Violence Against Women And Role Of Health Professionals

A Training Curriculum

Course Coordinator: Padma Bhate-Deosthali

Faculty: Manisha Gupte, Renu Khanna, Aruna Burte, Amar Jesani, Seema Malik

Documentation: Sana Contractor, Sangeeta Rege, Nidhi Sharma

Cehat

Centre for Enquiry into Health and Allied Themes, Mumbai

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For additional copies of this report, please contact:

Centre for Enquiry into Health and Allied Themes (CEHAT)
Survey No. 2804 & 2805,
Aaram Society Road,
Vakola, Santacruz (E),
Mumbai - 400055
Tel.: (91) (22) 26673154, 26673571
Fax: (91) (22) 26673156
Email: cehatmumbai@gmail.com
Website: www.cehat.org

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Preface

Violence against women is known to have far reaching health consequences. Early efforts to address VAW were made by CEHAT in collaboration with MCGM (Municipal Corporation of Greater Mumbai). The joint initiative in 2000 enabled the setting up of a public hospital based crisis center, Dilaasa for responding to violence against women and girls. Key features of this model comprised of engaging health providers to recognise signs and symptoms of violence, its health consequences, and execution of therapeutic and legal responsibilities towards survivors of VAW. The genesis for designing the course curriculum emanated from the experience of setting up the Dilaasa centre.

In the past decade, the public health sector in different states have made efforts to create a health care response to VAW. This has generated a tremendous need for training of health care providers (HCP) at different levels. CEHAT responded to this need by conceptualizing a course for Health Care Providers in 2006. The nine-day course delineated concepts related to VAW, provided skills to respond to survivors as well as equipped its participants to design a response in their available resources.

Recent acknowledgment by National Health Policy (2017) called upon the health sector to mainstream gender concerns as well as make systematic efforts to respond to VAW. It is now opportune for CEHAT to publish its course curriculum to make it accessible to all those engaged on the issue of VAW. The curriculum provides an in -depth understanding on each topic along with evidence, methodologies to conduct sessions and essential reading materials. We hope that the curriculum is useful to medical and nursing educators, civil society organisations and other professionals to use the content for training of providers.

Sangeeta Rege
Coordinator, CEHAT

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Bridging the gap in current medical discourse: The course on Violence Against Women and the Role of Health Care Providers

Violence against women is a universal phenomenon and violates the basic human rights of women by taking away their liberty and freedom and inflicting pain, causing injury, disability, other debilitating physical and mental health problems and even death. According to a UNIFEM study in 2003, at least one out of every three women has been beaten, coerced into sex or abused in her lifetime. One of the most comprehensive global studies on domestic violence by the WHO (2005) found that one in six women is a target of domestic violence. The National Crime Records Bureau (NCRB) and National Family Health Survey (NFHS) reports indicate that large numbers of women are experiencing violence in their homes.

Violence places women at a high level of vulnerability to morbidity and mortality. Pregnancy complications, adverse birth outcomes, HIV infection in non-consensual sex, unwanted pregnancy, unsafe abortion/abortion-related injury, gynaecological problems, psychological problems/ fear of sex/ loss of pleasure, low levels of immunity due to increased levels of overall neglect and decline in access to nutrition and health care, are some of the outcomes of violence. Empirical evidence from India is being generated steadily. Domestic Violence has been linked to a host of immediate and long-term outcomes like sapping women's energy, compromising their physical health including reproductive health, and making them more vulnerable to sexually transmitted infections including HIV/AIDS (WHO, 2005). A recent study among 2199 pregnant women in North India indicated that births among mothers who had faced domestic violence are 2.59 times more likely to lead to pre-natal and neo-natal mortality (Ahmed, Koenig & Stephenson, 2006).

Violence has a deep impact on women's mental and emotional health, eroding their self esteem and leading to a variety of mental health problems that can sometimes lead to suicide (WHO, 2005). The mental health consequences include depression, feelings of anger and helplessness, self-blame, anxiety, phobias, panic disorders, eating disorders, low self-esteem, nightmares, hyper-vigilance, heightened startle response, memory loss, and nervous breakdowns. Self-harm may be in the form of refusal to eat, suicidal ideation and general neglect of one's health. Suicides and attempted suicides have a strong association with domestic violence. In the year 2003, 16 percent (41 out of 257) of the women who received counselling services at

Dilaasa had attempted suicide.

The first contact for the victims and survivors of violence is the health professional. Treating injuries caused by violence, collecting medical evidence in cases of sexual assault/burns or conducting autopsy are the services that the health professionals routinely provide to the victims. The medico legal documentation is of prime importance in the court of law as is the doctors' testimony. It is important to note that ill health or disclosure of certain health problems like mental illness, HIV/AIDS or tuberculosis can lead to violence against women.

It is therefore imperative that health professionals be trained adequately to understand the complex linkages between violence and health and their role in caring for victims/ survivors of Violence Against Women(VAW).

Response of health professionals:

Internationally, VAW was recognised as a health issue as recently as 1992-93. Two international conferences during this period brought the links between violence and health sharply into focus. World Health Organisation(WHO) soon produced guidelines for health care professionals to respond to the issue. However, the response from health systems and health professional varies in different countries. While some have clearly laid down policy and protocols for hospitals and the profession, others like India do not have such protocols.

In India, the response of health professionals and health systems to the issue has been abysmal. The medical and nursing education does not emphasise violence as a health issue. The medico legal documentation of domestic violence, rape, suicides, homicides, deaths in police custody, caste or communal violence is not done effectively. The lack of training to investigate violence and respond to specific needs of victims result in a response laden with a medico legal perspective rather than that of care and ethics. Medical education must wake up to this fact and reform its curricula to include training on understanding VAW, related laws, health consequences of violence and how to respond and care for the victims and survivors.

Development of the course curricula:

The course 'VAW and role of health care provider' is designed to equip medical and nursing professionals, both teachers and practitioners, to recognise various forms of violence against women, its causes and health consequences. It provides various tools for identifying and recording VAW as well as specific skills for screening and responding to survivors. This is the only curriculum available in India for such training. Its significance is underscored by the absence of discourse on violence within the medical and nursing curricula. The recent law against Domestic Violence(PWDVA) identifies Health care providers (HCP) as one of the Service Providers which mandates them to document the current and past episodes of violence faced by the patient, inform her about the law and if necessary, also make a Domestic Incident Report. In the absence of any training during medical education, doctors cannot carry out this role.

Genesis of the course curricula: The content of the course has been designed based on the training of hospital staff conducted by CEHAT for its project called *Dilaasa*, during the period 2000-2004. *Dilaasa* has been established as a department of the hospital to respond to survivors of VAW. This was done to ensure that it is able to create its own relational and functional space and establish links with other departments and staff. It also puts this department on par with other departments of the hospital.

