important information during counselling. The other two respondents said that vital information was repeated and emphasized by the counsellors. All the respondents indicated that during the calls the counsellor summarized the main issues discussed.

### Referring Others

Three of four respondents had referred this service or intended to do so to people they know.

### Calling Again

Three of the four respondents stated that they had called the Helpline more than once, but at the same time it was evident that they stop calling once their problem gets solved or if they are referred to a specialist. The response also showed that respondents use the Helpline services at different stages of their lives. As mentioned above, one male respondent first called to know about the precautions needed while engaging in sex during pregnancy and later on he called to know about the precautions that should be taken while engaging in sex in post delivery phase.

### Reported Outcomes of Counselling

Reduction in fear and tension and sorting out of confusions were some of the immediate effects of talking to the counsellor, as described by three of the four callers. And for one male caller it helped him in getting relaxed and subsequently increased his work performance. Apart from this, two respondents reported increased levels of confidence, courage, morale and information. For a respondent, the Helpline counselling has triggered off the process of conscious thinking about herself/himself. It prompted her/him to make plans for his/her life.

### Confidentiality

All the respondents indicated that they were

very sure that their information would not be shared by the counsellors with anyone else.

### 6.3 Feedback from Key Informants

While most Key Informants were not able to give specific feedback on the quality of sexuality counselling provided by the TARSHI Helpline, their general sense is that TARSHI's counselling is of the highest order. This impression is based on TARSHI's published papers, books and presentations. The feedback of the trainers and past counsellors was more informed because of their closer association with the Helpline. Nine of the 25 key informants invariably mentioned confidentiality as one of the important factors of providing good counselling services. To quote a respondent who has been closely associated with TARSHI in the capacity of a trainer:

*The confidentiality practiced is of the highest order. I do not have access to any information on Helpline documentation unless they choose to give it. No particular calls are discussed unless to give examples. Generalization is done based on the data and the patterns shared. 'We got this call' I have not even been allowed into the counselling room. I'm amazed by this, listening to calls has never been allowed.*

(Female, K 1)

K 1 also highlighted the rights based approach of the Helpline.

*This is a very unique service in Delhi, it is non-judgmental, did not ask questions, confidential and rights based.*

(Female, K 1)

A person who frequently referred individuals to the TARSHI Helpline had the following to say:

*I had people getting back to me saying thank you so much but it's too personal to ask more than that. I have only said I hope they were helpful and they've said yes.*

(Female, K 15)

### 6.4 Peer Assessment System

Each counsellor first filled her own assessment forms and then she received feedback from her peers. The scores from all team members were compiled on a single sheet. This sheet was then the basis of the Performance Assessment feedback interview with the manager. The focal person did not know how individual team members rated her, thus maintaining confidentiality.

Performance assessments were done twice a year, in July and December of each year. The December ones were linked to salary raises. At the end of the training of new counsellors, they were oriented to the Assessment Proforma. It encapsulated what was required of them as exemplary sexuality Helpline counsellors. It was used as a tool to focus their learnings from the training into practice.

The experience with this system was that (i) it worked best when used on peers and not when the experience and seniority gap is too wide. (ii) it tended to get tedious when there was a large group of counsellors (six) and when it was done twice a year. (iii) the scores could begin good discussion of aspects that counsellors needed to improve.

For the purpose of this study, we selected all the Performance Assessment forms for four counsellors (out of a total of 10) who had worked longest on the Helpline. Mean scores on each dimension were calculated and compared for the first and the last appraisal.

Annexure 3 shows that the scores of the counsellors have improved over subsequent evaluations. Only the few boxes highlighted show the scores that have not improved. From the improvement in the counsellor's scores, we can conclude that the peer review system has contributed to ensuring the high quality of counselling provided by the Helpline.

## Conclusion

TARSHI's sexuality counselling is very high quality. This is triangulated by an analysis of the records of callers, Callers' feedback and feedback of key informants. TARSHI practices counselling as it should be done – not advising or directing but exploring options, helping callers to think of pros and cons of all decisions. The counsellors cover a wide range of issues ranging from sexuality of disabled persons, persons with multiple sexual partners, transgender persons. All these issues require a

high level of non-judgmentalism and freedom from personal biases. This is reflected in the records maintained by TARSHI. TARSHI counsellors demonstrate the ability to confront difficult callers. This chapter also indicates that the concept of quality of sexuality counselling needs to be expanded to incorporate how to deal with crank calls, how to manage boundaries and how to do a rights' based, women-centered sexuality counselling.

## Chapter 7

# Outcomes of Sexuality Counselling

This chapter begins by discussing the possible outcomes of sexuality counselling suggested by key informants. The results of TARSHI's sexuality counselling as gleaned from the callers' feedback and the analysis of callers' records are examined. And finally certain programmatic outcomes are discussed.

### Possible Outcomes of Good Quality Sexuality Counselling

Many key informants – mainly managers of the Helpline and the trainers of the counsellors – felt that good sexuality counselling leads to demystification of matters related to sex and sexuality. People are better informed about their bodies, and their sexual and reproductive health. Sexuality counselling leads to persons becoming more comfortable about their own bodies and their own sexuality. A manager counsellor at TARSHI from her experience of ten years at the Helpline states:

*Counselling helps people to make choices, clear clouds of confusion, 'should I have sex?' Helps Callers figure out their comfort zones, clarify their own confusions, e.g. attraction to same sex and other issues that is painful and confusing. Action follows after this kind of clarification of confusion. So counselling helps people feel good about themselves.*

(Female, MC 1)

They are able to resolve issues around their own sexuality. For example, they stop feeling guilty about being gay, or stop thinking that 'they needed to be cured'. They feel validated if they believe that sex should be for pleasure and not just for procreation. One of the trainers of the Helpline counsellors feels that sexuality counselling:

*...[increases the feeling of] being in charge of one's life and one's sexual life.*

(Female, T 3)

She stated that people are more open to talking about sexuality. There is greater ease in using language to name sexual organs, in dispelling their own myths and doubts related to sexuality. There is reduction in social stigma and shame related to sexuality.

Relationships improve. People receiving sexuality counselling are able to better negotiate with partners, have better, more pleasurable and 'fun' sex. Gender sensitiveness increases. Another manager of the TARSHI Helpline recounts the results of sexuality counselling that she has encountered.

*Men becoming more sensitive about sex, to women's bodies and their rights.[In situations of] arranged marriage and sex on the first night [being able to] delay sexual activities.....men saying thanks.....*

(Female, M 2)

Another trainer of the Helpline counsellors said that sexuality counselling could be expected to give certain results although they are methodologically difficult to track in telephone counselling. She feels that the attitudinal changes after sexuality counselling would be reflected in behaviour changes. People would take greater responsibility for their sexual actions. There would be reduction in risky sexual behaviours. People would practice safer sex.

*Sexuality counselling should at least make a person rethink an act e.g. If it is a coercive act being able to look at issues of coercion, violation and pleasure.*

(Female, T 1)

Help seeking would increase. People would know where they can go for specialised help, for example, for premature ejaculation, or for

treating sexually transmitted diseases, or for accessing safe abortion services, or for sexual abuse.

The ultimate outcome of sexuality counselling according to some respondents is better sexual health: lesser unwanted pregnancies, better spacing, use of contraceptives, lesser sexually transmitted infections and so on.

K7 summarises the outcomes of sexuality counselling as follows:

*... becoming more comfortable with your own sexuality, whether it's heterosexuality or homosexuality. In most cases of non-heterosexuality, let's say, being very much better informed in matters related to sex, sexual health and reproductive health for both men and women even young people.*

*Then again I am very hesitant somehow to put sexual abuse and violence related to sexuality under sexuality counselling. But if referral is a part of sexuality counselling, then issues related to sexual abuse would be addressed, so (there would be) people with more information on what to do, how to do, how to handle sexual abuse related issues, where to go for help, more specialized help, that kind of a thing.*

*People having safer sex, people having access to safe abortion,*

*People becoming more open actually in talking about sexuality, in some way removing shame, stigma, related to sexuality in our culture.*

*Perhaps people growing up into talking... negotiating better with their partners, people getting in to relationships and marriages with more information about what they like, having better sex, having more pleasurable and fun sex,*

*... seeking medical help if required, let's say if it's a premature ejaculation issue, coming*

*from low self esteem or is it a medical issue. If they are informed they would be able to seek help. Either the sexuality counselling centre itself should have a medical staff or wherever they may refer to. So... better sort of streamlined, medical sort of issues or that kind of stuff ...because a lot of sex related stuff can have a medical... Things like... I am sure sexuality related counselling includes things like sex change, looking for sex change operations, giving correct accurate information that would stop malpractice or let's say ... inform people enough so that they don't get in to something, that could actually be harmful. Again abortion is an example ... Going for sex change operation without actually thinking over it and thinking everything would be alright... sort of having this romantic notion. So not getting in to slightly risky and of course risky sexual behaviour, sexual abuse ... all that would reduce. These could be the outcomes.*

*May be not having too many kids or spacing kids out. If you are looking at contraception, all that is part of it. And really addressing STDs and other problems that women have, on time, so to have a better sexual health.*

(Female, K 7)

## Outcomes of Sexuality Counselling for TARSHI Callers

Reduction in fear and tension and sorting out of confusions were some of the immediate effects of talking to the counsellor, as described by three of the four callers. And for one male caller TARSHI's counselling helped him in getting relaxed and subsequently resulted in increased work performance. Apart from this, two respondents reported increased levels of confidence, courage, morale and information.

*Yes, there was a lot of change. My confidence increased. We rectified our sexual practices. We put into practice what we heard through the counselling Helpline. Sex is a very important thing. I feel that calling up the*



*Helpline 2-3 times a year is a huge morale booster.*

(Male, RK 1)

For one respondent the Helpline counselling triggered off the process of consciously thinking about herself. It prompted her to make a plan for her life.

### *Two Callers...*

*RK 4 called 6-7 months ago when his wife was pregnant. They wanted to know whether they could engage in intercourse ('sex') during her pregnancy, what precautions they needed to take. He said 'we could ask them things that we couldn't even ask our doctor, or anyone else.'*

*He said that his wife had called first with these concerns. [It is unclear whether they had been together when they made the earlier call or that they had made more than one call earlier]. The present call was because now the baby delivered and he wanted to know what precautions they should take in the post delivery phase.*

*The Helpline counsellor, he stated, was like a 'helping hand', a 'helping friend'. She explained well, used simple language, she listened, and he felt comfortable. He did not feel that she was, in any way judgmental, he felt safe enough to ask whatever he needed to and to call back again with a new set of questions.*

*He got information about the TARSHI Helpline from their website. He remembered reading about the Blue Book for any questions on sexuality.*

*He has not referred anyone to the TARSHI Helpline yet. He questioned whether he could meet the counsellor face to face ('personally'). He was told that it is strictly a telephone Helpline; he seemed to suggest that it should also be a face-to-face service. His other suggestion was that there should also be a doctor available on the Helpline. The first time when they called, they were given telephone numbers of some doctors but for some reason they couldn't go for a consultation.*

*RK 4 also suggested that the website should have the facility of people putting in their questions and receiving online responses.*



*RK 5 wasn't sure of her sexual identity. But this was only a part of it. She was very unsure of herself and angst ridden. She was afraid of being shunned by loved ones and she didn't know whom to approach for her problem. Through some close friends from NGOs she got to know about the TARSHI Helpline. Initially she didn't have the courage to talk to the counsellor and first couple of times she put the phone down without saying a word. Eventually she was able to speak to the counsellor.*

*She found the counsellor very kind, compassionate and understanding. While counselling, complete anonymity was maintained and she got clarity on her issue. The counselling helped her to deal with being a lesbian. The counsellor helped to calm fears and treated her in a non-judgmental way. She called the Helpline three or four times. She got the courage to come out as a lesbian at least to her friends. The counsellor helped her to access a good therapist who could give her personalized attention.*

*RK 5 is still in the process of sorting out her issues. She is preparing herself to come out to her parents. Although she doesn't quite know how she is going to do this but she is planning for it and wants to be the first one to tell her parents about her sexual identity.*



The analysis of callers' records reveals certain outcomes of previous counselling episodes, like, having more satisfying sex, feeling validated, having more authentic and honest relationships with partners. For example, Caller 1 (Female, 27 years old) was able to improve her experience of sex after receiving information about her body. Against her first call the following was noted:

*Married for 2 months. Sex not enjoyable. Had heard a lot about sex being very exciting but it has turned out to be a damp squib. .... Wanted to know where exactly penetration takes place. Information given on genitals. Suggested place mirror between legs and try observing various parts. Also told that many women not familiar with their bodies. In the next call 5 days later, the record states, on our suggestion, they found the vaginal opening and have had vaginal sex (earlier he was probably penetrating the urinary opening!).*

Another caller, Caller 2 in her 22<sup>nd</sup> call expressed that she felt validated when she spoke to the counsellor.

*Caller feels hollow and gets depressed about her future. She thinks a lot and wonders if others think too – **Validated feelings**. Said she feels validated when she speaks to counsellor.*

Thus while in telephone sexuality counselling, it may not be possible to draw firm conclusions about outcomes of the counselling, on the basis of the case studies, it is possible to state that the services fulfill a need. Box 7.1 below summarises the patterns in possible outcomes of sexuality counselling that emerged out of this study.

