



## **Policy Brief**

**The need to better address sexuality and sexual health issues,  
including good quality sexuality counselling in India**

Expanding reproductive health (RH) services to better address sexuality and sexual health issues continues to be a challenge in many countries, while the reasons for intensifying these services are becoming more urgent. For example, HIV-positive people are living longer as treatment becomes more readily available. This positive development brings new challenges in terms of preventing transmission and supporting those living with HIV. A growing number of health facilities now conduct routine testing, such as in antenatal care programmes to help prevent mother-to-child-transmission (PMTCT). But experience has shown that when HIV testing becomes routine, counselling – which could help prevent new infections – often suffers.

Information alone is not enough to help people make good choices. Counselling helps people to examine their feelings around certain issues (for example, contraception) and their fears about taking the first step in seeking help (such as a fear of going to a gynaecologist). And counselling gives people an opportunity to discuss the pros and cons of any potential choice they make (such as whether or not to have sex). Sexuality and sexual health-related issues are especially fraught with emotions, fears and values that need clarifying and sorting out before a person can make a decision on a given issue – such as whether to have sex, insist on a condom, have an abortion or an HIV test. Good quality, non-judgmental counselling helps a great deal in this regard.

Currently, not much data exists on how to effectively train health staff in sexuality counselling. Training content, duration, and follow up, and how to sustain good quality counselling, are all questions that need to be addressed. Despite good intentions to expand RH services to the broader concept of sexual and reproductive health (SRH), many programmes continue to struggle with the content of the “S” in SRH.

In order to generate an evidence base for developing guidelines on providing good quality sexuality counselling, the World Health Organization (WHO) and the Royal Tropical Institute (KIT) conducted descriptive studies of four programmes in different countries. These studies aim to contribute to the knowledge base about identifying information needs around sexuality and identifying what is required for good quality sexuality counselling services. The four programmes studied were:

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

This policy brief summarises the findings of a review of TARSHI’s telephone helpline operating in New Delhi, India.

### **Research methods**

The findings of the TARSHI case study are based on data from a desk review, in-depth key-informant interviews with policy makers, government officials, representatives from NGOs and other helplines, donors, international organisations, counselling trainers, past and present counsellors and managers of the TARSHI Helpline. Focus group discussions with proxy helpline callers were also conducted and feedback from TARSHI helpline callers was obtained through the internet and telephone interviews. Selected case records of repeat callers were analysed and the peer assessment system of TARSHI counsellors was reviewed.

### **The context in India**

Since the International Conference on Population and Development (ICPD) in 1994, India has seen some progressive changes in its health policies and programmes. While policy and programme documents focus on gender issues, male involvement, reproductive tract infections (RTIs) and sexually-transmitted diseases (STDs), discussion of issues related to sexuality has by and large been left out. The Health Ministry has ventured into the area of reproductive rights but not into sexual rights. Despite the discussion on lessons learned from the Reproductive and Child Health Programme (RCH I) and the importance given to RTIs and STIs and adolescent health issues, sexuality was again bypassed in RCH II.

India was one of the first countries to implement family planning, adopting a strong focus on contraceptive methods and little or no discussion on sexual health or sexuality. The need to address sexuality counselling combined with treatment and/or referral options emerged from the National Family Health Survey II<sup>1</sup> which showed that 39% of the women included in the survey reported at least one reproductive health problem, 36% reported vaginal discharge or

urinary tract infection, 13% reported painful intercourse and 2% reported bleeding after intercourse.

India was one of the first countries to legalise abortion, under the Medical Termination of Pregnancy (MTP) Act of the early 1970s. However, secrecy around unwanted pregnancies and resultant abortions is still high. Adolescents, both married and unmarried, use abortion services in significant numbers – between 20 and 30%, of which 70 to 80% are second trimester abortions.<sup>ii</sup>

NACO regularly carries out behavioural surveillance surveys around sexual behaviours of vulnerable groups, such as 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 vulnerable groups.<sup>iii</sup> How much and what kind of sexuality counselling is provided to these groups is not documented.

In India, over 87% of infections occur through sexual transmission. Despite some progress made through the implementation of HIV prevention and sexuality education programmes, many challenges remain<sup>iv</sup>. Indian culture, despite its diversity, 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 'masturbation'.

Rapid changes in India, such as the expanding economy and the explosion of the media and the internet, are leading to increased 'commoditisation' of sex and sexuality. The market-driven modern notions of sexuality are in direct conflict with traditional values. Conflicting messages by the media - sex for pleasure versus sex within marriage for procreation, and double standards for male and female sexuality - are creating a lot of social confusion around sexuality.

### **Needs identified through records of callers to TARSHI and interviews**

The sexuality counselling services of TARSHI in New Delhi, India are provided through an anonymous telephone helpline where people call in and discuss issues relating to sexuality. Callers are also able to seek information about referral to medical services and other centres of information. The anonymous setting provides a space where issues that are felt to be embarrassing can be discussed.