Under this project, a systematic needs assessment study was carried out at the hospital to understand the perception of staff towards violence against women and to understand the existing systems and procedures for dealing with reported cases of violence by women. The assessment highlighted that medical and nursing professionals do not recognise VAW as a health issue but perceive it as a problem of law and order only. They consider violence against women, particularly domestic violence, a private matter and avoid asking questions even if they see obvious signs of injuries. Their attitude towards the survivors is that of victim blaming and they often feel that the women might have instigated/provoked violence. The study of the medico legal register highlighted serious gaps in documentation and also the lack of training in writing the injury reports.

The capacity building of the hospital staff began based on these findings. As the project aimed at setting up a crisis intervention department in the hospital, there was a lot of

interaction with the staff through dialogues, meetings and workshops. These helped in identifying topics for the ongoing training.

This training has led to an increased understanding about VAW amongst the staff and motivated them to become trainers themselves and take responsibility for sensitising their own colleagues.

The significantly high number of women seeking services at Dilaasa indicates that training and monitoring of health care response definitely helps hospital staff to recognise signs and symptoms of violence faced by women. The Dilaasa crisis centres have now been institutionalised through the National Health Mission (NHM) at 11 peripheral Municipal Hospitals in Mumbai. At present, counselling services are being provided by trained hospital staff in across these municipal hospitals. The Municipal Corporation is committed to institutionalise the sensitisation and training programmes of HCPs to respond to VAW.

Having conducted these courses for a period of four years with almost 120 health professionals, CEHAT decided to design a course based on these training sessions. The faculty for the course – Amar Jesani, Aruna Burte, Manisha Gupte, Renu Khanna and Seema Malik –have developed the various training sessions for the project. All of them have been closely associated with this pioneering project from its inception. The course begins with understanding of various concepts, then builds an understanding of VAW and skills on how to communicate with women who may report violence, sensitises the participants to issues around communalism and their role in such situations of violence, and orients them to the social and psychological needs of survivors of violence and role of counselling in reducing this trauma. The last session provides them with the necessary tools to understand their role towards their patients who are survivors of violence from the ethics perspective. The course is designed to help participants understand the root causes of violence which are entrenched in the social structure that allow discrimination based on gender, caste, class and religion.

The course offers the following:

1. Understanding of various concepts

1.1 Gender and patriarchy

1.2 Discrimination and Violence

1.3 Intersectionality

1.4 Formation of identities based on caste, class, religion and gender.

2. Human Rights Approach

2.1 Understanding violence against women

2.2 Definition of VAW from Human rights documents and Indian law.

2.3 Prevalence of VAW

2.4 Myths and facts on VAW

3. Understanding VAW as a health issue

3.1 Health consequences of violence

3.2 Role of medico legal documentation

3.3 VAW as a public health and human rights issue.

4. Role of health care providers in responding to survivors:

4.1 Screening for identifying violence

4.2 Protocols and procedures for documentation and collection of medical and forensic evidence

4.3 Role of crisis intervention counselling and collaboration with police and the court.

4.4 Ethical responsibility of doctors and nurses in responding to violence and caring for survivors.

The pedagogy:

The pedagogy of the course is participatory with a combination of lectures, group work, group discussions and case studies. It also includes role plays where participants will play the roles of the health care provider, survivors and their family. Our experience has been that this enhances the participants' understanding of the issue and builds their confidence in dealing with it. These practice sessions highlight in an interesting way, the do's and don'ts for health care providers. Individual exercises help participants to reflect on their own experiences and biases. This is a new experience for the health professionals as they have never been exposed to such a methodology; it helps them to move from their role as providers and pushes them to reflect on their attitudes.

A panel discussion comprising of a medico-legal expert, lawyer and police official, highlights the roles of various sectors in responding to the survivors of violence. The experts help participants understand their legal obligations and the procedural problems that pose

obstacles in caring for patients.

Finally, a visit to the crisis intervention department demonstrates how a hospital can respond sensitively to the issue of VAW and provide counselling services. This is accompanied by discussion with staff members who have been trained as trainers. There is a short module for administrators as well. The doctors and nurses, who are trainers, describe how the training changed their own practice; how they conduct training and the kind of questions and barriers they face from their own peers. The administrators suggest different ways in which various administrative hurdles can be overcome. A resource kit includes the latest evidence from literature and other relevant material on the issue of violence against women.

Impact of the course so far:

Past participants of the course have graded the course as excellent and relevant. In their words:

"I did not know about gender and patriarchy- it has opened up my eyes",
"I can now give holistic treatment to the patients who come to me",
"You should train the seniors and administrators as they create a lot of problem when we want to help women"
"You should ensure that this is included into our curricula"
"I came to know about my own biases"
"Nurses can really play very important role"
"I was never taught how to examine a rape case and did not even know the importance of different samples"

Actions by HCPs post the training course: The participants of the past courses have been doctors, nursing tutors, nurses, medical superintendents, researchers, counsellors, social workers, public health advocates and so on. All of them have been able to make changes in their own practice and also influence their peers.

- Some HCPs convinced their senior officials and organised training programmes for all doctors from maternity homes, while others conducted orientation training for their peers in their own hospitals.
- Almost all participants distributed posters and other material in their own facilities to create awareness on VAW as a health issue.
- Dhule Nursing College, Maharashtra has been organising two day training for

their final year nursing students on recognising and responding to VAW. The nursing college has incorporated ths content into the training of ASHAs – Accredited Social Health Activist (under the National Rural Health Mission).

- One of the course participants working on HIV/AIDS has incorporated a two hour session on responding to Sexual Violence for training of counsellors at the Integrated Counselling and Testing Centre (ICTC) which has also been incorporated into the Saksham programme under the Global fund.
- Another interesting initiative was undertaken by a group of participants who were superintendents of maternity homes from the Bangalore Municipal Corporation. Being in leadership positions they were able to not only internalise the concepts but also build primary health care intervention for responding to domestic violence.
- The last course was organised in collaboration with the Government of Maharashtra and senior nursing tutors from 23 nursing colleges were deputed for this. Following this, the department of nursing education agreed to include the course content in their teaching.

We hope that this module will influence the medical and nursing educators to incorporate this course content in their respective curricula.

Padma Bhate-Deosthali
Former Co-ordinator, CEHAT

Table of Contents

1. Introduction to the Training Course

1. Introduction to the Training Course

Duration: 30 minutes

Objectives:

- To understand the women's movement in India with reference to violence against women and place the role of health systems within that.
- To introduce the purpose and overview of the course.

Methodology: Lecture

Content:

1. Placing Dilaasa within the struggle of the women's movement against VAW.
2. Dilaasa as a model - partnership, roles of the BMC/CEHAT, services, sensitization, research and documentation.
3. Rationale and objectives of the training, training design, administrative issues.

GETTING TO KNOW EACH OTHER

Duration: 1 hour

Objectives:

- To get to know each other.
- To understand their roles and strengths of their roles as HCP and aspects that they want to change.

Methodology:

The participants form pairs and share the following information with their partner:
Name, designation, years of service, an adjective that describes them starting from the first letter of their name, what they like about their work, what they dislike about their work and what they want to change, what makes them laugh, why they are here.