### Box 7.1 Possible Outcomes of Sexuality Counselling

- Demystification of sex and sexuality
- Information and awareness increase
- Increased comfort with one's body, sexuality
- Resolution of one's own sexual issues
- Easier communication around sexuality
- Reduction in stigma and shame related to sexuality
- Improvement in sexual relationships, pleasurable and fun sex
- Respecting rights, reduction in coercion, abuse
- Safer sexual behaviours
- Increase in help seeking when necessary
- Better sexual health
- Attitudinal and behavioural change

### Programmatic Outcomes

Key informants also spoke about certain programmatic outcomes of sexuality counselling. Once sexuality counselling increased people's awareness and information levels, it would result in a greater consciousness of their rights and a demand for more comprehensive services. Sexuality counselling would be accompanied by medical services for problems like premature ejaculation and sex change surgery. These comprehensive services would also be free from malpractice, for example the current practice of charging excessive amounts for abortions for unmarried girls would not be allowed to exist.

Another outcome would be increased written resources on sexuality counselling as have been produced by TARSHI. The experience garnered through the Helpline, the meticulous documentation of over 59,000 calls has led to the production of knowledge around sexuality, sexuality counselling and how to run good Helplines. The Red and Blue books that TARSHI produced in 1999, have been reprinted 7 times and have been translated into 5 Indian

and one foreign (Khmer) language and almost 50,000 copies of the English and Hindi versions have been distributed. One hundred thousand Tamil copies were printed by an NGO working on HIV/AIDS in Chennai, Nalamdana. 'Common Ground' was first published in English in 2000 and then reprinted once after that. The Hindi 'Common Ground' was printed in 2003 and is being reprinted currently.

## Chapter 8

# Conditions for Quality Sexuality Counselling

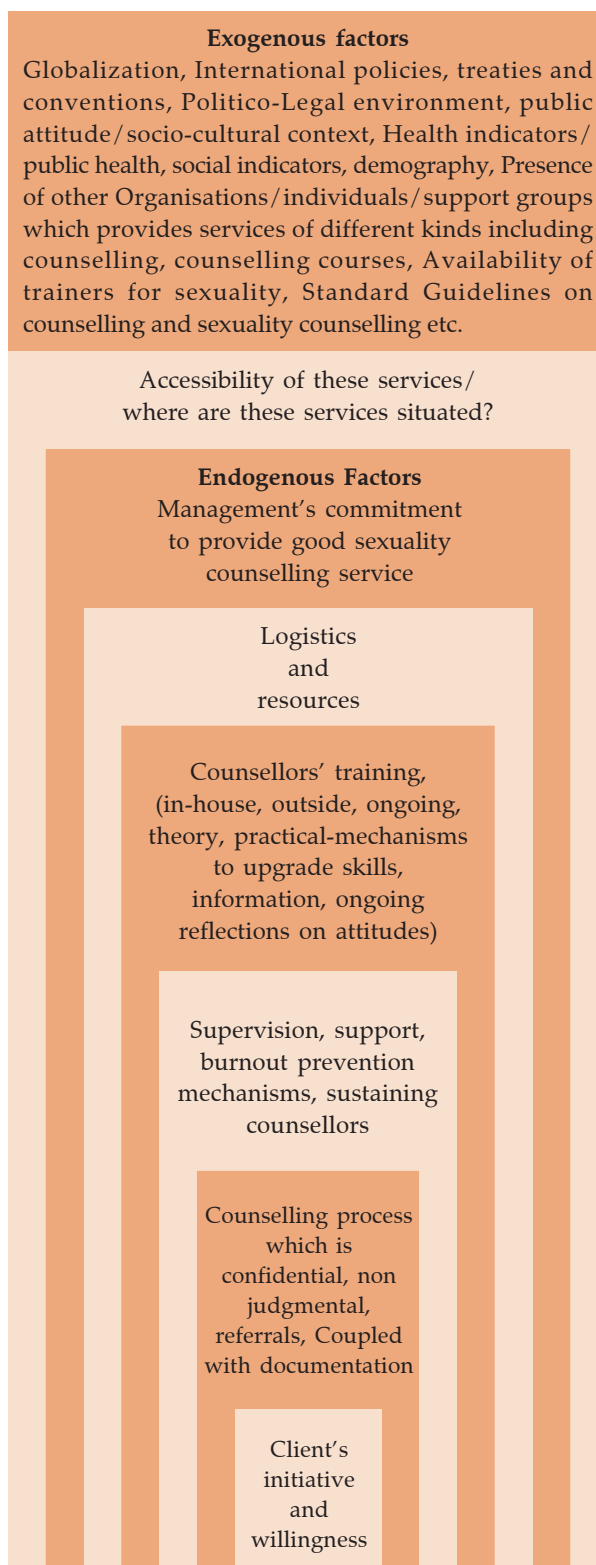
This chapter deals with conditions, which are necessary for providing good sexuality counselling service. Since the study site in India was TARSHI, which provides telephonic counselling only, at some places special mention of conditions for telephonic counselling has been made. This chapter draws from the in-depth interviews of key informants, including past counsellors, counsellors and managers, facility assessment and Focused Group Discussions with proxy users.

A number of exogenous and endogenous factors have a bearing on the quality of sexuality counselling. The following diagram shows the positioning of the different factors in a particular context. These factors are interlinked and greatly influence each other. They ultimately decide the quality of sexuality counselling that reaches the client.

The exogenous factors play a crucial role and affect the endogenous factors significantly. Exogenous have been dealt with at length in the Chapter 3. This chapter will deal with the internal factors that should exist in order to provide promising sexuality counselling.

### 1. Organisation of Services

TARSHI's experience shows that stand-alone telephonic sexuality counselling services are quite effective. There are mixed opinions about telephone versus face-to-face counselling. Advocates of telephonic counselling state that it is cost effective. Clients do not have to spend money for transport or time for commuting to reach a counselling centre. The only cost to the caller is the cost of the phone call. Sexuality related issues are sensitive and ridden with taboos. Telephone counselling provides anonymity and privacy to callers, they are in control, and if they feel uncomfortable at any



point in time they can terminate the call. There are others who say that face to face counselling is required.

*All Helplines have to back up with face-to-face. We've seen it in a Helpline. A Helpline functioning in the air is not enough. Back-up is required, support groups, outreach etc. Helpline gives only information. Suppose a person would feel better speaking with an individual. And here we are talking about women.*

(Female, K 3)

*High burnout rates... Face to face gives a different sense of what you are doing.*

(Female, K 3)

K 3 thinks that only telephone counselling which is not backed by face-to-face counselling, can lead to high burnout rates.

Several callers have indicated that they would like a facility where they can meet the counsellors face-to-face. One repeat caller interviewed over the telephone (RK 3) also suggested that personal interaction with counsellors might also be helpful.

The boys' FGD reveals the following:

*Facilitator: What do you think, from where can they get information? Do you think it's necessary that there should be a Helpline and the number should be displayed in every street, so that people can access it, they are able to call and talk?*

*R: It's good and this kind of facility should be available.*

*R: People will feel about the cost and would like to get it for free. They will be more inclined towards free sources of getting information.*

*R: Even if such services are available, accessing them is difficult because they are mostly far off. Even programmes like these are*

*held at far off places and it becomes difficult to attend them. And if calls are free then it will be good.*

*Facilitator: What do you think is better – to make a call or to meet someone in person?*

*R: It will be good to have a mobile number so that I can go and talk in private. Talking face-to-face may be good for mature people but for young people like me it may not be very comfortable talking with someone face-to-face. We are not that mature. It's more comfortable talking on phone; one is able to express oneself freely over phone.*

*R: Our societal structure is very tight. If we talk about sex and say something wrong, people will make fun... People will look at you in a strange way and say oh, this is the person who was talking, he must be having something on his mind, or he has some problem or deficiency, whatever you may call it but you are treated strangely. I feel that even boys here are not coming out openly because they might be feeling that somebody may leak out their secrets outside. There is a feeling of insecurity.*

*Facilitator: That is true! We can take guarantee for ourselves but there is this fear that these things may go out.*

*R: Yes, we all fear that what if all this gets out and our parents come to know about it. We may talk whole day, call names and swear by mother and sister and use abusive language, but that is not a problem, because it's granted by the society and acceptable. But I agree with the other gentleman when it comes to talking about sex, people will say Oh! He is a bad boy! He will have to talk stealthily, away from home even if the guy has a genuine problem. I think the most important thing is that people don't have confidence that they can talk to someone face-to-face, so there is lack of confidence as well.*

*R: I think 80% people are not able to talk face*

*to face and say that I have this problem and I don't know how to deal with it. But my feeling is that if there is an indirect medium for talk then 99% people can talk about their issues and say freely that I have this problem and how can I solve it they can ask their queries easily.*

*R: Mobile Helpline will be really good.*

Within a framework of comprehensive and integrated sexuality services both a telephone counselling service and a face-to-face service may have their different roles to play. A face-to-face service could provide couple counselling more effectively, although it would increase travel cost to the user, as well as time, both for commuting and waiting if the counsellors are busy.

## 2. Human Resource Development

### Criteria for Selection of Counsellors

**Gender** Logically it would appear that for better rapport and level of comfort of callers, counsellors should be of the same sex as the caller. TARSHI's early experience shows that male counsellors on the Helpline were not suitable for sexuality counselling because female Callers were not comfortable talking to male counsellors. Male callers on the other hand had no such problems.

*Women access TARSHI services because there were women counsellors available. Men were anyways comfortable talking to women counsellors. They talked very openly.*

(Female, PC 2)

The counsellor's ability to make the client feel comfortable is more important than the sex of counsellor as illustrated by a repeat caller's feedback:

*Since I was talking to a lady, initially I was not comfortable. But she helped me to open up. And soon I was quite comfortable. She helped me a lot. If you ask me on a scale of 1*

*to 10 how comfortable I felt, I would rate it at 10 on 10.*

(Male, RK 3)

The women participants of the FGDs mentioned that they would feel comfortable talking to a female counsellor whereas the male proxy users did not mention the preferred gender specifically.

*.... instead of men if there are women (counsellors) then it will be more appropriate.*

(Female, FG 2, RA)

**Volunteers vs. Paid Counsellors** The key informants' feedback points out that paid counsellors would work better than volunteers. There were apprehensions about the motivation, interest, seriousness, continuity, quality and commitment to do the work by a counsellor who is doing it on voluntary basis. Two of the three past counsellors mentioned long period of training as an inhibiting factor for the volunteer being not able to do the sexuality counselling.

*Amount of time that one can spend is important. Training takes time, around 3 or 4 months. Would volunteers be able to give this kind of time? By volunteers, students come to my mind... I think voluntary would be difficult. For good quality, continuous service, paid counsellors would be better. You need high levels of interest and commitment to do this work.*

(Female, PC 3)

Another past counsellor interviewed had the following to say:

*Pay is a very good motivation, at the end of the day we are women, there is lot of emphasis on women to earn on their own, and therefore a paid counsellor is better than a volunteer. Volunteer may not be able to devote required time for training – it is full time engagement – and hence the quality may suffer. Volunteer may not have that much seriousness.*

(Female, PC 2)

**Education** No evidence was found during the study to establish a relationship between the quality of sexuality counselling and the level of education of counsellors. TARSHI recruits fresh post-graduates in social sciences, if their job responsibility is only as counsellors. Post-graduates with experience are recruited if they are expected to handle other organisational tasks along with counselling. The past counsellors were fresh post-graduates in social sciences and for two out of the three it was their first job.

**Age** Initially TARSHI was recruiting fresh, young post-graduates for the Helpline. Currently the counsellors are older more experienced professionals. The point to consider is whether younger counsellors might not require more intensive and longer training and whether burnout rates may not be higher among the younger counsellors.

The adolescent girls in the FGD mentioned that they would like to be counselled by a girl of their age or slightly older.

**Language** The counsellor should be able to understand and fluently speak and write the language in which counselling service is offered. TARSHI's experience shows that most callers are from working class backgrounds and hence comfortable in Hindi, the main local language in Delhi. It was highlighted by one respondent that even if a counsellor knows other languages, counselling should be restricted to the official language of the service. The reason for this is that it would be unethical to intermittently offer different languages, depending on the availability of counsellors who know these languages.

*The callers have to know English or Hindi. Some callers have been South Indian or Bengali but other languages are not part of the service. English and Hindi are the official Helpline languages and the counsellors' (sexuality counselling) expertise is built in*

*these languages. So even if counsellors know another language, they would not speak to callers in those languages because of expertise and also there would be no way of checking quality of the counselling provided (peers/supervisor may not know the language so can't assess the quality of information given etc).*

(Female, MC 1)

Language is an important issue when discussing sexuality. In most languages, terms related to the sexual organs and sexual acts are curse words, or extremely derogatory. Speaking comfortably about sexuality in a local language then becomes an important aspect of the counsellor's work.

**Openness to learn, values and attitudes related to sexuality and motivation to work on sexuality** and related issues are few other criteria for counsellors' selection which may be assessed in the interview process.

One past counsellor stated that keeping abreast with current affairs and making interlinkages is an important attribute of the counsellor.

*One should have the ability to make interlinkages with the other things that are happening – like if some porn magazine has come up or when there was huge publicity for Viagra pills, it invariably influences the nature of the calls that day.*

(Female, PC 1)

### **Staff Salaries, Benefits, and Incentives**

As mentioned by a respondent, keeping the counsellors happy is very important to ensure the quality of counselling service. One counsellor mentioned that the salary is an important factor while another mentioned that she took a cut in her compensation when she decided to join TARSHI, because working in an organisation with such high standards was a motivator for her. Thus it appears that a decent



remuneration, high professional standards, opportunities for personal and professional development, along with benefits and good working conditions are the main motivators for counsellors.