### *Profile of callers*

The callers are from diverse socioeconomic backgrounds and range in age from 10 to 76 years, though the majority are between 15 and 24 years of age. Most callers are from Delhi or nearby, but there are many callers who have migrated to the city from rural areas and still have their roots in rural India. Approximately 82% of callers are men, despite the fact that the service was 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 for TARSHI.

### *Content of the issues brought in by the callers*

In 2007, TARSHI analysed 57,773 calls received between 1996 and 2007. The pie chart shown on the next page 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.

*General information related to sexuality* refers to callers' questions about the body, anatomy, physiology, size and shape of genitals etc.

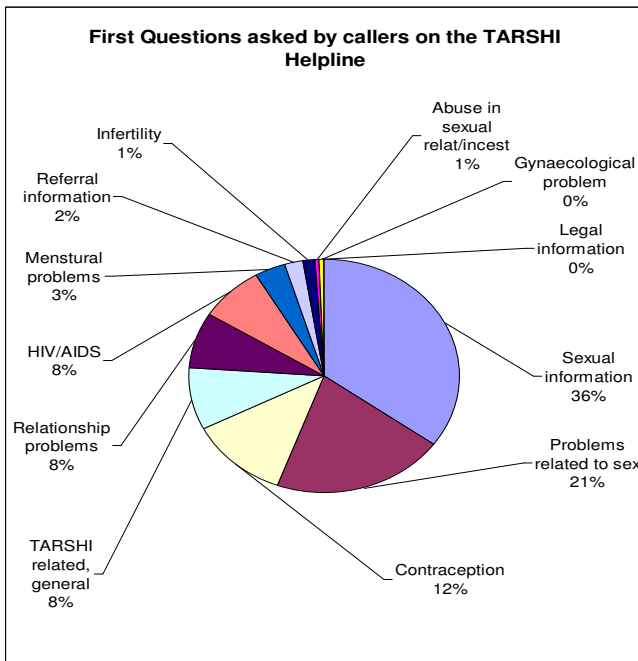
*Infection* includes concerns about sores, rashes, unusual discharge, symptoms of and fear of STIs, and concerns about HIV/ AIDS.

*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, and concerns about emergency contraception and abortion.

*Abuse* refers to concerns about any coercive sexual activity.

*Relationship* problems most commonly include concerns about callers' intimate relationships (wife doesn't love me any more, parents opposing marriage etc).



Most of the questions arise from a lack of basic information about one's body, and about sex and sexuality, reproductive and sexual health which is illustrated by the following excerpt from a caller's feedback to the researcher:

*RK 4 called when his wife was pregnant. He and his wife wanted to know whether they could engage in intercourse ('sex') during her pregnancy, and what precautions they needed to take. About the helpline, he commented: 'we could ask them things that we couldn't even ask our doctor or anyone else.'*

Findings from the records are corroborated by the four focus group discussions that were held with married men and women and adolescent boys and girls. The five focus group discussions with proxy users brought out the following issues:

- Curiosity and need for information about 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'

Women wanted information on the body, sexual relationships, desire. They also pointed to the need for safe spaces for women to access such information.

### **Quality of the services provided by TARSHI**

The conclusions concerning the quality of services provided by TARSHI are based on: an analysis of callers' records, key informants' feedback, callers' feedback and the analysis of counsellors' peer review forms. The analysis showed that the quality of the sexuality counselling provided by TARSHI is marked by high levels of confidentiality, evidence-based information, reliable referrals, and a rights-based, gender-sensitive approach. There is an organizational commitment to quality, with excellent supervision and support systems in place. TARSHI practices counselling as it should be done – not advising or directing but exploring options, helping callers to think of the pros and cons of all decisions. The counsellors cover a wide range of issues, ranging from the sexuality of disabled persons, to relationships with multiple sexual partners and issues concerning transgendered people. All these issues require a non-judgemental approach and freedom from personal biases.

### **What makes for good quality sexuality counselling?**

TARSHI fulfils a need for quality, ethical, rights-based, gender-sensitive, sexuality counselling services. It does so through:

- 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 organization.
- Intensive induction training incorporating perspective building, values clarification, conceptual understanding and skills building around sexuality and sexuality counselling.
- Close supervision, ongoing support and learning, self-reflection and self-evaluation of the quality of counselling provided, and use of peer review systems.<sup>vi</sup>
- Burnout prevention systems: discussions in team and office retreats are in-built mechanisms while meditation, exercise and therapy, if required, is encouraged.
- Referral systems that are tested and reliable

### **Conclusions and opportunities to mainstream information, education and counselling for a healthy sexual life**

The issues identified through the telephone transcripts and focus group discussions show not only the need for counselling on sexual health and sexuality but also a need for basic

information and education. The bulk of the callers to TARSHI are looking for information about their bodies, contraception and reproductive and sexual health. This basic information can be handled by one level of counselling that has a focus on information and education. More specialised sexuality counselling services could address issues such as healing from sexual abuse, issues related to gender and sexual identity and other complex topics.