Content:

1. Summarise what they want to change as HCP and expectations from the training.
2. Explain training methodology.
3. Collectively set norms for the training - punctuality, taking turns to speak, time, discussion, participation.

Module 1: Understanding Critical Concepts for Developing a Gender Sensitive Perspective

Session 1.1 Gender

Duration: 2 hrs

Objectives:

- To create awareness about the difference between sex and gender
- To sensitise participants to the manifestations of gender
- To understand the process of social construction of gender

Methodology: Game and Story followed by group discussion

Game: Sex and Gender

The game is used to make participants understand the difference between sex and gender. The trainer reads out 21 statements (Tool 1) and asks the participants to raise their hands, or stand up and sit down or come in or out of a circle, based on their answers on whether the difference is related to sex or gender (Annexure1).

Story: 'Munna and Munni'

The story of twins, a boy and a girl, is used to understand the social construction of Gender. Tracing their lives from birth to marriage, the story brings to light the indoctrination of gender roles through various stages of life.

Process

The session begins with the game akin to 'land and sea' with the trainer looking for open space. The trainer facilitates the discussion around different statements. This is followed by the story bringing out the indoctrination of gender through socialization. Through this process, various concepts are introduced. Both these methods are followed by a discussion among the participants.

Session number – 1.1, 1.2 & 1.7 are based on the Process documentation of training of trainers at Dilaasa, 2003, Module I, Dilaasa & CEHAT. These sessions were documented by Resource Person Manisha Gupte.

Content:

Difference between Sex and Gender: This game helps participants distinguish between that which is biological or what we are born with and that which is social in nature. That which is biologically determined is called 'sex' and that which is a social construction is 'gender'.

Some key points from the game are as follows:

- Most physical characteristics like menstruation, child birth, breast feeding are biological in nature and there is not much confusion about it.
- Some physical characteristics like long hair for women are social constructs, but are so finely ingrained during our upbringing, that we almost consider it a biologically determined trait. That is why long hair is subconsciously associated with being a woman.
- Biological sex is largely permanent while gender can be changed. One cannot prevent a man's voice from cracking, or enable him to have children.
- Biological sex is not restricted to male and female. There are intersex persons who are ignored by both, science and society. There are also people who may have female sex organs but identify themselves as men. There are ways to change biology in those cases, when a person so desires. But often one finds that if a child with slightly 'ambiguous' sex organs is born, the doctor tries to make the child male or female.
- Roles that men and women perform are entirely socially determined. Although certain roles can be performed by both men and women, these roles are specifically assigned to either. For instance, in most houses, cooking is done by women, but if one were to step into a restaurant, the chefs are men. Similarly, mending of clothes in the house is usually done by women, but most professional tailors and dress designers are men. It is not wrong to cook and sew, but when these duties are expected only of women, it is a problem.
- Behavioural traits too, are socially determined. Men and women both have feelings of anger, but they react to it in different ways. Men may be more aggressive than women because it is considered acceptable for men to be violent, while women are expected to be gentle.

Gender is biological sex, valued or devalued by society.

- Gender = Biological Sex +/- Social Value.
- In a patriarchal society, having a boy has an added social value and a girl denotes drop in social value. If the first child is a boy, the response is positive. The next child can be a girl and it will not matter because the one mandatory boy has been born. In some families/ contexts, when a woman gets pregnant, photographs of girls are even removed from the house as it is believed to influence the woman into giving birth to a girl. Parents and families go to great lengths to ensure that only a boy is born. Doctors too, are complicit in this.

Social Construction of Gender:

The social construction of gender is explained with the story of twins, Munna and Munni.

Biologically girls and boys are not very different, but socialization begins in childhood: When the twins are newborn babies and are wrapped in a blanket neck down, it will not be possible to identify them other than from their genitals. Identification of a girl or boy through external characteristics is possible only with the development of secondary sexual characteristics such as roundedness of hip, fat storage in buttocks among girls and growth of facial hair and cracking of the voice among boys. But from the colour and style clothes, it is possible to distinguish between boys and girls even at age one.

Munna will wear shorts/pants while Munni will wear frocks. Even if Munni does wear T-shirt/ jeans, they will be brighter with feminine prints such as butterflies on it. Unisex clothes are also gendered. Even at such a young age we see the messages that society gives us.

Gender needs to be reinforced: When the mother breastfed both Munna-Munni while they were 3-4 months old, would Munni cry less if she was hungry, or say that she would drink less and let her brother to drink more or that she would drink later? Then it is important to reflect on why when she is 12 years old she lets Munna eat first and eat the best food in the house. If at the age of one, she would not give away her toy to her brother, then why post marriage does she not ask her brother for her share in the property? Statements like women are softer and more tolerant than men need reflection as these are what women are taught growing up. This is gender. Biological changes, on the other hand, occur without any prompting. Whether or not

a girl is told that she will menstruate, or a boy is told that his voice will change, these things will occur at puberty naturally. This is biological sex. Gender differences need repeated reinforcement while biological sex does not.

Gender indoctrination influences the roles that we will play as adults: When toys are brought for the twins, the boy will most likely get a bat and ball while the girl will a doll or kitchen set. Munna will invariably play with his bat and ball far from home on some playground. He will learn to cross the road, make friends with other boys in the area and negotiate with bullies. If he gets lost on his way home, he will learn to find his way. Since he spends so much energy playing outside, he will eat more hence his muscle mass is likely to increase and he is likely to grow taller. So with just the bat and ball, Munna gains confidence, negotiating skills, alliances and nutrition.

Munni, on the other hand, will play with her doll in a corner of the house. She will mostly play alone or with one or two other girls who live in the neighbourhood. Even at school, her friends will be those who live close by. She is constantly given the message that girls do not go outside, it is not safe. She will cook for the doll, feed her and sing her a lullaby. So the doll becomes a baby and she a mother.

If Munna loses/breaks his bat, he is asked to be careful and is chided for having to replace it. But if the doll's hands and legs are removed, Munni is told that she has hurt the doll even though it is inanimate. With Munni's gift, we train her to be a mother, housewife and home-maker. Evidently, there is differential treatment through this single act of gifting the girl a doll and the boy a bat and ball.

It is unacceptable for boys and girls to reverse roles: If Munna and Munni decide to play with each other's toys, it will be forbidden as it does not conform to the future roles that will be assigned to them. For Munni, the responses will be: "Are you a boy?", "What will you gain by playing outside?", "You will get hurt and come crying", "Work at home - it will help you in the future", "Your pretty dress will tear", "If you fall, your underwear will show" etc. For Munna, the responses will be: "Are you a girl?", "You are not a sissy" "Boys don't play with dolls" etc. Thus, gender controls both men and women. In fact, Munni may even be allowed to play with a bat and ball in today's context, but for Munna, playing with dolls still remains taboo.

This is because it is assumed that a woman, who is inferior, would want to be superior (like a man); but a man would not want to take a position inferior to the one he holds.