*Salaries and benefits that the counsellors get are on par with any other organisation. I don't think that any TARSHI counsellor at least whom I know has a particular problem with what was being provided to them.*

(Female, T 2)

Other motivators mentioned by past counsellors were positive outcomes reported by callers. Reporting of positive outcomes boost counsellors' morale. On being asked what have been the high points in her experience a past counsellor responded:

*Earlier we used to get lots of calls and callers would call back to say something has helped them and seeing callers moving on in life positively after counselling was a high point.*

(Female, PC 1)

### **Workload and Caller-Counsellor Ratio**

From TARSHI's experience it appears that to maintain quality, one Helpline should have more than one counsellor. The presence of the second counsellor is required for support for addressing problematic or complex calls, for providing relief if there are too many abusive or crank calls, for providing continuity of service in the event of a counsellor taking leave or vacation. On an average, one Helpline can optimally address 30 calls per 8-hour day if working at full capacity and one counsellor can attend 15 calls per day. The 'one Helpline - two counsellors' formula is not to be applied in a linear fashion as the number of Helplines are increased. For example, three counsellors could optimally handle two telephone lines.

### **Supervision and Support Systems for Providers**

Chapter 4 on TARSHI details the careful monitoring and supervision systems that

TARSHI has put in place over the years. Close supervision is required until it is proven that counsellors have developed the necessary perspective, language and skills to handle calls. Routine supervision is required for ongoing monitoring of quality of counselling provided, either through systematic analysis of the documentation or by auditing random calls on the speakerphone, or by mock or test calls, or then by instituting third party feedback elicitation as was done for this study. The six monthly self and peer assessment system followed by TARSHI is also an excellent quality assurance system. Feedback systems based on new technologies can also be developed, for example, web based tools as followed in this study. Or then digitalized electronic voice operated systems are used.

Support systems are very necessary for all counsellors and especially sexuality counsellors. Dealing with crank and abusive calls and with complex sexuality related issues of callers could lead to burnout. Space to share their own issues and anxieties should be built into organisational systems and processes. Recreation, physical exercise, meditation, mandatory breaks are all essential. On the professional side, attending meetings and training programmes, writing up one's experiences in an effort to find a larger meaning would be both personally healing as well as lead to professional development.

The past counsellors at TARSHI had the following to say:

*The counsellors (if they are working on regular basis 9-5 as counsellors) should be discouraged to work only as counsellors after 2-3 years. Not only because of burnout and mental exhaustion but for counsellor's own sake. I just feel that dealing with people's sexual problem day in and day out can have adverse effect on the counsellor.*

(Female, PC 1)

*Discussing, debriefing, taking breaks, two*

*days compulsory off after every three months in addition to weekly off was given.*

(Female, PC 1)

*Training and meetings in-house as well as outside just to make the counsellors feel connected (one tends to feel isolated on the Helpline), and just to keep abreast of what's happening in the outside world.*

(Female, PC 1)

### Training of Staff

The training of counsellors is a very important prerequisite for providing sexuality counselling. Respondents stated that training of counsellors is a huge investment and it is also necessary to ensure the quality of counselling. The training of counsellors should take place before they start to take calls. Chapter 4 describes briefly TARSHI's introductory training.

*For sexuality counselling, specialized training and refreshers are required. Even if a person has a lot of information on RCH, he/she cannot work as a counsellor unless he/she receives proper training on counselling. There is a huge need of training of counsellors. For example, how to handle bogus calls. People treat it as a sexline and not a Helpline. This is my training need.*

(Female, K 2)

*Some kind of linking with scientific information sources to keep the reference material up to date. Keeping abreast with scientific developments.*

(Female, PC 2)

Ongoing/refresher training is important to update the counsellor about new issues that emerge in the course of the work. Ongoing training can be done in a formal way by reading or regular workshops or in an informal way for example, through interactions with clients and addressing their needs for information or through debriefing meetings, informal discussions and so on.

*New issues keep coming up. I remember, one transsexual who wanted to go for sex change operation called up, at that time we didn't have much information on that issue, services available, which doctors etc. and she helped us and provided us with information.*

(Female, PC 1)

Training on sexuality counselling will necessarily require a decent amount of time. The concept of sexuality has first to be deconstructed with the participants, along with examining all the attitudinal baggage of morality and rights and wrongs. And then skills of communication and counselling around sexuality have to be built. TARSHI's initial training is for 12 – 14 weeks.

Since a major component of the training is related to changing attitudes and values of the trainee counsellors by helping them challenge their own values, the importance of creating a conducive environment was emphasized by the respondents. To quote a respondent:

*The environment should be created where people can ask anything, to put counter arguments. It should give a space to be politically incorrect. The Facilitators should address the politically incorrect responses instead of saying that it's wrong and they must help people view things from different angles. Change happens only with counter arguments.*

(Female, K 3)

In different ways several respondents stated that any sexuality training should not be done in a hurried manner.

*At least four days' initial training (3 days is negotiable) should be conducted for someone who has never been trained, giving adequate time is necessary. Need this much time for participants to be challenged.*

(Female, T 1)

TARSHI's training content is mentioned in

Annexure 4. Given below is the content suggested by the respondents. The actual content would of course depend on the profile of the trainees and their learning needs assessment.

- Evidence based knowledge and information on: Biomedical aspects of sexuality, all dimensions of growing up and related problems. Sexual rights and reproductive rights, basic human rights, principles of consent. Laws related to sexuality, how law perceives women
- Issues under SEXUALITY: What is sex, sexuality, gender, discrimination, marginalisation, heteronormativity, patriarchy, culture, tradition, sexual hierarchy, and sexual behaviour
- Drawing interlinkages: Looking at how religion, nation and state, media affect sexuality
- Perspective building: Training on gender and women's movement to provide an overall perspective, ideas around issues of gender, sexuality, identity, behaviour, sexual hierarchies, heteronormativity, marginalisation, disability
- Attitude changing: Value clarification group work, building openness
- Skill building: Learning how to handle crank calls, recognizing callers and picking up clues for establishing continuity, voice modulation, communication, making the client comfortable

The methods for sexuality counselling training necessarily have to be participatory, encouraging self-reflection.

*What we would do is, usually, some kind of a value clarification, right in the beginning. Then they go through the training and then do one (value clarification) at the end. Usually how I have set up is a three hours of free floating discussion, which was made enough challenging to one's emotional comfort as well*

*as not to make it provocative but to help them learn how to look within themselves, to what it is that they are doing and what they have learnt, in order to be able to make greater and greater accommodation. And that's how it used to be.*

*The parts that we had looked at were – to look at one's own hidden biases, one's comfort with one's own sexuality, and sense of entitlement and empowerment with it, and this is something that is progressive, it grows more and more. I think that really is the main focus for counsellors, who are going to be talking to people, who have questions about what's okay, what's not okay. Sexuality per se has lot of judgment ridden on it, within the larger society and community and people. All kinds of mental health stresses somehow tend to, among various things that they coalesce around, tend to mostly coalesce around sexuality and try to control it. What's ok, what's not ok, what kind of behaviour is appropriate. How much do we allow people to grow?*

(Female, T 3)

Calling other Helplines can be one way of learning for the counsellors. It also helps them in assessing the quality of services of other Helplines, which are there in their referral list.

*We would call other Helplines for learning. Many we felt were not as good. They did not give accurate information.*

(Female, PC 3)

Reading and basic study by trainees and then clarification by the resource persons was another method of imparting information.

*Usually basic study is done by them. They have got quite a few books in the library. They are supposed to go through all of it. And then I tell them tell me what's the point of clarification, in which they are more interested. What are the areas of concerns to*

*the counsellors, she does not feel comfortable answering or she does not have accurate information about.*

(Female, T 2)

### Who are Good Trainers of Sexuality Counselling?

Trainers for sexuality counselling training have to be extremely sound.

*Because training on sexuality is a sensitive issue and involves people's emotions and feelings therefore one has to be really good trainer to be able to handle lot of those issues. Because training is a specialized skill, one needs to be people's person and needs to have a non-judgmental attitude. Most of the people unfortunately are judgmental on the issues of sexuality.*

(Female, T 1)

*Who are people in India or in Delhi equipped to actually do sexuality counselling? Because sexuality counselling is actually a lot about 'morality'. You have to be not moral – so you need a special kind of training to actually be a sexuality counsellor. So it's not that simple-generally if you are coming from let's say NIMHANS or from wherever and you are a trained therapist then actually you can do sexuality counselling, it's not like that...*

(Female, K 7)

They have to be experienced. One of the past counsellors, who started as a counsellor in TARSHI and did only counselling for a period of two and half years, later began training new counsellors. This was the organisation's way of using her skills, preventing her burnout and retaining her in the organisation.

Trainers too have to be in the learning mode. They have to constantly evolve and adapt.

*Changes happen on the basis of learning e.g. sexual hierarchy [a concept in sexuality training] was not a part of the training that*

*I gave four years ago. I include it now. As your learning increases you make changes.*

(Female, T 1)

A good sexuality trainer has to be able to help people deal with issues, many times their own sexuality issues.

*For a good trainer who is infinitely patient and willing to listen and learn, it's not difficult. I have done training for different people – community workers, college kids. I don't push them to take a position. The trainer has to lay out the terrain for them, give them information, tell them what can be right, and allow them to make a choice themselves. A trainer may not be able to get people to say the same thing at the end of the training but the trainer must be able to shake them up and when they get out of the room they should be able to say that there are grey areas and they are uncomfortable about certain issues. A trainer should make people to think beyond the box in which they are trapped.*

(Female, T 1)

### 3. Infrastructure and Logistics

A telephone sexuality counselling service requires a sound proof, private room, big enough to accommodate the counsellors and the phone lines. The room and equipments should be in good working condition. If there is more than one counsellor in a room, the room should be divided by room separators so that the counsellors do not get distracted by each other's voices. Speaker phones are useful if more than one counsellor needs to listen in to problematic/complex calls and also for supervision.

*If we advertise the Helpline, it is flooded with calls, which become very difficult to handle. Then more staffing is required, more space is required, more funding is required.*

(Female, C 2)

Other requirements are adequate number of



tables and chairs, storage space or racks for storing callers' records, stationery like register, cards and pen for documentation, computers for keeping soft copies of client's records for easy retrieval. Depending on the climatic conditions, air conditioners and heaters may be useful.

On being asked how the quality should be assured, one respondent listed out many things, including the following:

*Soundproof room, privacy, nice colour, lighting, heater, no AC noise, no traffic sounds. Sometime back food smell used to come in to counselling room. It may disturb the counsellors.*

(Female, M 2)

It is also important to mention here that TARSHI has a good administrative support system which leaves the counsellors free to do only counselling and not get involved in the administrative issues of the organisation.

### **Monitoring and Evaluation Including Quality Assurance**

As mentioned earlier, taking the clients' feedback is not possible in the regular course of functioning of a confidential telephone sexuality counselling service. Two of the three past counsellors interviewed said that clients do sometimes report that counselling helped them, but this is not a dependable method of monitoring.

*I don't know how we would ever know about their dissatisfaction. Their satisfaction, we can judge from the call back rate. Repeat calls did happen. People would say 'the earlier call helped me, so I am calling again.' But not too often.*

(Female, PC 1)

According to another respondent, the client may not call again if his/her problems get solved, so use of call back rate to evaluate the effectiveness

of counselling services or quality of the counselling has a limited use.

*Isn't this like us? When we go to the doctor and are cured, we don't go back to express our satisfaction.*

(Female, PC 3)

Alternative ways of monitoring the service have to be identified. Regular analysis of the data – number of callers, sex desegregation of calls, kinds of issues that come up, reporting of outcomes by callers in subsequent calls – may provide ideas for further improving the service. Analysis of the nature of calls over time to assess how the needs of the callers are changing will also be useful.

Evaluation of any service is essential to achieve and maintain quality and ensure its usefulness to the clients. One past counsellor suggests:

*'An honest in-house evaluation of the Helpline should be done – in terms of where it started, where it is now, where it is now, what it has achieved, not achieved and what are its so called failure. This is very critical. Every year we had an evaluation, we did peer and personal evaluations. A critical organisational evaluation is required'*

(Female, PC 1)

### **Responsiveness of Services to the Client: Accessibility, Availability and Acceptability**

This study has established that there is an urgent need for quality sexuality information and counselling services. Ensuring availability of adequate and good quality services appears to be the first step. Some broader strategies for increasing availability are discussed in the next chapter. The factors affecting availability and accessibility are discussed here.

**Cost** The cost of the sexuality counselling service may be a barrier for people from lower economic background. Cost may also be a deterrent for adolescents who are primarily



dependent on their parents for money. The FGD conducted with unmarried adolescent girls indicated that they would not be able to get money from their parents for sexuality counselling services.

*Not possible, we won't get money for it (from parents).*

(Female, FG1, J 1)

The similar thought was echoed by a key respondent.

*And it should be a service where money is not an issue for these youngsters. Sexuality... these are the problems that come at puberty. How many Indian teenagers earn?*

(Female, T 2)

**Time of service** Availability of services also means the timing during which services are being made available.

**Language** The other factor that may hamper the availability of service for certain communities is the language in which the services are being provided although the TARSHI study could not garner any firm evidence for this observation.

The geographical situation of the service does not appear to have a bearing on the availability of the services at least telephone Helpline service. With the advent of the Internet, TARSHI has been getting calls from all over the country; some call more than once and speak for long periods of time though they seem to be able to ill-afford outstation calls. Maybe if the need is there and there are so few alternatives, people do call.

### Accessibility and Availability of Telephone Sexuality Counselling

Feedback from this study strongly points to the need to increase the availability of the service. Callers interviewed said that the telephone Helpline should run over weekends, the

number of hours and days of the service should be increased, the number of telephone lines should be increased so that people do not have to call repeatedly or wait if the line is busy. A past counsellor who used to get complaints from the clients said:

*'Should have been around the clock [in the evenings and over weekends]. Shortage of staff. People would call and say 'we were calling, but couldn't get through!'*

(Female, PC 2)

There may be some issues around sexuality where a client may need service immediately and cannot wait for longer duration:

*Things like pregnancy issues need to be addressed immediately. So tomorrow morning... on emergency contraception... I'm giving an example. I have had sex last night what do I do now?*

(Male, K 12)

Inaccessible telephone lines also affect referrals from other organisations and ultimately the reputation of the service.