Positive notions of sexuality need to be fostered and mainstreamed within society in order to enhance the sexual well-being of all people, young and old. In India, at least three government ministries - the Ministry of Health and Family Welfare (which covers HIV/AIDS), the Ministry of Human Resource Development (covering education) and the Ministry of Youth Affairs and Sports - have mandates into which sexuality can be integrated. The health sector, responsible for reproductive and child health and HIV/ AIDS, should seize the opportunity to mainstream the sexuality discourse.

#### *Organisation of sexuality-related services*

Sexuality counselling services can be provided face-to-face or through telephone helplines. Different groups will access sexuality counselling in different ways, depending on their sense of comfort and context. Younger people may prefer the anonymity of the telephone helpline, while heterosexual married couples may prefer face-to-face couples counselling.

#### *Information and education*

Widespread information dissemination will help to address a significant proportion of the issues that TARSHI's helpline responds to. Sexuality education should be integrated into programmes aimed at women's empowerment, HIV/AIDS education and adolescent life skills or development. These services can be situated at the community level, as well as within institutions like secondary hospitals, elementary and secondary level schools.

Referral and information outreach about the availability of sexuality counselling services is very important. This can be done using posters in public places, advertisements in print and electronic media, talks in schools and in the community. Referrals in terms of a tested and reliable referral system should be organised.

#### *Integration of sexuality and sexual health issues in health services*

Basic information and counselling on sexuality needs to be an integral part of reproductive and sexual health services<sup>vii</sup>. Quality assurance

mechanisms for sexuality counselling therefore need to be integrated into public and private services. Health care providers need to be made aware that taking a patient's sexual history is a necessary part of their job, and they need to be trained in talking about sexuality. A core set of sexuality-related questions needs to be introduced into sexual and reproductive health services as a part of taking the clinical history of clients visiting health care facilities.<sup>viii</sup>

#### *Integration of sexuality and sexual health issues in higher education*

Training for sexuality counselling is virtually non-existent in India. There are opportunities for this to be introduced in premier institutions like the Rajiv Gandhi Institute in Tamil Nadu, the Tata Institute of Social Sciences in Mumbai or the National Institute for Mental Health and Neuro Sciences in Bangalore, and in the basic training of doctors, nurses and social workers.

#### *Specialised services*

The more complex, sexuality-related issues, such as child sexual abuse, other forms of sexual violence like rape, issues related to sex reassignment surgery, may require referral to specialised services, such as TARSHI or a more advanced level of sexuality counselling services and training.

#### **General recommendations**

It is important to make explicit the definition of sexuality counselling because counselling is often confused with simple information provision. The common understanding of counselling in India is 'giving advice' or 'guiding' or 'educating'. A far preferable definition of counselling is helping clients to explore options and make their own decisions.

A wide range of sexuality-related services needs to be offered, beginning with information dissemination in local languages. The information should be scientific, rights-based, and gender-sensitive, and directed at the specific needs of different groups - children, youth, older persons, sexual minorities, people with disabilities etc.

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 need 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. And the providers should be trained in non-judgmental, non-exploitative, non-voyeuristic 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 the quality of sexuality counselling and how one measures the impact of sexuality counselling. The framework to assess the quality of sexuality counselling proposed in this study can be expanded to make various issues more explicit: the quality of information provided, techniques of exploring and probing, non-directive, non-judgmental approaches, managing dependence, rights-based, gender-sensitive counselling etc.

Further research needs to be developed and conducted. In particular, there is a need to develop general indicators for measuring sexual health that can be included in the outcomes of the MDGs.

Methodologies need to be developed to improve the measurement of outcomes of sexuality counselling interventions. Intervention studies to test comprehensive packages of sexuality education, sexuality counselling integrated in health and education services and referral to specialised services need to be developed.

In addition, minimal requirements for training counsellors and guidelines for providing quality sexuality counselling need to be tested.

## Conclusion

Sexuality has to be acknowledged as an important dimension of human existence. This policy brief gives some directions for what needs to be done in the area of sexuality counselling.

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## Footnotes

<sup>i</sup>NFHS-2. (2001) National Family Health Survey (NFHS-2) India 1998-1999. Mumbai: International Institute for Population Sciences and ORC MACRO; 2001

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

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

<sup>iv</sup>NACO (2008) The UNGASS Country Progress Report 2008MOHFW, New Delhi, India

<sup>v</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>vi</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.

<sup>vii</sup> Dixon-Mueller, R, (1993), The sexuality connection in reproductive health, *Studies in Family Planning* 24 (5)

<sup>viii</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)