Gender is dynamic: Gender is dynamic and changes over time, place, class, caste and community. Biological sex never changes in history and geography. It is possible to determine the biological sex of a 5000 year old skeleton from the pelvic girdle, age from calcification of bones and in the case of a woman, from the number of children borne by her from the shifting of her bones. Irrespective of the country, religion or caste a woman belongs to, she would bear the child in her womb for a period of 9 months and have milk in her breast. Whether she breast feeds or not would be culturally determined. However, this is not true of gender. Women from different ages, classes, castes etc. have different gender roles to play; their clothing clothes they wear are determined by their culture and caste.

There is not much difference between grandfather, husband and son. The greater leap has been between grandmother, mother and daughter due to the Women's Movement. This indicates that change is occurring. Example: fathers are far more involved in parenting and are educating their daughters more now than in the past. It is important to understand this because then we can see that customs like dowry are not 'natural'; they are social constructs that can be done away with.

Women's Body and Gender: Women carry many more symbols/markers of religion and caste than men. The common view is that women in western clothing have a negative impact on culture. The same is not held for men though – they are no longer seen in traditional attire. The length of hair – a body part that has no productive value, is reversible and causes no harm if cut - is determined by gender. Women cannot even take the decision of cutting their hair without consulting their family. Hindus have the concept of *'sadva'* and *'vidva'*. A married woman *(sadva)* does not cut her hair, but a widow (*vidva*) must shave her head as hair symbolises sexuality, sensuality and beauty.

Role of Social Institutions: The gender roles that we instil within children in the family are further strengthened through other institutions like the education system, the media, the market, the medical system, the systems of law, jurisprudence, state policy and through religion and culture. It is not possible for us to work at all levels, but we can at least make a difference and within our own lives wherever we work.

Tool 1:

Instructions: I (facilitator) will read out 21 statements one by one. After each statement, please raise your hand/ stand up/ sit down/ come in or out of the circle (the facilitator will choose a single method), if you agree with the statement. Let us try the first one – 'Women are gentle by nature' - if you agree, please (chosen method, e.g. remain standing). If you disagree, (opposite method, e.g., sit down).

Encourage some participants to speak about their agreement or disagreement. Discuss which of these statements reflect sex and which of these reflect gender and create an understanding and distinction of the two concepts.

The statements used are as follows:

1. Women are gentle by nature.
2. Men are better at playing cricket than women are.
3. Women menstruate.
4. Women are better cooks than men are.
5. Men are violent by nature.
6. Women have long hair.
7. Men have moustaches.
8. Women are better housekeepers than men are.
9. Men cannot do housework.
10. Men cannot control their sexual desire.
11. Men go bald with age.
12. Women are protected from heart disease in their youth.
13. Women eat after the men have eaten their food.
14. Girls play with dolls and boys with cars.
15. Women have ovaries.
16. Men have more hair on their bodies as compared to women.
17. Women bear violence silently.
18. Voice changes take place in boys as they grow up.
19. Men are not able to look after young children.
20. The body of a young girl gets more rounded as she grows up.
21. Women leave their mother's home when they get married.

Tool 2:

Munni and Munna: The social construction of gender

SITUATION 1

Let us imagine that twins have been born to someone we know. One of them is a boy and the other, a girl. We visit them at the hospital. They are wrapped in a cloth from below the neck. Can we make out the sex of the children? When can we start identifying whether children are boys or girls? Do we have to wait until puberty, when secondary sexual characteristics change?

SITUATION 2

Munna and Munni are three months old. They are both hungry. Does Munni cry less? Does she sacrifice her share of the milk for Munna? No, she does not. So how can we say that women are sacrificing by nature? Even when the twins are one year old, they both fight equally for toys, sweets, or their parents' attention. So why do they become so different when they grow up? We need to visit the twins again to find out.

SITUATION 3

The twins are now two years old. Munna is given a shirt and shorts to wear. Munni gets frocks and dresses. Do the children choose their own clothes at the age of two? No, we decide that. Because Munna is a boy, he is expected to wear a shirt and not a frock. Because Munni is wearing a dress, she is asked to sit properly with her feet close together and is told not to climb or jump in a way that reveals her underclothes. Gradually, she is told not to shout, not to laugh loudly - the list never ends.

Where do these expectations come from? Are they the children's natural desires?

SITUATION 4

The twins are now six years old. We have been invited to their birthday party. We go to a toyshop to buy presents for them. What is the question the shopkeeper asks us even before he enquires about our budget - whether the present is for a boy or a girl, isn't it? If it is for a boy, he shows us cars, bat and ball, planes, guns, mechanic sets and so on. And if it is for a girl, dolls, kitchen sets, embroidery and stitching sets, items to 'pretty up' such as hair clips, miniature cosmetics, fancy combs and so on are shown. We decide to buy a bat and ball for Munna and a doll a kitchen set for Munni.

What are the ramifications of these presents on the children?

SITUATION 5

Munna plays with the bat and ball outside in the open, away from home. Therefore, he gets a chance to go out, to learn to cross the road, to learn to negotiate with children of his age (or even older children when they snatch his toys). He breathes in fresh air, his muscles develop, his appetite grows and he learns to face the big bad world outside his home. He becomes 'tough', he learns to handle situations on his own and soon earns the confidence of his parents. They begin to trust him with outdoor work and involve him in decision-making too.

On the other hand, Munni plays with the doll and the kitchen set inside the house, in the kitchen or in the corner of the living room. What is the script used when she is playing? "Feed the baby", "Kiss the baby, it is sleepy now", "What have you cooked today?", "What does your baby like to eat?" etc. Munna can enter the house, banging his bat on the staircase, but if Munni bangs her doll on the wall, we immediately tell her not to hurt the baby.

What values are we inculcating in each of them? How are we preparing them for the roles that they will be expected to play when then grow up? How does this upbringing define what is eventually considered 'natural' in men and women?

SITUATION 6

After a few days of playing with their own toys, the twins get bored and want to exchange their presents. Munni picks up the bat and ball and gets ready to go to the playground. What is our response to that? "You'll be the only girl, how can you play with the boys?", "What will the neighbours say?", "You'll tear your nice dress", "What will you do if someone follows you or harasses you?", "Why are you behaving like a tomboy?" etc. On the other hand, if Munna gets tired of going out and wants to play at home with Munni's doll, what would our response be to that? "Oh no, he's going to be a sissy when he grows up", "Why does he want to behave like a girl?", "Where did I go wrong in bringing him up?", "I hope no one notices him play with the dolls, or else they'll ridicule him in school", "He should be playing outside, not sticking to his mother's apron like this," and so on. If children refuse to play the gender roles we assign them, it creates a great deal of anxiety within us. We make them change their behaviour according to what we think is appropriate for their sex. We punish them if they resist. We even go to counsellors for behavioural therapy. Therefore, accepting a prescribed gender role is not

as natural as we would like to believe; it is forced upon us by society.

What are the manifestations of such gender norms on Munna and Munni when they grow up?