*Many time even we ourselves tried (after callers whom we referred called back to say that the lines were busy)... so we also tried the number. We told our office boy to keep calling, but many times we found the phone wasn't connecting. So we thought so many people try to call TARSHI but they do not get through, so we changed to XX Foundation. Then we started referring to the XX Foundation.*

(Male, K 8)

Accessibility of services is not only important from the callers' perspective but also from the provider's viewpoint. Low number of calls were reported by a counsellor as another cause of burnout.

Acceptability of the service can be ensured by making it congruent with callers' expectations. The five focused group discussions revealed

that each group had their own set of expectations and notions of a good sexuality counselling service. The adolescent girls' group said that they preferred telephone counselling to face-to-face counselling because 'they would not be scared of asking such questions on phone.' They wanted free services. Counselling should be available in schools but not through teachers, the girls suggest that the counsellor should be of their age or slightly older than them. The women participants of FGDs want counselling services through a neighbourhood centre. They want women counsellors. They want privacy and confidentiality to be ensured. And they do not want doctors to counsel them. The men in the FGDs wanted services where they could take their wives too. In contrast to the women they wanted counselling through doctors in hospitals but they would not like payment to be an issue. According to the men, the counsellor should not be someone whom they know but they should be able to trust the counsellor. In principle, it would seem that the acceptability of the service has to be determined by interviewing the potential client group before the details of the service programme are decided.

Another aspect of acceptability is the continuity of the counselling. TARSHI ensures continuity through its meticulous documentation and recording system. Counsellors can refer back to the notes made on previous calls and take off from where the repeat callers left off. The documentation system is so good that even callers have been impressed by how different counsellors have an idea of their issues and needs.

### **Proxy Users (married men's FGD) Expectations from a Sexuality Counselling Service**

The married men wanted the following from a sexuality counselling service:

*Participant 2: We would expect that they give us good advice, which should be helpful to us, not harm us... and ... second thing is*

*that he should be able to answer all our queries without hesitation. And we should be able to feel comfortable about talking openly. Even if it is a minus point about us, whether our manhood has declined or our penis is small... or we are facing premature ejaculation...whatever the problem is ... or my penis is not getting proper erection.... we should be able to talk about everything without hesitation... and the counsellor should also be such that he can answer that thing openly. And he should be able to give advice openly and without hesitation.*

*Participant 6: He should give right counselling and should have kind behaviour so that one should be able to suggest that counselling centre to 10 other people.*

*Participant 2: Everyone here is from middle class families. No one here earns a great deal. We would also expect that if a medicine is so expensive that we can't afford, if it can be given to us for free, then it would be very helpful to us.*

*Participant 7: No, no... I did not mean that a friend should be a counsellor. I am saying that their behaviour should be friendly... To take counselling means that we are trusting that person ... we go to a second person for counselling because we have faith that he will give good advice ... hoping that that will solve our problem ... But, if he misbehaves with us, then how can we go to him.*

### **Linkages and Referral Networks**

A good sexuality counselling service has to have linkages with organisations and groups across sectors – specialist organisations working on issues of child sexual abuse, LGBT issues, professionals working in the field of mental health (psychiatrists, psychotherapists), medical doctors, adoption agencies, lawyers, organisations working on violence against women issues, and so on. TARSHI has a good

referral system. It maintains an updated file of reliable and quality organisations providing a range of needed services. Details of their timings, rates, location, and phone numbers are available in the file and the counsellors provide all these details while referring callers.

The socio-cultural legal context along with policy environment decides the nature of the relationship between the sexuality counselling service and the government departments and agencies. In India although there are opportunities for integrating counselling services within the public health system (these opportunities are discussed in Chapter 9), there are also a number of challenges e.g. availability of training institutes, training capacities, training courses which can cater to the scale of operation.

A respondent unequivocally stated that she would like her organisation to function independently of the public health programme because she believed that otherwise the services would be straitjacketed.

Another factor which plays an important role in deciding the success of linkages is policies of bilateral donors.

### Funding

It is a challenge for any organisation to secure long-term funding for the sexuality counselling service. Donors are not willing to support service provision indefinitely. While the idea of a sexuality counselling Helpline was new, funding support was forthcoming. As the experience of the service grew, there were other pressures and the proportion of the organisational budget on the Helpline decreased.

It is evident from the data provided by TARSHI (i.e. total number of calls received per year and number of counsellors that were there each year) that the scale of sexuality counselling

services provided by TARSHI has been reducing. In 1996–97 the entire budget of TARSHI was for the Helpline. From 2001 to 2003, the Helpline formed 50% of the organisation's total budget. And in 2006-07, the Helpline is a mere 20% of TARSHI's resources. According to one respondent the probable reasons of this reduction in the proportion of the budget, is that the 'Counselling service' not being given enough priority.

*I think one is priority ... initially Helpline was TARSHI's focus. A lot of energy went into it, there were a lot of advertisements, 4-5 counsellors, no question of no backup and on average 60-70 calls per day were taken by the counsellors and some were pretty long. But as the organisation grew the Helpline took a back seat. Now TARSHI does a lot of things. The vision that is there for other things is not there for the Helpline.*

(Female, PC 1)

Now according to the Helpline manager there is practically no external financial support for the Helpline and a lean three-day-a week service is being sustained. Many factors which contribute to an effective sexuality counselling service get adversely affected because of the funding crunch e.g. space, number of staff, morale of the service provider, promotional activities, availability of service, planning for the service. To quote a respondent:

*Due to fund crunch, we can't retain our staff and no planning can be done.*

(Female, M 2)

Because the service is not actively advertised any longer, on many days the number of calls is very low.

*The low number of calls scares us. Why is the phone not ringing? Under calling and overcalling are both reasons for burnout, anxiety. It may lead to burnout because counsellor's skill is not used.*

(Female, C 2)

Any Helpline needs funds for the following:

- Salaries of counsellors
- Rent for space and telephones
- Supplies, stationery
- Publicity of the Helpline number
- A computer for data entry and documentation
- Adequate furniture and equipment

Support activities also need to be budgeted for, like:

- Training and staff professional development
- Documentation and research
- Monitoring and evaluation

### Leadership and Reputation

TARSHI has acquired an enviable reputation in the field of sexuality in India and in the South and South East Asian region. The reputation of the organisation however appears to be largely present amongst those working on sexuality especially marginalized sexualities. TARSHI does not appear to be very well known amongst the mainstream, whose work is to do with 'applied sexuality' – by applied we mean sexuality as it is linked to the mainstream in different sectors like Health, Education, and Youth Affairs.

*Their engagement in the field of sexuality for such a long time has sharpened their understanding and skills. They are fed from the ground, because of the Helpline. It is vice versa. Their understanding of sexuality has grown more comprehensive and inclusive because of the Helpline.*

*They are not just limited to the Helpline they do other things on sexuality too. They also link conceptual analysis of sexuality and they bring that back for informing their counsellors.*

(Female, K 5)

### Conclusion

This chapter examined the conditions required for good sexuality counselling. It appears that careful selection of counsellors, rigorous training, which includes not just evidence, based information on sexuality and health but also dealing with one's own sexuality related issues as well counselling skills and rights and gender perspectives, are fundamental for a good service. Supportive monitoring and burnout prevention systems are equally important. There is a range of opinions on whether sexuality counselling should be provided over the telephone or face to face. It appears that there is place for both kinds of services. A point of concern is the paucity of financial resources for sexuality related services. Where can resources be mobilised from, is a moot question.

## Chapter 9

# Discussion, Conclusion and Recommendations

We refer back to the conceptual framework presented in Chapter 8 to guide the discussion in this chapter. The exogenous factors in the macro policy and social and economic contexts are examined first to assess the opportunities and threats for the sexuality counselling agenda. And then the endogenous factors are examined to see what contributes to good quality sexuality counselling service. And finally, we end with a discussion on some emerging conceptual issues.

### Opportunities

Although the organisation's name, Talking About Reproductive and Sexual Health Issues positions it within the health sector, TARSHI in fact responds to sexuality issues across sectors. It addresses sexuality issues of children and youth through its publications, school programmes and other interventions in the education system. It engages with the rights of sexual minorities. It responds to reproductive and sexual health related information needs of callers. The inter-sectoral approach to sexuality is in fact a strength of TARSHI making it suitable for bringing the sexuality agenda into various macro policy arenas. The policy level context offers opportunities for mainstreaming sexuality. At least three ministries – Health including HIV/ AIDS, Education and Youth Affairs – have mandates into which sexuality can be mainstreamed. Youth Affairs provides the most positive context for mainstreaming sexuality issues. We choose to call it a 'positive context' because development of young people's sexuality is a normal phenomenon and therefore positive notions of sexuality can be allowed to be developed. The Health sector with its emphasis on reproductive and child health and HIV/ AIDS offers another opportunity for mainstreaming the sexuality discourse – however, here sexuality would be viewed in the disease context, or the fertility control context,

as 'risky sexual behaviours' and 'sexuality that should be controlled.' The mental health field also offers possibilities of bringing in sexuality because of links of sexuality with an individual's self-concept and mental health status. As highlighted in Chapter 1, in at least four of the MDGs that India has committed itself to, there is an opportunity for sexuality education to be incorporated. At least five of the Socio-Demographic Goals of the National Population Policy offer an opportunity for sexuality education and counselling. These are all strategic arenas where the sexuality and sexual rights agenda can be introduced by organisations like TARSHI.

Sexuality issues are being addressed only by the National AIDS Control Programme and not by the Reproductive and Child Health Programme or the National Rural Health Mission. Sexuality counselling is not yet a part of sexual and reproductive health services in the country. Sex education in schools has run into serious problems because significant sections of policy makers, educationists as well as the general public feel that sex education goes against Indian values and culture. Sexuality counselling is being provided by a range of persons in the country from informal providers like *hakims* (traditional healers), sexology 'Clinics', gynaecologists, counsellors, psychotherapists. Formal, certified training for sexuality counselling is virtually non-existent in the country. For the NACP – 3, NACO is looking for national institutions that can undertake the sexuality training agenda.

This study also highlights that the rapidly changing context, in terms of development of the markets, explosion of media and proliferation of the Internet, is leading to increasing commodification of sex and



sexuality. The market driven modern notions of sexuality come into direct conflict with traditional values. So while on the one hand, there is increased reporting of sexual violence like rapes and child sexual abuse (indicating a greater openness to disclosure of what was perceived as stigmatizing), there are also increased honor killings based on traditional values. Conflicting messages by the media – sex for pleasure on the one hand, and sex within marriage for procreation, on the other; double standards for male and female sexuality – create enormous social confusion around sexuality. All these urgently call for increased sexuality counselling services.

Training for sexuality counselling is virtually non-existent in the country. There are opportunities for this to be set up in premier institutions like the Rajiv Gandhi National Institute of Youth Development in Tamil Nadu, the Tata Institute of Social Sciences in Mumbai or the National Institute for Mental Health and Neuro Sciences in Bangalore.

### And Threats

While these opportunities exist at the policy level, there is also a perception of very real threats amongst those working on sexuality issues. The challenges that need to be addressed include patriarchal, conservative mindsets, and lack of evidence based information. Fears of censorship, and that the government can clamp down on those working on sexuality issues especially with a rights based approach and on issues of sexual pleasure, were articulated by respondents for this study. Examples were cited of the Information Minister closing down a radio station addressing sexuality issues, in the 90s. Other policy level barriers that were mentioned were: quick transfers of officers in the Youth Affairs ministry – they barely get educated on young people's issues (including

sexuality) and begin to develop rapport with concerned NGOs and they get transferred to new positions! And that policy makers are not going to consider sexuality as an important enough issue to invest resources into.

### Content of Sexuality Counselling

The nature of issues that people want information on or counselling for, emerging from this study indicates that most of the questions arise from a lack of a very basic information about one's body, sex and sexuality, reproductive and sexual health (including menstruation and contraception). Some other questions are related to misconceptions and beliefs related to sexuality, many of which are related to the social construction of male sexuality. And finally there are issues related to relationships, including sexual relationships and lack of communication between partners reflecting the core of sexuality, that is, power relations and control. These issues that TARSHI callers want counselling on are consistent with what is found in the literature.

The TARSHI data shows that there are differences between the first queries of women callers and men callers. While men wanted general information related to sexuality, women's first concerns were related to contraception. This is similar to a study done in Kenya<sup>39</sup>.

The range and intensity of issues that TARSHI addresses point to degrees of specialization required in sexuality counselling. For example, bulk of the callers seek information around the body, contraception and reproductive and sexual health issues. These can be handled by one level of sexuality counselling training. The more complex sexuality related issues, for example, child sexual abuse, other forms of

<sup>39</sup>Kim Y M, Kols A, Mwarogo P, Awasum D (1999) Differences in counselling men and women: family planning in Kenya. *Patient Education and Counselling*. 39: 37– 47.

sexual violence like rape, sex change surgery related issues, may require referrals to specialized services or the more advanced level of sexuality counselling training.