SITUATION 7

Munna and Munni are now 20 years old. Munni will soon be married to a boy her father has selected. She knows how to cook and clean, and is good at stitching and mending clothes. She has a degree in home science. Her parents have collected money for her dowry. They will give Munna the house and Munni the dowry. Munna has a degree in hotel management and is a chef at a good restaurant. He has a decent salary. Munni's fiancé is a dress designer for a boutique. He also has a good annual income. The dowry from Munni's parents will help him set up his own shop.

We often say that women are better cooks than men are. Then why are most restaurant owners and world-famous chefs men? If men do not mend their own clothes because they do not know how to stitch, then how is it that most tailors are men?

Session 1.2 Patriarchy

Duration: 1.5 hrs

Objectives:

- To create awareness about patriarchy as the root cause of gender inequality.

Methodology:

Exercise: Participants respond to the following questions:
On whose name is the property or agricultural land? Whose name do the children get despite coming out of a woman's womb? Whose name does a woman take on after marriage?
Lecture and discussion: on the concept of patriarchy, how it operates and how it has permeated into different spheres.

Content:

The facilitator asks the participants to recall the name of their father, their grandfather, their grandfather's father and so on. S/he then asks them to recall the name of their mother, their grandmother, grandmother's mother and so on. What emerges is that we remember the ancestry of our father but not that of our mother. This is because it is the name of the father that is attached to everything – whether it is property or children. Most property is in the name of the man – even when the woman or her family may have contributed to it. Even in some cases when the couple are both earning and have bought the house jointly, one sees that a husband's parents consider it their 'right' to live in their son's house, but the woman's parents do not.

Similarly with respect to children, although it is the woman who conceives, carries the foetus for nine months and gives birth to the child, the name given to the child is always that of the father. This is absurd because motherhood is a certainty, while fatherhood is merely speculation; only the mother of the child knows who the father of the child is. Yet, it is the father's name that the child takes. When a child does not have a father's name, it is derided and called a 'bastard'. But when a child is motherless, it receives compassion.

Some societies in our country, such as in Kerala and the North-east are considered 'matriarchal' either because the man moves to the woman's house when they marry or the women bear their mothers' names.

What is Patriarchy: What emerges from the above discussion is that ownership and power in our society is in the hands of men. It is **patriarchy** that enables this. Patriarchy encompasses in its entirety, the structures of domination and exploitation of women in society.It literally means rule of the father or the Patriarch (a male member of the household or society). Defined simply, it implies a system in which father or the male member, who is considered the head of the family controls all economic and property resources, makes all the major decisions of the family, and thereby maintains ongoing control over all members of the family and those related to it. The combined power of all men, which is the combined power of all 'fathers' is **patriarchy**.

How are gender and patriarchy linked: Patriarchy as a concept operationalises itself through gender. Patriarchy can be called the hardware and gender the software. One can draw an analogy with the example of *Ramleela* in the Indian context. Although *Ramleela* is enacted over the years at various places in the country, the way *Ravan* behaves is the same. One does not see *Ravan* breaking the arrow instead of *Ram*, or *Ravan* having an ethical dilemma over forcibly taking *Sita* away. *Ravan* plays *Ravan's* role and Ram will play Ram's role. There will be no change in their dialogues either. One can say that 'gender' is the script that is recited and 'patriarchy' gives this script a stage.

Another example is that of Rape. When a woman is raped, the rapist is a man; the police who writes her report is also a man; the doctor who examines her at the hospital is also a man; the lawyer who fights her case is a man and the judge who makes a judgment is also a man. Therefore, we say that the chances of a woman getting justice are negligible. But even if the police, doctor and judge are women, the outcomes may not be different. Because, men as well as women who are in power will function in the same patriarchal structure that is the legal system, and therefore recite the same script.

MODES OF PATRIARCHAL CONTROL

Control over women's productive or labor power: Men control women's productivity both within the households and outside in paid work.

- Within the household women provide all kinds of free services to their children, husbands and other members of the family, throughout their lives. But this housework is not considered 'work'.

- Men control women's labour outside the home in several ways. They may force women to sell their labour or may prevent them from working. They may appropriate what women earn or selectively allow women to work intermittently.

- When women are excluded from better paid jobs, they are forced to sell their labour at very low wages or work within the home. Women are expected to be superwomen who work outside in addition to doing household chores, however men doing household work is still not accepted in society.

Control over women's reproduction and sexuality: Men also control women's reproductive power.

- Women often lack knowledge about their bodies due to controls imposed during their puberty. Any attempt by a girl to openly discuss or understand her sexuality is taboo. At the same time, however, she is encouraged to beautify herself to satisfy the sexual demands of a man.

- Women generally do not have the freedom to decide how many children they want, when to have them, whether they can use contraception or terminate a pregnancy.

- Rape, and the threat of rape, is a significant way by which men control women's sexuality.

- In order to control women's sexuality, their dress, behaviour and mobility are carefully monitored by familial, social, cultural and religious codes of behaviour.

- Child marriage is a form of restricting women's sexuality. This essentially means that if she is married early, it will ensure that she does not have sexual relationship with any other person. A child born through the marriage will definitely belong to the husband, to whom the man can hand over the property.

- Woman's place in the family is largely for procreation, beyond that her value in the family tree is limited. Therefore a woman who is unable to have a child is considered useless by the family as the lineage of the family cannot be carried forward.

Control over women's mobility: In order to control women's sexuality, production and reproduction, men need to control women's mobility, as seen in:

- Restrictions on leaving the domestic space
- Limits on interaction between the sexes
- The imposition of *parda*

All control over women's mobility and freedom is gender specific; men are not subject to the same constraints.

Control on Property/ economic resources and decision making: Most property and other productive resources are controlled by men**.**

- Property is passed on to the males in the family.
- All major areas related to decision making are in the man's hands. Similarly, in a patriarchal structure, the eldest man has the power to rule over not only all the women but also all the men younger to him.
- If a woman is a widow, she would be dominated over by her sons. In fact her right to own her husband's house can also be snatched away by her sons.

Manifestations of Patriarchy within specific Institutions

The Family

Family is the basic unit of society where the exploitation of girls/women takes place.

- The man continues to be considered the 'head of the family', despite the fact that 40 percent of the households are being headed by women.

- The man owns everything – both in terms of property and children – and all decisions are taken or must be approved by him.

- Boys are given higher value (son preference) and socialised to carry on the 'bread-winner's role and further the family lineage. Girls are considered a burden, a temporary member of the family, and socialized to take care of domestic work and be prepared to lead an adult life outside that of the natal home.

- Women receive the lowest priority for development, be it their education or their health. A son's education is always prioritized over that of his sisters and a woman will invariably forego treatment for illness.

- Sexual division of labour benefits boys and men, since girls and women are engaged in productive, reproductive, and domestic work of the family and men are engaged only in productive work.

Educational institutions

- Opportunities of education for a girl child are far less than that for a male child. The role expectations of the girl child also influence the content, form and methodology of education.

- The educational curriculum, timings of school, behaviour towards girl children, the training of teachers are all reflective of the biased attitude towards girls.

The Media

- The media most effectively portrays the values of patriarchy, the upper class, the upper caste and the dominant religion. Women continue to be portrayed as being subjugated in their multi-dimensional roles as a caring wife, a nurturing mother, an obedient daughter,

a dutiful and submissive daughter-in-law, a sexy partner, a glamorous executive enticing the press, a God-fearing subject, etc.

For instance, there is an advertisement of an ointment called *Moov,* where the daughter-in-law applies the ointment, her pain reduces and she goes back to doing more work. In the advertisement, she is shown to have a 'supportive' father–in-law who sympathizes with the amount of work she is doing. However, throughout the advertisement, he sits in an arm chair, reading a newspaper. He does not get up from his chair to help the daughter-in-law in her tasks.

Medical system

- Women's health has been given value only in relation to her child-bearing role.
- The husband's consent is invariably sought when a woman comes to seek abortion.
- Women's bodies have been considerably used for experiments, particularly in the area of family planning methods, which are geared to exploiting women's bodies to the exclusion of men's bodies.
- Medical research has not sufficiently understood and analyzed women's health issues. For example, the mental health of women is not given due recognition and even symptoms of menstrual cycle and physical stress are considered psychosomatic and neurotic.
- Hysteria was defined by Aristotle as a disorder that women suffer from because "the womb wanders through the body and when it reaches the brain the woman goes mad." The womb is also said to 'wander' if it is not able to bear a child. Similarly in early books of medicine, menstruation was defined as the "weeping" of the uterus. Thus, it implies that all women, by virtue of possessing a uterus are prone to 'madness'.

Religion

- Religion has primarily been under the control of men — the priests, the prophets, the maulvis. All religions regard male authority as supreme, God-made, supernaturally ordained. In fact, all major religions have been created, interpreted and maintained by upper class and upper caste men.

- Women are considered impure because they menstruate. They are not allowed to attend religious ceremonies or step into religious places while menstruating.

- Widows are treated with no dignity – they are not allowed to attend auspicious festivals, they have to wear white, live sparsely and may be sent away. Men, on the other hand, are allowed to get married as soon as their wives die.

- Religious texts continue to glorify certain images of women (e.g. Sita, Savitri, etc.), thus perpetuating stereotypical roles for women in society. They prescribe norms of conformity to societal values of an ideal wifehood and motherhood. Any deviation is considered sinful, to be condemned by God, and results in social ostracism.

- The personal laws draw their basic tenets from respective religions and are effectively used to deny women their fundamental rights, and this thereby strengthens man, since women's rights to property, inheritance, divorce, maintenance and custody of children accrue to the interest of men.

Law and legal procedures

- The whole system of jurisprudence in India has a feudal and colonial bias, and operates on principles of inequity and gender bias.

- Personal laws pertaining to family, marriage, divorce, custody, and inheritance are in congruence with different religious norms, which prioritise men and disempower women.

- The structure and process of the legal system makes justice inaccessible to women,

e.g., in procedures related to getting bail where often property and other legal documents are necessary, and in the absence of which women are denied basic legal rights.

- The rape law categorically states that non-consensual sexual intercourse of a man with his wife is not rape.

- Lawyers and judges too bear the same notions about women and this is reflected in their judgments. A study of judges done by Sakshi, an organization in Delhi, found that majority of the judges said that it is okay to hit a wife occasionally, but not too often. In the same study it was revealed that almost 60-70% of judges said that women get raped because of the way they dress.

How can one bring about change?

It is emphasised that if we truly want to bring about equality between men and women, we need to work with structures/institutions and mechanisms that are controlled by patriarchy and that perpetuate its influence. This is what feminism has tried to do. A feminist believes that violence happens because of a structure that allows violence to happen; this structure is patriarchy. Hence a feminist is against the concept of power in human relations. Even if patriarchy becomes matriarchy, and male domination becomes female domination, it is still not acceptable.

Health care providers work within a health system which is also patriarchal. What they can do is to try and bring about a change in the structures that they have control over. They can change the way women are treated at the hospital and the behaviour of health care providers towards them. They can also better understand the position of a woman in her household and in society and offer choices accordingly.

Session 1.3 Intersectionality

Duration: 1.5 hrs.

Objectives:

- To explain the concept of Intersectionality
- To explain the concept of Hegemony

Methodology:

Exercise: Power Walk (Tool 3):

This exercise needs to take place in an open ground or a large hall with ample space for participants to move around. Each participant will assume one identity and line up in the middle of the ground/hall. Twenty nine statements will be read out to them. The participants will have to take a step backward or forward depending on what they think the person assuming that identity will be able to do in response to the situation being read out by the facilitator. Examples of situations are whether they would be able to eat a meal of their choice or whether their opinion would be of any importance in community matters. Participants are given 5 minutes to respond to each statement assuming the character they have been assigned. For instance, a politician would respond differently as compared to a sex worker. After the facilitator has read out all the statements, the participants are asked to look around and see for themselves where different people are located. All the participants are at different positions on the field. They are told that there is a wall of resources in the front and all of them have to run when signaled and capture their space on it. It is observed that the ones in front have the easiest access to the wall, whereas those at the back do not get any space. Participants are then asked to calculate their scores.

Scores are calculated by totaling the number of responses with 'yes' …

The Power Walk is a very strong tool in explaining the concept of Intersectionality. Since the participants are expected to enter into the roles of various characters such as politician, wife of a politician, religious leader, widow, asylum-seeker, homosexual living in a small town, they are able to experience various privileges as well as disadvantages based on gender, caste, class and community.

Session number 1.3 has been designed by Manisha Gupte for the Advanced Training Course on Economic, Social and Cultural Rights, Chiang Mai, 14th – 20th May, 2006.

Content:

After the game is played and participants have got their scores, the various identities are discussed in detail. Most people scoring above 20 would be rich, politically connected, religious leaders or wives of religious leaders, politicians, contractors etc. Those with very low scores would be people belonging to the minority community, some living in camps post riots, illegal immigrants, male prisoner, widow of a man who dies of AIDS, mentally challenged individual in a state-run asylum, second wife of a man. Those with very low scores would have had to face several issues related to food security, sexual preferences, destitution due to being an illegal immigrant, forced into prostitution by a boyfriend, being a pavement dweller, curbed freedom of speech and fear of terrorism in the course of imprisonment. When it comes to women with scores as low as 3, these women belonged to religious minority. Such women suffer doubly due to religious fundamentalism.

However, it is important to note that in the same household, the husband had scored 29 whereas the wife had scored only 21. In spite of the same background, the man enjoyed more privileges than the woman. It is also pointed out that none of the characters that were women scored the maximum of 29.

It is stated that different factors affected the choices that people could make depending on social and political positions, religious orientations, gender, class, caste, age and the like.

Various aspects of Intersectionality: A man has more power than a woman, further if a person belongs to the majority religion, is a heterosexual, belongs to the economically privileged class, is educated, employed, owns property, lives in an urban locality, is married, able bodied (i.e. does not have any physical disability), free from being institutionalised, is a citizen (not a refugee), the person has lot of power. Having more of these characteristics would make the person powerful and lower these characteristics would make the person powerless. Just as all men are not a single homogenous group, neither are women. Within patriarchy some women are less victimised than others; especially those women who follow the rules by getting married, bearing sons etc. will face less brunt than those who deviate by remaining single and as a result face abuse.