The repeated nature of calls and callers calling at different points in their reproductive cycles with new questions affirms Dixon-Mueller's thesis that information and counselling on sexuality need to be an integral part of reproductive and sexual health services<sup>40</sup>. 'Few clients report that health care practitioners ever ask them about sex, despite the evidence suggesting that such discussions – not merely those about sexual risk, but also about positive sexual experiences and satisfaction – yield significant benefits. Although most clients would welcome such dialogues, few feel comfortable to initiate them on their own. In turn providers often feel uncomfortable discussing sex with their clients or feel ill equipped to have such conversations<sup>41</sup>.' Health care providers need to be sensitized that sexual history taking is a necessary part of their job and they need to be trained in talking about sexuality. A core set of questions on sexuality that can be part of the clinical history of clients coming to health care facilities with reproductive and sexual health complaints, needs to be introduced into sexual and reproductive health services<sup>42</sup>.

### What Makes for Good Quality Sexuality Counselling?

Given the context described above, TARSHI fulfills a need for quality, ethical, rights based gender sensitive, telephone sexuality counselling services. TARSHI's quality services are due to:

- Careful selection of counsellors: their openness to learning and engaging in efforts to change perspectives related to sexuality, were assessed over a number of interactions with different persons in the organisation.
- Intensive induction training: incorporating perspective building, value clarification, conceptual understanding and skill building around sexuality and sexuality counselling. An important finding of the TARSHI review is that the trainers have to be extremely competent, self-reflexive, patient and non-judgmental (in the sense that they have to provide space for trainees to grapple with their biases and internalized notions of sexuality).
- Close supervision, ongoing support and learning, self-reflection and self-evaluation of quality of counselling provided, peer review systems<sup>43</sup>.
- Burnout prevention systems: meditation, exercise, discussions in team, therapy for self, if required, retreats.
- Referral systems that are tested and reliable.

It is important to also recognize that the quality of the sexuality counselling provided by TARSHI is marked by an organisational commitment to:

- Confidentiality
- Evidence based information provision
- Non-judgmental attitude
- Facilitating exploration of options and absence of directiveness/prescriptions
- Managing boundaries between counsellor and caller

<sup>40</sup> Dixon-Mueller, R, (1993), The sexuality connection in reproductive health, *Studies in Family Planning* 24 (5)

<sup>41</sup> Higgins, Jenny A and Jennifer S. Hirsch (2007), Pleasure Deficit: Revisiting the 'Sexuality Connection' in Reproductive Health, *International Family Planning Perspectives*. 33 (3)

<sup>42</sup> Nusbaum MRH and Hamilton CD, (2002), The proactive sexual health history, *American Family Physician*, 66 (9) cited in Higgins, Jenny A and Jennifer S. Hirsch (2007), Pleasure Deficit: Revisiting the 'Sexuality Connection' in Reproductive Health, *International Family Planning Perspectives*. 33 (3)

<sup>43</sup> Kim Y M, Putjuk F, Basuki E, Kols A (2000) Self-assessment and peer review: improving Indonesian service providers' communication with clients. *International Family Planning Perspectives*. 26 (1): 4-12.

- Rights based, women centered, gender sensitive perspective

Some of the abovementioned aspects of TARSHI's counselling need to be incorporated into the existing frameworks of quality of counselling. These will be discussed at the end of this section.

Couple counselling has been mentioned as a dimension of quality of counselling<sup>44</sup>. However, an anonymous telephone counselling does not lend itself easily to couple counselling, unless the two partners themselves decide to be together when calling the Helpline.

The range of issues that callers present and the complexity of the issues – sexual needs of persons with disability, issues of women with multiple sexual partners, information needs and confusions of persons wanting sex change surgeries, conflicts of men who like to cross-dress – test the counsellors' skills and non-judgmental attitudes.

### Organisation of Sexuality Related Services

Comprehensive sexuality services need to be organized. In order to create an open environment for the development of sexuality related discourse, widespread information on sexuality needs to be disseminated. This information should be evidence based, rights and gender sensitive and non-judgmental and non-moralistic. Widespread information dissemination will help to address a significant proportion of the sort of issues that TARSHI's Helpline responds to. It will also help to 'normalize' several other issues like confusions around sexual identity for which people call the TARSHI Helpline.

Sexuality counselling should be integrated within a service delivery model – for example, within the health care system, education system, women's empowerment programmes, adolescents' life skills or development programmes. These services can be situated at the neighbourhood or community level, as well as within institutions like secondary hospitals, elementary and secondary level schools.

Sexuality counselling services can also be stand alone – either face-to-face or through telephone Helplines. Different groups will access different modes of sexuality counselling, depending on their own context. Younger people may prefer the anonymity of the telephone Helpline, heterosexual married couples may want to access face-to-face counselling.

Backward and forward linkages should be clearly organized. Information outreach about the availability of sexuality counselling services is very important, through posters in public places, advertisements in print and electronic media, talks in schools and in the community. Forward linkages in terms of a tested and reliable referral system should be organized.

### Emerging Conceptual Issues

*Definitions.* The review of TARSHI's sexuality counselling shows the operationalisation of the definitions that the study started with<sup>45</sup>. TARSHI recognizes that sexuality is a central aspect of being human, that sexuality is a multi-faceted concept encompassing sex and gender identities and role, sexual orientation, pleasure, intimacy and reproduction. The fact that sexuality is influenced by the interaction of the biological, psychological, social, political, legal, ethical, religious and cultural factors is borne out by TARSHI's approach to preparing the

<sup>44</sup> KIT (2006 – forthcoming) Systematic review on gathering evidence to promote sexual health. Amsterdam, KIT Publishers.

<sup>45</sup> WHO (2005) Integrating Sexual Health Interventions into Reproductive Health Services: Programme Experience from Developing Countries. Geneva, World Health Organization.

counsellors of the Helpline. Sexuality has to be understood in the context of power and social relationships. It begins from the basic idea of freedom from violence and disease and moves onto the more positive articulations of choice, pleasure, dignity and diverse understandings of the body, desires and sexual preferences<sup>46</sup>. TARSHI also subscribes to a positive definition of sexual health<sup>47</sup>, which requires a positive and respectful approach to sexuality and sexual relationships, recognizes sexual pleasure and upholds sexual rights of all persons.

Sexuality counselling as practiced by TARSHI can be tentatively defined as follows:

*Create a climate where callers can feel safe to express themselves and their concerns related to their sexuality – body, sexual relationships, sexual preferences, needs and desires – receive information, validation, be helped to explore alternatives and arrive at decisions affecting their sexual lives.*

It is important to make the definition of sexuality counselling explicit because counselling is a much-misused word today. The common understanding of counselling is ‘giving advice’ or ‘guiding’ or ‘educating’, and not ‘helping clients to explore options and make their own decisions’. And around sexuality, it is so much easier to warn, advice, guide, and prohibit clients!

### Framework for Quality of Sexuality Counselling

TARSHI’s sexuality counsellors are non-directive, non-judgmental and non-moralistic. The counsellors handle the pressures of the callers to make decisions for them. They

provide evidence based, rights based, gender sensitive information, help the callers weigh the pros and cons and make their own decisions. The counsellors respect the rights of the largely male callers – while drawing attention to the rights of their partners to be free from coercive and painful sex.

The framework to assess quality of sexuality counselling proposed by this study (Annexure 1) can be expanded to include these aspects: namely, *quality of information provided, exploring and probing, non-directive, not making decisions for client, non-judgmental (free from moralistic biases), managing dependence, judgment about ‘crank’ and abusive calls, rights based, gender-sensitive.*

It may be useful to highlight here that the information provided by the counsellors while being evidence based, should not be value free. Counsellors providing information or counselling on sexuality with its core of power relations, within a woman sensitive rights perspective are expected to provide information that will promote gender equality and in that sense may be biased towards women.

### What is Rights-based and Gender-sensitive Sexuality Counselling?

Some further conceptual work is required around how human rights, sexual rights and women’s rights interact with each other in the context of sexuality counselling. For example, similar to the stance of the TARSHI counsellors, some authors have cautioned against the promotion of a gender neutral ‘right to sexual pleasure’ as a basic human right, arguing that men’s demands for sexual pleasure can infringe on women’s rights<sup>48</sup>. How are concepts of gender, construction of masculinities and

<sup>46</sup> CREA (2006) Sexual Rights and Social Movements. CREA: New Delhi

<sup>47</sup> WHO (2005) Integrating Sexual Health Interventions into Reproductive Health Services: Programme Experience from Developing Countries. Geneva, World Health Organization.

<sup>48</sup> Oriel J, Sexual Pleasure as a human right: harmful or helpful in the context of HIV/AIDS? **Women’s Studies International Forum**, 2005, 28(5): 392–404, cited in Higgins, Jenny A and Jennifer S. Hirsch (2007), Pleasure Deficit: Revisiting the ‘Sexuality Connection’ in Reproductive Health, *International Family Planning Perspectives*. 33 (3)

femininity operationalised in sexuality counselling? What can the counsellor do to change the mindsets of callers like Caller 10 who said 'No Indian wife will want to do what you are suggesting!' when the TARSHI counsellor suggested certain sexual acts that the wife could do to increase pleasure for both the man and the woman. TARSHI has the experience of over 59,000 calls to do the kind of theorizing suggested above.

### Conclusion and Recommendations

We conclude this report by responding to the objectives of this study and the research questions stated in Chapter 2.

The review of TARSHI's sexuality Helpline shows that with rapid changes in the socio-economic context, including globalization and opening of the markets and the media, notions of sexuality and norms around sexuality are in a state of tremendous confusion. While on the one hand there is seemingly greater openness due to advertising on television and talk shows on sexuality related issues, and also due to the imperatives of the HIV/AIDS pandemic, on the other hand nothing seems to have changed in the gender norms and double standards governing sexuality. Youth and older people are in a state of confusion with the conflicting messages coming at them from different quarters. Religious groups are going back in time and proscribing dress codes and codes of conduct, which are centuries old. Intolerance for sexual minorities continues. In this confusing context TARSHI's Helpline is providing a much needed service.

The Helpline addresses a wide range of concerns, ranging from basic information related to the body, sex, conception and contraception, to issues around sexuality of disabled persons, persons in same sex relationships, persons with multiple sexual partners and so on.

The quality of the sexuality counselling provided by TARSHI is very good. It is marked by high levels of confidentiality, evidence based information, reliable referrals, and a rights based, gender sensitive approach. There is an organisational commitment to quality, with excellent supervision and support systems in place, including good burnout prevention systems.

TARSHI's counsellors, young women with postgraduate degrees in social sciences, are carefully selected and rigorously trained over 12 to 14 weeks. The training is experiential, promoting self-reflection and attitudinal change, as well as building skills in communication and counselling around sexuality issues. There is a select group of highly committed and competent professionals who provide the training to the counsellors. In a sense these trainers are role models for the counsellors.

TARSHI has been producing classic publications based on the experiences gathered through the Helpline. These publications are in demand and some have been translated into several languages. TARSHI has also been using the lessons learnt from running this Helpline to form a network of organisations running Helplines – in their regular meetings, they reflect on their issues in an attempt to improve their services.

It is difficult for an anonymous Helpline based sexuality counselling service to track the behavioural, individual and health outcomes of its service. Some callers do report follow-up actions in subsequent calls and these are recorded. From the callers' reports it appears that the counselling service helps in providing the needed information and clearing the callers' confusion, it helps in improving the 'morale' of the callers as well as their self-esteem. There are also instances of the callers reporting back about the referral services availed.



Sustaining such a service is an issue. Sexuality per se is an issue that is low down in donors' and policy makers' list of priorities. Sexuality counselling in the context of HIV/AIDS, or Sexual and Reproductive Health, or Young People's Development and Rights may find some takers. Making such services paying may be challenging. Our FGDs indicated that the youth especially do not want to pay for sexuality related information and counselling. Financial resources are one aspect of sustainability. The other aspect is burnout and interest in running such a challenging service day in and day out. There is considerable effort involved in finding, training and retaining counsellors who will continue to give high quality of services for more than two years.

### Recommendations

There are two sets of recommendations: first for TARSHI and second more general, macro-level recommendations.

#### For TARSHI

TARSHI needs to consolidate its considerable experience in the field of sexuality and sexuality counselling and assume a leadership role in India in order to bring sexuality onto policy makers' agenda. Our analysis indicates that there are at this point in time several opportunities for such advocacy. At least three ministries – Health including HIV/AIDS, Education and Youth Affairs – have mandates into which sexuality can be mainstreamed. However, there are several challenges that need to be addressed – patriarchal, conservative mindsets, lack of evidence based information, frequent transfers of officers and bureaucrats, agendas which are perceived to be far more critical than sexuality.

These challenges need to be addressed through concerted, coordinated advocacy by a coalition of a wide range of organisations ranging from those in education, health, law and justice, women's and children's empowerment, youth

affairs and so on. Advocacy strategies that should be used should be primarily educational, explaining the criticality of addressing sexuality issues for social transformation and casting sexual rights within the framework of equity. Confrontational or adversarial advocacy may boomerang on a sensitive issue such as sexuality and lead to hardening of conservative positions. TARSHI could prepare policy briefs based on the data analysed from its records and present these to the different ministries, and proactively suggest an agenda for each ministry.

Based on its experience of training sexuality counsellors, TARSHI could use their manual 'Basics and Beyond', to advocate for Sexuality and Sexuality Counselling courses in academic institutions and universities. Departments of Human Development and Family Studies, Psychology, Schools of Social Work, would be eminently suitable to house such courses. The Public Health Foundation of India may be another institution through which such a course may be introduced in the public health institutions to be started in different parts of the country.

And finally, the expectation of callers as well as many of the key informants (past counsellors, trainers and others who have known of TARSHI's service over the years) is that the Helpline service be extended beyond its current three days a week, six hours a day routine. To this, the TARSHI managers' response is 'we would be happy to do that, but who is willing to support the extension of the service?'