Similarly, the position of power that a person enjoys is not permanent and can get transferred to another's position of power. They nullify the effects in that case. For example, the wife of a rich man in a village who owns fields has far greater power than a strong labourer working on her fields on daily wages. She can scold the labourer, but not her husband. However, when her husband is away in the city leaving her alone with the labourer at home, power shifts to the labourer as she becomes sexually vulnerable.

Gender and Religion: Women belonging to the minority community have to face majority as well as minority fundamentalism. After the Muslim-targeted riots, Muslim women stopped voicing abuse by their husbands out of fear that the husband would be charged with grave offences and never be released. Thus they trade their human rights for the freedom of their men. Minority women are left with few options.

Sexual Orientation: Another important and much debated aspect is the sexual orientation of people. Under Section 377 of the IPC, homosexuality has been condemned and called unnatural. The recent change in law is important for the movement as it decriminalises homosexuality. However psychiatry still continues to list it as a mental health disorder.

Transgenders and Intersectionality: When a transgender comes to the health facility, there is confusion as to which ward the person will be admitted to - the male ward or the female ward or which toilet the person will be allowed to use. Health systems are not sensitive to such people. They are denied other rights too, such as the right to education. Such violation of their rights by the society leaves them with few options to earn a livelihood. They turn to begging and prostitution, which results in further ostracisation.

Cultural hegemony: The facilitator will explain the concept of cultural hegemony – a term developed by Antonio Gramsci, an Italian Marxist. Hegemony refers to the social, cultural, ideological or economic influence exerted by a dominant group.

A person, who belongs to an underprivileged class, looks up to those who belong to the superior class or those in power. For example, the Brahmins who belong to the highest rung of the caste system exert such dominance over the rest of the society, that their view becomes the worldview. As a result, a Dalit, who belongs to the lowest rung of the caste system, aspires to become a Brahmin. It is a sort of ideological control.

Similarly, a woman in an abusive relationship with her husband seeks to improve her condition through her son. When the same woman assumes the role of a mother-in-law in a patriarchal system, she wields her power to oppress the daughter-in-law. The status quo of power imbalance is thus maintained through such ideological control.

Tool 3:

The Power Walk

Preparing for the game:

1. Please give out one of the following characters / roles to each of the participants. Slips can be cut out from the following sheet. Each participant has only one character (or role) assigned to her / him.
2. Each of the roles on the cut-out slip should be stapled on the entire list of questions. So while the roles of the participants will be different, the questions for all the players will be identical.
3. Request the group to carefully read their role. Ensure that each participant is familiar with the role assigned to her/him. Ask them to imagine themselves as the character they have been assigned.
4. All the questions that will be answered should be for the character that is being played and not for the participant herself / himself. This request has to be oft-repeated.
5. The answers expected are not what the character would 'choose' to do, but what s/he would be 'able' (or allowed) to do, given the social / economic / political / cultural position the character holds.

How to play the game:

1. If you have access to a large open space, you could get all the participants to stand next to each other, facing you.
2. Please leave equal space behind and ahead of the line, as the characters will move in that direction after each question is answered.
3. Ask one question at a time. The answer will be binary (yes or no). 'Yes' indicates a positive choice, whereas 'No' indicates the inability to make that choice or access that right.
4. If the answer to a particular question is 'yes', the character moves one step

ahead of the row. If the answer is 'no', the character moves one step behind the row.

5. This pattern is repeated for each question.
6. At the end of the game, all the characters will be at different positions on the field.
7. Please ask each one to turn around and see for themselves where different people are located.
8. In case you have a wall in the front, you could add to game by saying, "This is the wall of resources. All of you can now run and occupy a space against it."
9. You will find that the ones in the front had easiest access to the wall, whereas those at the back did not get any space (some, who are too far, do not even try to run, as they know that they will not reach the wall in time).
10. Please get the group in for a discussion.

Characters

1. You are a widow aged 30, living in a rural community. Your husband died of HIV-AIDS last year.
2. You are a 25 year old sex worker. Your boyfriend had sold you into a brothel when you were 15 years old.
3. You had an accident four years ago and have been on a wheelchair since then. You are a middle class, 20 year old woman.
4. You were mentally challenged at birth. You live in a state-run home. You are a male, aged 16.
5. You are a 35 year old woman who is an executive in a multinational company.
6. You are a male prisoner, aged 40 years. You were arrested last year, for being an illegal immigrant.
7. You are a woman prisoner, aged 30 years, who is serving a life imprisonment for having killed her violent husband.
8. You have been in a mental asylum for the past five years. Your husband has now remarried.
9. You are a 35 year old middle class rural woman. You are the second wife of your husband.
10. You are a 45 year old male refugee, staying in a temporary camp. Your wife and child have been left behind in your own country.
11. You are a 35 year old man from an ethnic minority, living in a village that is dominated by the majority community.

12. You are a 40 year old man from a religious minority, living in a rehabilitation camp after an ethnic riot.
13. You are a 16 year old woman from a religious minority, living in an area dominated by your own community.
14. You are a 25 year old male, living in a drought-affected area and have to migrate for labour, six months of the year.
15. You are a gay male aged 22 years, secretively living with your 40 year old, rich partner in a small town. His wife lives in the village.
16. You are a 20 year old woman who loves another 30 year old married woman. Your family wants to get you married now and is looking out for a suitable groom.
17. You are a 40 year old poor urban woman who sells balloons in the city. You have two children and a sick husband.
18. You are a 25 year old poor rural woman, deserted by your husband, living with your parents. You have no children.
19. You are a man aged 60, displaced due to the construction of a large dam. You live on a pavement in a big city.
20. You are a 35 year old rich man, having a flourishing business in a city. You are politically well-connected.
21. You are a 30 year old rich woman. Your husband has a flourishing business in the city.
22. You are a 50 year old local politician who has big connections with other politicians in the national capital.
23. You are a 45 year old national level politician who is supported by rich businessmen.
24. You are a 55 year old building contractor who constructs huge malls in a city.
25. You are a 60 year old male doctor with a flourishing practice in a small town. You live with your wife, son and daughter-in-law.
26. You are a 30 year old woman, living in a conflict area, where the military and local insurgents are at war with each other. Your brother is part of an extremist group.
27. You are a 30 year old male, living under military dictatorship for the past five years. You were once arrested for giving a political speech.
28. You are a 20 year old woman, living in a country governed by religious fundamentalist law. Your husband has threatened to bring you in front of the local community because he suspects you of infidelity.
29. You are a 45 year old male, powerful religious leader. You own rich agricultural land.