#### General Recommendations

There needs to be a multiplicity of sexuality related services beginning from information dissemination in local languages, information that is scientific, rights based, and gender sensitive. Information should be directed at specific needs of different groups – children, youth, older persons, sexual minorities.

Sexuality counselling services should be established at various levels and in institutions across different sectors.

Curricula for Sexuality and Sexuality Counselling should be developed and instituted in various academic institutions, including in the training institutes of health care providers and teachers. Core faculty would have to be carefully trained, as TARSHI's experience has shown.

Protocols to ensure high standards in sexuality related services should be developed and made mandatory. Recognition and certification should

be provided only to those institutions that follow the protocols.

Sexual history taking should be made part of the practice of sexual and reproductive health care providers. The providers should also be trained in communication around sexuality.

Theoretical and conceptual work needs to be done around definitions of sexuality, sexual health, sexuality counselling, human rights – sexual rights – women's rights – gender perspectives' on sexuality, frameworks for assessing quality of sexuality counselling and how does one measure the impact of sexuality counselling.

# ANNEXURES



## Annexure 1

# Tools, Consent Forms, Frameworks to Assess Quality of Sexuality Counselling

### List of Tools and Informed Consent Forms

1. **Key Informant Interview Guide**
  - A. Organisations/individuals who refer to TARSHI
  - B. Organisations/individuals that TARSHI refers to
  - C. Organisations familiar with TARSHI service and working in the field of SRHR
  - D. Policy makers and Donors
  - E. International organisations
  - F. In-depth Interviews with Trainers
2. **Tool to elicit Callers' feedback**
  - A. Telephone Interview from Repeat Callers
  - B. Internet Feedback Form
3. **Facility Questionnaire**
4. **Managers and Counsellors Interview Guide (including Past Counsellors)**
5. **Client FGD guide**
6. **Informed Consent Letters**
7. **Framework to assess Quality of sexuality counselling from records**
8. **Guide to Interviewee's Codes**



## 1. Key Informant Interview Guide

### 1A. Topic Guide for Key Informants and Stakeholders

#### Organisations/individuals who refer to TARSHI

These interviews were carried out by the researchers and were recorded in written notes as well as through taped recordings, depending on the context and the preferences of the respondent.

Respondent Number \_\_\_\_\_

Date of Interview \_\_\_\_\_

Time of Interview Commencement \_\_\_\_\_

Name of Respondent's Organisation \_\_\_\_\_

Position within the Organisation \_\_\_\_\_

Length of Time with Organisation \_\_\_\_\_ / \_\_\_\_\_ (months/years)

Link of the Organisation to TARSHI \_\_\_\_\_

- Has your Organisation ever referred anyone to TARSHI for counselling? When was the last time someone was referred by you/your organisation?
- In your opinion, for what reasons do people seek counselling?
- What topics do they cover in sexual health and sexuality related concerns?
- According to you, what topics should be covered in this type of counselling?
- In what contexts or for whom do you think this 'sexuality or sexual health counselling' should be offered?
- In terms of outcomes or benefits to the client, what in your opinion have been/are the outcomes of the sexuality counselling?
- What are the positive/exemplary aspects of sexuality counselling that should be emulated or replicated/scaled up?
- What do you think are the greatest constraints to offering sexuality and sexual health counselling within an organisation like TARSHI? (e.g. time, privacy, cost, skills, provider discomfort with talking about sex, etc.)
  - a. What do you think are the greatest external constraints (threats) to (TARSHI) providing this type of service? (e.g. legal barriers, social, cultural or religious opinions or barriers, etc.)
  - b. How about strengths and opportunities?
- Do you have anything else you would like to say or add?

*Thanks for your participation!!*

Time interview ends \_\_\_\_\_

## 1B. Topic Guide for Key Informants and Stakeholders

### Organisations/individuals who refer to TARSHI

Respondent Number \_\_\_\_\_

Date of Interview \_\_\_\_\_

Time of Interview Commencement \_\_\_\_\_

Name of Respondent's Organisation \_\_\_\_\_

Position within the Organisation \_\_\_\_\_

Length of Time with Organisation \_\_\_\_\_ / \_\_\_\_\_ (months/years)

Link of the Organisation to TARSHI \_\_\_\_\_

- TARSHI refers Callers to your organisation? How many? How often? When was the last time?
- In your opinion, for what reasons do people seek counselling?
- What topics do they cover in sexual health and sexuality related concerns?
- According to you, what topics should be covered in this type of counselling?
- In what contexts or for whom do you think this 'sexuality or sexual health counselling' should be offered?
- In terms of outcomes or benefits to the client, what in your opinion have been/are the outcomes of the sexuality counselling?
- What are the positive/exemplary aspects of sexuality counselling that should be emulated or replicated/scaled up?
- What do you think are the greatest constraints to offering sexuality and sexual health counselling within an Organisation like TARSHI (e.g. time, privacy, cost, skills, provider discomfort with talking about sex, etc.)?
  - a. What do you think are the greatest external constraints (threats) to (TARSHI providing this type of service? (e.g. legal barriers, social, cultural or religious opinions or barriers, etc.)
  - b. How about strengths and opportunities?
- Do you have anything else you would like to say or add?

*Thanks for your participation!!*

Time interview ends \_\_\_\_\_

## 1C. Topic Guide for Key Informants and Stakeholders

**Organisations familiar with TARSHI services and those in the field of SRHR.**

Respondent Number \_\_\_\_\_

Date of Interview \_\_\_\_\_

Time of Interview Commencement \_\_\_\_\_

Name of Respondent's Organisation \_\_\_\_\_

Position within the Organisation \_\_\_\_\_

Length of Time with Organisation \_\_\_\_\_ / \_\_\_\_\_ (months/years)

- Are you aware of TARSHI's telephone counselling service? Can you tell me about this service?
- Do you know or has your Organisation ever referred anyone to TARSHI for counselling or other services? If other services, which ones?
- In your opinion, for what reasons do people seek counselling?
- What topics do they cover in sexual health and sexuality related concerns?
- According to you, what topics should be covered in this type of counselling?
- In what contexts or for whom do you think this 'sexuality or sexual health counselling' should be offered?
- In terms of outcomes or benefits to the client, what in your opinion have been/are the outcomes of the sexuality counselling?
- What are the positive/exemplary aspects of sexuality counselling that should be emulated or replicated/scaled up?
- What do you think are the greatest constraints to offering sexuality and sexual health counselling within an Organisation like TARSHI? (e.g. time, privacy, cost, skills, provider discomfort with talking about sex, etc.)
  - a. What do you think are the greatest external constraints (threats) to (TARSHI) providing this type of service? (e.g. legal barriers, social, cultural or religious opinions or barriers, etc.)
  - b. How about strengths and opportunities?
- Do you have anything else you would like to say or add?

*Thanks for your participation!!*

**Time interview ends** \_\_\_\_\_

## 1D. Topic Guide for Key Informants and Stakeholders

### Policy Makers and Donors

Respondent Number \_\_\_\_\_

Date of Interview \_\_\_\_\_

Time of Interview Commencement \_\_\_\_\_

Name of Respondent's Organisation \_\_\_\_\_

Position within the Organisation \_\_\_\_\_

Length of Time with Organisation \_\_\_\_\_ / \_\_\_\_\_ (months/years)

- I am here to explore your opinions about Sexuality Counselling. How important is Sexuality Counselling from your standpoint? Why or Why not?
- Which organisations are providing Sexuality Counselling?
- What topics do they cover in sexual health and sexuality related concerns?
- According to you, what topics should be covered in this type of counselling?
- In what contexts or for whom do you think this 'sexuality or sexual health counselling' should be offered?
- What are the positive/exemplary aspects of sexuality counselling that should be emulated or replicated/scaled up?
- What do you think are the greatest constraints to offering sexuality and sexual health counselling within an Organisation like TARSHI (e.g. time, privacy, cost, skills, provider discomfort with talking about sex, etc.)?
  - a. What do you think are the greatest external constraints (threats) to (TARSHI providing this type of service? (e.g. legal barriers, social, cultural or religious opinions or barriers, etc.)
  - b. How about strengths and opportunities?
- How should counsellors for Sexuality counselling be trained and supervised?
- Is there any policy or plan at the national level, which is of interest to the field of sexuality counselling?
- Do you have anything else you would like to say or add?

*Thanks for your participation!!*

Time interview ends \_\_\_\_\_

## 1E. Topic Guide for Key Informants and Stakeholders

### International Organisations (UNAIDS, UNICEF, UNIFEM)

Respondent Number \_\_\_\_\_

Date of Interview \_\_\_\_\_

Time of Interview Commencement \_\_\_\_\_

Name of Respondent's Organisation \_\_\_\_\_

Position within the Organisation \_\_\_\_\_

Length of Time with Organisation \_\_\_\_\_ / \_\_\_\_\_ (months/years)

- Are you aware of TARSHI's work? Could you tell me a bit about what you have done together?
- What do you know about TARSHI's telephone Helpline?
- What topics do they cover in sexual health and sexuality related concerns?
- According to you, what topics should be covered in this type of counselling?
- In what contexts or for whom do you think this 'sexuality or sexual health counselling' should be offered?
- In terms of outcomes or benefits to the client, what in your opinion have been/are the outcomes of the sexuality counselling?
- What are the positive/exemplary aspects of sexuality counselling that should be emulated or replicated/scaled up?
- What do you think are the greatest constraints to offering sexuality and sexual health counselling within an organisation like TARSHI (e.g. time, privacy, cost, skills, provider discomfort with talking about sex, etc.)?
  - a. What do you think are the greatest external constraints (threats) to (TARSHI providing this type of service? (e.g. legal barriers, social, cultural or religious opinions or barriers, etc.)
  - b. How about strengths and opportunities?
- Do you have anything else you would like to say or add?

*Thanks for your participation!!*

Time interview ends \_\_\_\_\_



## 1F. In-depth Interviews with Trainers

Respondent number \_\_\_\_\_ to be filled in advance

Sex:        F        M

Training background information:

Age:

Sex:

Education

(which)

(attainment in years):

Organisation:

Site:

### Training

- How long have you been a trainer on counselling?
- Where have you been trained to be a trainer? By whom, when, how long?
- Do you get any on-going training?
- How often do counsellors get trained, is there any follow-up training, what kind of support systems has been put in place for the counsellors?
- What material and/or curriculum do you use?
- Was the training ever evaluated?
- Can you tell me about the working conditions of the counsellors, including working hours, salary, training opportunities, etc?
- Do you have experiences with burnout of counsellors? What is the institution putting in place avoid burnout symptoms and conditions?
- Do you think it is important to include sexuality related issues into the training curriculum?
- What are the most common issues related to sexuality that you think should be included in the curriculum?
- What kind of issues related to sexuality do you feel the clients have more difficulties talking about?
- What kind of issues related to sexuality do you think counsellors have difficulties talking about? How do you deal with this in the training?
- What is your personal belief about the outcomes of sexuality counselling?
- What do you think is a good counselling service related to sexuality?

- What issues related to sexuality is included in the training curriculum material?
- Have you had changes over time in connection to the content of the training? What changes and why?

### **Counselling and Quality**

- What do you think clients feel about the counselling services provided at your clinic/facility?
- What aspects do clients like about these counselling services? Why?
- What aspects do clients not like about these counselling services? Why?
- What do you think about the client provider interaction (reception, continuity, discrimination, and attitude, competence of provider, language, confidentiality and privacy)?
- How is confidentiality and privacy guaranteed?
- What do you think about: duration time (waiting time for different aspects of service provision), duration of time for counselling sessions?
- Convenience: How convenient is the geographical location, opening hour, administrative procedures?
- Accessibility: How accessible is decision making, gender, cultural beliefs, payments and location?
- Information (sources of information, follow up, referral, choice of treatment location, continuity of care)?
- Are there any things you do not like in providing counselling services? Why?
- What do you find important about the training for counselling that should be replicated or scaled up?
- Would you suggest any changes for improvement? How?

### **More General**

- Are there any local/traditional forms of counselling here?
- What sexuality counselling related to sexual health and sexual rights issues is provided in the area?
- Is/are there any policy (plans) at national level which is of interest in the field of counselling with respect to sexuality and sexual health?
- What is the general public opinion about sex and sexuality? Is it possible to speak openly about it?
- Is there cultural and religious diversity in society or catchments area? How do these influence the project focus on sexuality?
- Are there any other things you would like to mention? Or do you have any questions yourself?

*Thank you for your cooperation*

## 2. Tools to Elicit Callers' Feedback

### 2A. Telephone Interview from a Repeat Caller

- How was the experience of calling the TARSHI Helpline for you?
- To what extent was it useful for you?
- Why did you call TARSHI? What was the issue with which you called?
- Did you receive answers to your questions?
- To what extent did you feel that the counsellor understood your issue?
- Did you ever feel that the counsellor was judging you?
- To what extent did you feel comfortable talking to the counsellor?
- Did you ever refer anyone else to the TARSHI Helpline?
- Did you call TARSHI more than once?
- Did anything change in your life as a result of calling the TARSHI Helpline?
- Do you have suggestions for TARSHI for improving their services?

## 2B. Internet Feedback Form

1. Please enter the ID no. given to you by the Helpline counsellors.
2. How did you learn about counselling services at this centre?
3. What made you call the Helpline?
4. What information and counselling services did you receive in the course of your conversations on the Helpline?
5. Were you encouraged to express your concerns and feelings?
6. Did you feel that the counsellor listened attentively?
7. To what extent did you feel that the counsellor understood your dilemmas and needs?
8. To what extent did you feel validated (that your feelings were understood)?
9. During the calls did the counsellor use words (language) you could understand (clear and simple terms)?
10. During the calls did the counsellor use a kind and warm tone?
11. During the calls did the counsellor give you time to absorb information and to respond?
12. During the calls did the counsellor allow you to ask for clarification about information given?
13. During the calls did the counsellor repeat and reinforce important information?
14. During the calls did the counsellor summarize the main issues discussed?
15. Were you able to discuss the issues you wanted to discuss?
16. Did the counsellor review with you your immediate plans and intentions (answer if relevant to your concern)?
17. Were you referred to another service?
18. Whom did they refer you to? Please give the name of the service if you remember.
19. Did the counsellor give contact and other details (rates, timings, address etc.) of the referral service?
20. If you were not referred, do you think that you needed to be referred?
21. What services would you have liked to be referred for?
22. Do you feel confident that the counsellor you spoke to would not share information about you with anyone else?
23. What aspects could the counsellor have done better?
24. What did you like most about the counselling?
25. What did you dislike most about the counselling?

26. Were your expectations of this type of service delivery met?
27. Would you recommend the counselling service to a friend?
28. What can be done to improve sexuality counselling at this centre/facility? Please state 2 possible ways of improving sexuality counselling.
29. Do you think that counselling through the telephone is a good way of addressing sexuality concerns? Please explain your answer in the comments section?
30. Do you have any additional remarks?

### 3. Facility Questionnaire

Questionnaire Number: \_\_\_\_\_

Name of Facility \_\_\_\_\_ Facility No: \_\_\_\_\_

Date \_\_\_\_\_

Time Interview Started \_\_\_\_\_ Ended \_\_\_\_\_

Name of Data Collector: \_\_\_\_\_ Code: \_\_\_\_\_

Seek Informed Consent \_\_\_\_\_ (fill attachment)

Respondent Number \_\_\_\_\_ (to be filled in advance)

#### Personal Information

1. Present position: \_\_\_\_\_
2. What is your position? \_\_\_\_\_
3. How long have you worked in this position? \_\_\_\_\_

#### 1. Accessibility of Your Facility

- a) How many days per week are counselling services offered at this facility?
- b) What is the size of your catchments population?
- c) What kind of counselling services do you provide (please list them)?
- d) What are the general characteristics of clients (sex, age, socio-economic status, ethnicity, marital status, religion – *ask for summary if available*)?
- e) Do patients have to pay for services? If yes, then what services do they pay for? How much does each service cost?



2. Give an overview of the personnel in your facility			
Total	No. in the facility		No. received training counselling
a) Number of managers			
b) Number of counsellors			
c) Number of social workers			
d) Others (specify)			
e) What are the criteria for counsellor staff selection?			
f) Recruitment procedures?			
g) Training: What kind of training? How often is training carried out? What are the contents of the training?			
h) Are there staff shortages in this facility?	<b>Yes</b> 1	<b>No</b> 2	

3. PLEASE NOTE THE CONDITION OF COUNSELLING LOCATION:			
<ul style="list-style-type: none"> <li>- Cleanliness</li> <li>- Privacy (no open areas for others to view counselling session in progress)</li> <li>- Confidentiality – How are clients’ records and forms stored? _____</li> <li>- Setting (comfortable surroundings conducive to counselling environment)</li> </ul>			
4. Counselling		<b>yes</b>	<b>no</b>
a) Are guidelines/protocol followed?		1	2
b) Is referral available if necessary?		1	2
c) Is referral to other services available?		1	2

5.	<b>Infrastructure for Consultation/Examination</b>	<b>Yes</b>	<b>No</b>
	Private space for counselling session	1	2
	Confidentiality contracts signed	1	2
	Follow-up cards	<b>Yes, seen</b>	<b>Not, seen</b>
6.	<b>Guidelines for counselling</b> ( <i>List basic ones at the center and ask what is available in the branches</i> )		
	Other?		
7.	<b>Is there a register where information on clients' is recorded?</b> (If yes, ask to see the register)	1	2
8.	<b>Is there a standard guideline or protocol for providing focused sexuality counselling?</b> (If yes, ask to see the guideline)	1	2
9.	Do you follow a specific protocol especially describing the counselling interventions?	1	2
10.	Do you follow national guidelines especially describing the counselling interventions?	1	2
11.	Do you follow a (gender) protocol specifically describing the counselling interventions with respect to sex of the counsellor versus sex of the client?	1	2
12.	Do you follow protocol specifically describing the counselling interventions with respect to couple counselling?	1	2
13.	How many counselling calls (both new and repeat) took place during the previous 12 complete months?	New visits	
		Revisit	
		Not Applicable	
14.	Do supervision and support systems exist at this center?	<b>Yes</b>	<b>No</b>
	<ul style="list-style-type: none"> <li>• How is supervision done? _____ _____</li> <li>• How often? _____</li> <li>• Debriefing done?</li> <li>• Feedback given?</li> </ul>	1  1 1	2  2 2

15.	What do you see as the strong elements of the counselling sessions provided at TARSHI?	
16.	What are the weak elements of TARSHI counselling sessions?	

Below is a list of possible outcomes of counselling sessions. Could you please confirm whether or not, in your opinion these outcomes can be seen as a result of your counselling services?

17.	Service delivery and health system outcomes:	Yes	No
	Increased use of health services by all groups in need of sexuality counselling	1	2
	Increase in demand for contraceptives	1	2
	Increase in demand for STI/HIV testing	1	2
	Increase in partner-notification	1	2
	Decrease in repetitive STI infections	1	2
	Increase in adherence to treatment	1	2
	Improved capacity of health delivery system (training of staff and support, policies' implementation, referral systems, etc.)	1	2
	Increased written resources on sexuality counselling, including policies and protocol	1	2
	Other outcomes or 'changes'	1	2

#### 4. Managers and Counsellors Interview Guide (Including Past Counsellors)

- Since how long have you been doing this work? What training did you get? What is/was your motivation for this work?
- What have been the high points in your experience? Why?
- What have been low points? Why?
- How can quality be assured? (Probe for workload, training, publicity, supervision and support, follow-up and referral, logistical arrangements)

#### Other Questions Suggested

- What influences the norms and beliefs around sexuality (religion, age, family beliefs, spiritual, education level, culture, peer pressure, etc.)?
- What kind of information on sexuality counselling do you offer clients in general? How would you rate the quality of the information?
- Can you explain why anyone would seek help related to sexuality? *Probe (dating, love, relationships, marriage, self-esteem, assertiveness, decision making, pleasure, sex, achieving sexual and reproductive health goals, fertility and prevention of pregnancy, unwanted pregnancy, sexual identity, gender relations, sexual violence)*
- In your experience, do the clients' backgrounds influence their decision on where to seek services? *(If yes)* How?
- From your experience, what could be the outcome/benefits of counselling on issues related to sexuality?
- Can you describe the challenges/problems associated with sexuality counselling?
- How can these challenges/problems be overcome?
- Are there any support mechanisms for counsellors? How? When? Why?
- Do you have suggestions for good sexuality counselling?

## 5. Clients FGD Guide: Men

(Revised after Ethical Review Committee Meeting)

Same tool used for FGDs with women as proxy users.

Men whose profile matches TARSHI's Callers: between 15 and 30 years of age, from in and around Delhi. This FGD be facilitated by a man. Purpose of the FGD:

- To explore and triangulate norms and values related to sexuality
  - Sources of information
  - Have they heard of TARSHI's Helpline
  - What would they expect from such a Helpline in terms of Contents/Issues and Quality.
1. (From) where do people like you learn about sexuality related issues/information?  
*(Dating, love, relationships, marriage, self-esteem, assertiveness, decision making, pleasure, sex, achieving sexual and reproductive health goals, sexual desires, fertility and prevention of pregnancy, unwanted pregnancy, sexual identity, gender relations, sexual violence).*
  2. When do men or boys like you think about the things we have just discussed (above)?
  3. What do you think men/boys like you mostly worry about?
  4. Why do you think anyone would seek help related to sexuality counselling?
  5. Have any of you received information/counselling about these issues?  
From where?
  6. What specific information or counselling (on what issues) did you receive?  
Was it helpful?
  7. Is there something else you would have liked/or would still like to learn about?
  8. How would you feel about telephone counselling on sexuality and related issues?
  9. What would you expect from sexuality telephone counsellors?
  10. Do you know of any traditional/private sexuality counselling services?
  11. What problems do you think people experience while seeking sexuality counselling? *(Access, cost, distance, language, privacy, confidentiality, provider attitude)*
  12. What influences the (current) norms and beliefs around sexuality *(religion, age, family beliefs, spiritual, education level, culture, peer pressure, etc.)?*
  13. What are the benefits of sexuality counselling/how does counselling help an individual?

## 6. Informed Consent Letters



### Informed consent form for TARSHI managers and counsellors

Hello, My name is Renu Khanna. I am doing a review of TARSHI's telephone Helpline on behalf of WHO, Geneva and KIT, Amsterdam. We would like to understand better the quality of service provided here. We understand that your counselling services have a good reputation and would like to learn from this. We hope that this information will help to improve this service and other services provided to people in other places.

#### Procedures Including Confidentiality

If you agree we would like to interview you about the counselling sessions you provide. During the interview you will be asked about what kind of issues you discuss during the counselling, how you think clients feel about the counselling related to sexuality issues, what they find difficult, what you find difficult and how the Organisation supports the provision of counselling.

To make sure that we do not forget or change what you are saying to me; I will write down the answers you give (tape the conversation). Everything that will be said, written down or taped will be kept totally confidential. Your name will not be recorded or written down. The researchers who will read the notes for analysis will not know your name or your face. The notes/tapes will be kept in a locked space and the tapes destroyed after the content has been written down.

Also the publication on the practices that are conducted here will be attributed to the services in general and not to you.

#### Risk, Discomforts and Right to Withdraw

During the interview I may ask you things that you find personal or you may feel uncomfortable to talk about some topics. However, I do not wish you to feel uncomfortable and you can refuse to answer any question or stop the interview whenever you wish. The fact that you are not answering some questions will not be shared with your superiors and will not in any way affect the way you are treated at work or outside work.

#### Benefits

The results of the study will help to improve this service and services in other places. If you do not want to participate there will be no effect on your job and nobody will hold this against you.

#### Sharing the Results

After the assessment of the counselling is completed, we will be sharing the results with the community through a stakeholder meeting. In addition, the results will be available in written form through our Organisations. If you would like to participate in the stakeholder meeting or would like to receive a copy of the report, please let us know and we will make this possible for you.



### Consent and Contact

Do you have any questions that you would like to ask?

Are there any things you would like me to explain again or say more about?

Contact details:

If you have any other questions about this study later you can contact any of the following persons:

**Renu Khanna**, sahajbrc@yahoo.com, (M) 09427054006, **Anke van der Kwaak**, Senior Advisor, Health Systems Research and SRHR, A.v.d.Kwaak@kit.nl, Phone number 0031– 205688497

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from at anytime without in any way affecting me.

Print name of participant \_\_\_\_\_

Signature of participant \_\_\_\_\_

Date \_\_\_\_\_

A copy of this Informed consent form has been provided to the participant \_\_\_\_\_ (initialed by the researcher)



KONINKLIJK INSTITUUT  
VOOR DE TROPEN  
ROYAL TROPICAL INSTITUTE

### **Informed consent form for Key Informants**

Hello, My name is Renu Khanna. I am doing a review of TARSHI's telephone Helpline on behalf of WHO, Geneva and KIT, Amsterdam. We would like to understand better the quality of sexual and reproductive health counselling services provided in this city. We understand that some of the counselling services provided have a good reputation and would like to learn from this. We hope that this information will help to improve services provided.

#### **Procedures Including Confidentiality**

If you agree we would like to interview you about TARSHI's sexual reproductive health and HIV/AIDS services and also about where people go when they have problems or concerns about their sexual life and health, your evaluation of the quality of these services and in how far they meet the needs of the people in the community; what you think could be improved or changed.

To make sure that we do not forget or change what you are saying I will write down the answers you give. Everything that will be said, written down will be kept totally confidential. Your name will not be recorded or written down. Notes will be kept in a locked place. Only the team of researchers will have access to the notes.

The publication on the findings will be attributed to the services in general and not to your particular site.

#### **Risk, Discomforts and Right to Withdraw**

You are free to refuse to answer any question for any reason.

#### **Benefits**

This study may not help you directly but the results will help to improve sexual health services.

#### **Sharing the Results**

After the assessment of the counselling is completed, we will be sharing the results with the community through a stakeholder meeting. In addition, the results will be available in written form through our Organisation.

If you would like to participate in the stakeholder meeting or would like to receive a copy of the report, please let us know and we will make this possible for you.

### Consent and Contact

Do you have any questions that you would like to ask?

Are there any things you would like me to explain again or say more about?

Do you agree to participate in the interview?

Contact details:

If you have any other questions about this study later you can contact any of the following persons:

**Renu Khanna**, sahajbrc@yahoo.com, (M) 09427054006, **Anke van der Kwaak**, Senior Advisor, Health Systems Research and SRHR, A.v.d.Kwaak@kit.nl, Phone number 0031– 205688497

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from at anytime without in any way affecting me.

Print name of participant \_\_\_\_\_

Signature of participant \_\_\_\_\_

Date \_\_\_\_\_

Day/Month/Year

A copy of this Informed consent form has been provided to the participant \_\_\_\_\_ (initialed by the researcher)

## 7. Framework to assess Quality of Sexuality Counselling from records

- Sexuality issues addressed
- Evidence of privacy and confidentiality
- Evidence of non-judgmental attitude and non-discrimination
- Details of Information provided
- Details of Referrals made
- Validation: Giving permission to talk
- Exploring and Probing
- Listening
- Woman centeredness
- Other aspects of quality counselling: not making decisions for client, managing dependence, evaluating own counselling etc.

## 8. Guide to Interviewee's Code

**Callers** – Repeat Callers whose records were studied

**C** – Counsellors

**K** – Key Informants

**M** – Managers

**MC** – Manager Counsellors

**PC** – Past Counsellors

**RK** – Callers who were interviewed over the telephone

**T** – Trainers

**TR** – Callers who filled the Internet feedback form

## Annexure 2

# Epidemiological Information Related to Sexual and Reproductive Health in India

### 2.1 Information from the National Family Health Survey 3<sup>49</sup>

**Table 2.1.1 Marriage and Fertility**

	NFHS – 3 2005-06	NFHS – 2 1998-99	NFHS – 1 1992-93
Women age 20-24 married by age 16 years (%)	44.5	50.0	54.2
Men age 25-29 married by age 21 (%)	29.3	NA	NA
TFR (children per women)	2.68	2.85	3.39
Women age 15-19 who were already mothers or pregnant at time of survey (%)	16.0	NA	NA
Median age at first birth for a women age 25-49	19.8	19.3	19.4
Married women with 2 children wanting no more children (%)	83.3	72.4	59.7
With 2 sons	89.9	82.7	71.5
One son, one daughter	88.1	76.4	66.0
Two daughters	62.1	47.0	36.9

<sup>49</sup> National family Health Survey 3 (2005– 06) [Online] Available from: URL: <http://www.nfhsindia.org/factsheet.html> (Accessed on: 21/09/07)



**Table 2.1.2 Family Planning Currently Married Women (age 15–49)**

	NFHS – 3 2005-06	NFHS – 2 1998-99	NFHS – 1 1992-93
Current use: any method (%)	56.3	48.2	40.7
Any modern method (%)	48.5	42.8	36.5
a. Female sterilization (%)	37.3	34.1	27.4
b. Male sterilization (%)	1.0	1.9	3.5
c. IUD (%)	1.8	1.6	1.9
d. Pill (%)	3.1	2.1	1.2
e. Condom (%)	5.3	3.1	2.4
<i>Unmet need for family planning</i>			
1. Total unmet need (%)	13.2	15.8	19.5
2. For Spacing (%)	6.3	8.3	11.0
3. For Limiting (%)	6.8	7.5	8.5

**Table 2.1.3 Knowledge of HIV/AIDS among Ever-Married Adults (age 15–49)**

	NFHS – 3 2005-06	NFHS – 2 1998-99	NFHS – 1 1992-93
Women who have heard of AIDS (%)	57.0	40.3	Na
Men who have heard of AIDS (%)	80.0	Na	Na
Women who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	34.7	Na	Na
Men who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	68.1	Na	Na

**Table 2.1.4 Women's Empowerment**

	NFHS – 3 2005-06	NFHS – 2 1998-99	NFHS – 1 1992-93
Currently married women who usually participate in household decisions (%)	52.5	Na	Na
Ever married women who have ever experienced spousal violence (%)	37.2	Na	Na

## 2.2 Information Related to HIV/AIDS

**Table 2.2.1 Summary Results of STD/RTI Community Prevalence Study  
(NACO 2003)**

Diseases	Low – Moderate		High	
	Urban	Rural	Urban	Rural
No STD/RTI	83.9	86.0	84.8	82.0
Normal excluding Candidiasis & B.Vaginosis	94.2	95.3	94.0	88.3
Trichomoniasis	2.7	1.8	1.5	0.3
Candidiasis	6.6	5.5	6.6	8.1
Bacterial Vaginosis	7.2	6.4	4.0	6.5
Chancroid	0	0.1	0	0.1
Herpes – 2	0.6	0.7	1.6	1.9
Syphilis	0.4	1.0	0.8	1.2
HPV	1.6	0.8	0.4	0.3
HIV	0.1	0.3	1.4	1.1
Gonorrhea	0.2	0.1	0.2	0.6
Chlamydia	0.1	0	0.4	0.2
Multiple Infection excluding Candidiasis	0.4	0.2	0.2	0.3
<b>STI Prevalence</b>	<b>5.8</b>	<b>4.7</b>	<b>6.0</b>	<b>6.2</b>

## 2.3 Information Related to Sexuality from the Durex Survey

Table 2.3.1

	India	Global
Age when first received sex education (years)	15.6	13.2
Age formal sex education should start (years)	13.9	11.7
Age of first sex (years)	19.8	17.3
Number of sexual partners	3	9
Unprotected sex (%)	21	47

Table 2.3.2 Have you ever had any of the following

	India (%)	Global (%)
An unplanned pregnancy aged under 15	3	4
An unplanned pregnancy aged between 17 and 18	3	5
An unplanned pregnancy age 19 or over	9	10
A sexuality transmitted infection	4	13
None of the these	86	77

Table 2.3.3 Areas which need greater public awareness

	Indian (%)	Global (%)
Chlamydia	8	34
Genital warts/HPV	29	31
Gonorrhoea	23	37
Hepatitis	28	45
Herpes	14	33
HIV/AIDS	87	72
Pelvic inflammatory disease (PID)	21	20
Syphilis	33	45
Trichomoniasis	6	18
None	4	3
I've not heard of most of these	12	8

**Table 2.3.4 What government should invest in?**

	Indian (%)	Global (%)
Sex education in schools	47	34
Education initiatives (e.g. National Condom Week)	9	7
Free contraception	4	20
Advertising campaign	6	4
STI/HIV prevention in developing countries	11	8
Research into a vaccine for HIV/AIDS	6	9
Research for a cure for HIV/AIDS	11	11
Awareness of abstinence before marriage	2	3
None of these	2	2
I'm not concerned about these issues	2	2

**Table 2.3.5 Best way to raise awareness of safer sex**

	India (%)	Global (%)
A sexual health awareness day	13	9
Posters highlighting the importance of safer sex	18	10
Free condoms where high STI/Unplanned pregnancy	15	32
Encourage governments to discuss safer sex issues	16	17
Teaching materials for schools and HCPs	36	28
None of these	2	4

## Annexure 3

# Changes in Assessment Parameters of Four Counsellors

*N.B. – 1 means Excellent and 5 refers to negative impact*

**Table: Changes in Assessment Parameters of Four Counsellors**

Indicator	Counsellor's Code							
	CA		DS		KS		NP	
	Sep 2001	Dec 2002	June 2001	July 2003	Dec 1997	Nov 2000	Dec 1996	Dec 2002
Information	2.8	2	2.5	1.8	2.1	2.3	2	1
Ability to communicate effectively	2.6	2	2.2	1.8	3	2	2	1.3
Interest in new information	2.3	2	1.9	1.5	1.6	2.3	1.4	1.3
Sharing new information with team	2.6	2.5	2.1	1.5	2.6	2.7	1.6	2
Awareness of other related issues – gender, socio-economic realities, psychological issues, etc.	3	1.9	2	1.3	2.5	2.3	1.9	1.3
Comfort with own sexuality	2.2	1.8	1.5	2	2.4	2.1	2.6	2
Comfort with talking about sexuality	2.7	1.8	1.5	1.5	2.2	1.6	2.3	1.5
Counselling skills	2.7	1.9	2	1.3	2.8	2.2	2.2	1.7
Empathy	2.6	2.3	2.2	1.8	3.2	1.9	2.5	1.3
Listening skills	2.8	2	2.4	1.8	1.8	1.8	1.8	1.7
Compassion	2.3	2.3	2.4	2.3	2.4	1.8	2.7	2
Non-judgmental attitude	2.7	1.8	2.1	1.5	1.8	1.7	2.5	1.2
Genuineness (not pretending)	–	2.1	–	–	–	–	–	2
Openness to feedback	2.9	2.3	2.2	1.8	1.7	1.8	1.8	1.7
Willingness to give feedback	3.3	2.1	2.6	1.5	3.2	2.1	2.8	1.3
Ability to stay in tune with Caller and remain separate	3.4	1.9	2.2	1.5	1.6	1.8	2.2	1.7
Ability to identify own reactions to calls	–	2.2	–	–	–	–	–	1.5
Ability to healthily handle own reactions to calls	3.1	2.2	2.2	1.5	2	1.5	1.9	1.5

Indicator	Counsellor's Code							
	CA		DS		KS		NP	
	Sep 2001	Dec 2002	June 2001	July 2003	Dec 1997	Nov 2000	Dec 1996	Dec 2002
Willingness to improve on unhealthy reactions to calls	–	2.1	–	–	–	–	–	1
Voice modulation	2.1	2.1	2.1	1.5	2.7	1.8	2.1	1.5
Language fluency – English	1.8	1.9	2	1.5	2.4	1.6	1.4	1.5
Language fluency – Hindi	3.7	2.6	2.2	2	2.8	1.8	3	1.5
Politeness on the phone	2.3	2	1.7	1.8	1.8	1.6	1.9	1.7
Ability to handle crank/abusive calls	3.7	1.9	1.7	1.5	2	1.6	2.3	1.3
Contribution to burnout prevention meetings	3	2.1	2	1.8	3.5	2.6	3	1
Referral skills	2.8	2		1.8	1.8	2	2.3	1.5
Documentation skills – clarity & comprehensiveness	–	2.2	2.3	2.5	1.2	1.7	1.8	1
Creativity/new ideas	2.8	NA	1.5	1.5	2.2	2.4	1.8	1
Initiative shown	2.7	NA	1.8	1.8	2.2	2	1.4	1
Ability to carry/fulfill responsibilities given/taken	2.3	NA	2.5	1.8	1.4	1.3	1.2	1
Analytical and abstraction ability	2.2	NA	1.5	1.3	2.8	2.1	2.6	1
Ability to carry out tasks independently	2.4	NA	2.1	1.5	1.8	1.3	1.4	1
Team spirit/inter-personal relations	1.2	NA	1.3	1.5	1.8	1.4	2.2	3
Decision-making skills	2.8	NA	2	1.8	2.4	1.5	2	1
Problem-solving skills	2.5	NA	1.9	1.5	2.6	1.8	2	1
Communication/presentation skills	2.3	NA	2.2	1.8	2.7	2.1	2	2
Organisational 'fit'	2	NA	1.8	1	1.8	1.2	1.4	1
Work quality	2.2	NA	2	1.8	2.2	1.5		1
Dependability/reliability	2.3	NA	2	1.8	1.2	1.1	1.2	1
Punctuality	2.3	NA	1.8	2.5		1.2	1.6	1
Discipline	3.3	NA	2.6	2	1.5	1.3	1.8	1
Inter-personal relations	2.3	NA	1.7	1.5	1.8	1.3	2.2	3



## Annexure 4

# Overview of Training Content for Helpline Counsellors

### Week 1

Understanding sexuality

Back to basics I – anatomy and physiology

Back to basics II – conception and contraception

Back to basics III – abortion

Life cycle change and sexuality

Varieties of sexual behaviour

Making the connection – links between sexuality, reproductive health, sexual health and rights

### Week 2

Back to basics IV – menopause, HRT

Sexual problems – men and women

Sexual choice/preference – an introduction

Gender and patriarchy – an introduction

Sex work and prostitution – an introduction

International treaties and conventions – an introduction, UDHR

Counselling skills – an introduction to concepts

TARSHI Helpline documentation – an introduction

### Week 3

Back to basics V – infertility

Back to basics VI – infections

Back to basics VII – HIV/AIDS

Rights – sexual and reproductive

Counselling skills – theory and practice

'Alternative' sexualities

Violence Against Women – an introduction

CEDAW, Beijing and Cairo documents

#### **Week 4**

Rape and other forms of sexual violence

Incest and child sexual abuse

Disability issues – an introduction

Transgender issues

Counselling skills – theory and practice

Burnout

#### **Week 5**

Sexuality and rights

Politics and sexuality

Hazardous contraception

Sex pre-selection issues

Counselling skills – theory and practice

Pornography

Legal issues I – an introduction

#### **Week 6**

Masculinities

Suicide and crises intervention

Legal issues II – marriage, dowry, domestic violence

Legal issues III – sexual harassment in the workplace

Legal issues IV – transgender issues

Data entry of Helpline documentation

#### **Week 7–10**

Miscellaneous and pending issues are covered

Practicing counselling skills

Role plays

Listening to calls on Helpline

Data entry of Helpline documentation

Revision of information

Visits to other Organisations, meetings and events

## **Week 11–14**

Taking calls on the Helpline under supervision

Documenting calls

Data entry of calls

Continue to revise and refresh information

Miscellaneous and pending issues are covered

### **Training includes:**

- Reading on information, issues and concepts
- Presentations
- Book and report reviews
- Role plays
- ‘Mock’ calls
- Observing calls on the TARSHI Helpline
- Entering Helpline documentation into the computer (data entry)
- Going through old Helpline documentation
- Visiting organisations and attending meetings
- Writing reports and minutes of meetings
- Miscellaneous activities that help enhance skills of the trainee

## Annexure 5

# Glossary

ANC	Ante Natal Care
CSA	Child Sexual Abuse
FHOK	Family Health Options Kenya
Hijra	Transgender
HRGs	High Risk Groups
ICPD	International Conference on Population and Development
KIT	Royal Tropical Institute, Amsterdam
LGBT	Lesbian, Gay, Bisexual, Transgender
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MSM	Men who have sex with Men
MTP	Medical Termination of Pregnancy
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NPP	National Population Policy
PLHA	Persons Living with HIV/AIDS
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Technique
RAM	Rapid Assessment Methodology
RCH	Reproductive and Child Health
RH	Reproductive Health
RTIs	Reproductive Tract Infections
S & D	Stigma and Discrimination
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TARSHI	Talking About Reproductive and Sexual Health Issues
TASO	The AIDS Support Organisation
VCTC	Voluntary Counselling and Testing Centre
WHO	World Health Organisation

## Annexure 6

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