30. You are the 30 year old wife of a powerful religious leader. You live in a big house, in a joint family.

Questions

1. Would you have the freedom of speech or be able to write an article with political views?
   YES NO

2. Would you be free from the fear of torture during the next few weeks?
   YES NO

3. Would you have food security for the next three months?
   YES NO

4. Would you have the opportunity for higher education?
   YES NO

5. Would you be involved in decision-making related to important matters within your home?
   YES NO

6. Would your opinion be of any importance in community matters?
   YES NO

7. Would you be able to control your own earnings?
   YES NO

8. Would you be able to afford an important, but expensive surgery?
   YES NO

9. Would you be able to take a week long vacation in a holiday resort?
   YES NO

10. Would you be able to eat a meal of your choice?
    YES NO

11. Would you be able to (or allowed to) move about on your own?
YES NO

12. Would you be able to (or allowed to) move around alone after sunset?
YES NO

13. Would you be free from sexual harassment at home or at the workplace?
YES NO

14. Would you be able to go to court if your rights were violated by those around you?
YES NO

15. Would you be able to vote without fear in a national election?
YES NO

16. Would you be free from physical violence in your home or workplace?
YES NO

17. Would you have enough access to clean drinking water?
YES NO

18. Would you be able to seek immediate treatment for your illness?
YES NO

19. Would you be free from arbitrary arrest (or detention) during the next two months?
YES NO

20. Would you be treated with respect at the health centre?
YES NO

21. Would you be able to attend important meetings in your community?
YES NO

22. Would you be sure that your home will not be demolished in the next two months?
YES NO

23. Would you be able to participate in the elections in your community or country?
YES NO

24. Would you have the choice to marry the person of your choice?
YES NO

25. Would you be sure of not getting displaced (from where you live now)?
YES NO

26. Would you be able to buy basic amenities, such as cooking gas, for your household?
YES NO

27. Would you be able to negotiate the use of condoms when you have sex?
YES NO

28. Would you be able to do a job of your choice?
YES NO

29. Would you be able to rest in the evening after a hard day's work?
YES NO

Total number of answers with YES _____

Total number of answers with NO _____

Not completely sure about the answer _____

Small group discussion after the game:

Points for discussion:

1. (In case the game was played on the open ground) Why were different people located at different places on the open ground?
2. Who were the people with the highest YES scores and who were those who had the maximum NO scores? Why do you think that happened?
3. Why were you able to make the above choices?
4. Why were you not able to make certain choices?
5. What were the factors that affected your choice (or lack of choice)?
6. In what way did class, caste, gender, ethnicity, religion, disability, sexuality, political or religious freedom, citizenship, displacement affect your rights?
7. Did your differing identities have a specific impact on your rights? (For example, in what way did gender affect your choices, in what way did class affect your choices?)
8. (In case the group had the 'wall resource' part of the game too) Why did some of the people get more resources than others?
9. In what way can we correct the disparities and discrimination that some people face?

This game can help to elicit:

a) the intersectionality of human rights
b) the inter-relatedness of various rights and opportunities
c) that the inter-relatedness between civil and political rights and economic, social and cultural rights
d) how multiple locations of disempowerment or empowerment affect your rights
e) how power 'transfers' itself (e.g., a rich woman may be more privileged than a poor man in class-related choices, but less privileged than him in gender-related choices and certainly less privileged than a man from her own class / ethnicity).
f) how discrimination affects people and negates their ability to access rights or make choices
g) how resources go to those who are already privileged in society and how those who are already discriminated against suffer further disentitlement.
h) why we can not be neutral about gender, caste, class, disability, ethnicity, sexual preference in our work, and why we need to recognise and address difference as well as discrimination
i) that substantive (corrective) measures are needed to attain real equality

Session 1.4 Discrimination

Duration: 1.5 hrs

Objectives:

- To develop an understanding about discrimination which exists in society
- To understand effects of discrimination at various levels – economic, social, cultural, political, family and individual

Methodology:

Lecture/PowerPoint Presentation

Content:

The facilitator will ask the participants to share what they understand by the term 'Discrimination' and whether there is any difference between the terms discrimination and violence.

- For any violence to occur there has to be intent to harm and hurt while in discriminating against someone, the result/consequences are also important. Discrimination is the breeding ground to perpetuate violence and abuse. It cuts across history as well as contemporary times. For example, sex selection is a recent development which is a current form of discrimination but the preference for a son is age-old. This has also created a skewed sex ratio. Earlier, the female child was killed, but eventually the law made such acts punishable, hence the sex selection and determination technique offers the same choice in a sophisticated manner.

- Discrimination could be intentional or unintentional. An example of intentional discrimination is of a person who believes that looking at a widow is inauspicious and refuses to open the door to a widow. An example of unintentional discrimination is that of a festival that calls for married women to participate, thereby excluding widows, albeit unintentionally.

- The Convention on Elimination of all forms of Discrimination Against Women namely CEDAW, has aptly defined discrimination as any distinction, exclusion or restriction which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise of

all rights in the social, cultural, political and economic spheres. This could be exclusion as well as inclusion.

- Discrimination propagates and grows on itself. Thus any historical discrimination increases the likelihood of such a group facing further discrimination and thereby marginalization. An example is that of the intelligence tests - such tests are made for the urban population and hence cannot be applied to the rural people. Usage on a rural population will yield misleading results, perhaps that of low intelligence. This may result in deprivation of the opportunity to be educated and invariably lead to unemployment. In the West; such tests made for white people were applied for the Black people, thereby concluding the latter as having low intelligence and thereby were deprived of education itself. Not getting education would naturally mean that such people won't get employment either. If such a snowballing effect needs to be rectified, special measures need to be taken in favour of the discriminated people.

- Recalling the Power Walk exercise, one could understand that some people could easily reach the wall of resources whereas those at the back could not reach it even if they tried hard. In such a situation, special provisions need to be made for those at the back to be able to reach the wall of resources or the wall of resources needs to be transferred to the rear.

- Another example that could be cited is related to opportunities for girls. If we want girls to avail of the opportunity for education along with boys, we would need to introduce measures to equalize the chances of their participation. This could be done by using the concept of positive discrimination by providing toilet facilities for girls, minimise the work load at home, provide tuitions and also free education.

- A poignant example of positive discrimination: Ask participants to think of a scenario of 4 children participating in a running race where one has Reebok running shoes, one has slippers, another is bare foot and the last does not have legs. Positive discrimination would entail giving something extra to those who are at a disadvantage vis. a vis. the competition. For the one who has no legs, there would be a need to provide that person with a wheel chair.

Session 1.5 Equality

Duration: 1.5 hrs

Objectives:

- Develop understanding about equality and different approaches to equality.

Methodology:

Lecture

The facilitator introduces the topic, 'approaches to equality' and states that discrimination cannot be rid on its own. There are four approaches to equality.

Content:

Formal (or sameness) approach

This approach assumes equality between people who are socially unequal. Thus it neither recognizes difference nor addresses it. Such an approach is based on neutral laws that favour the powerful.

Example: A woman needs maternity leave which a traditional stereotypical man does not need. Hence giving the man the same amount of leave is not required. For example, the organization MASUM has a policy on paternity leave where the leave is given to only those men who will help out the woman with rearing the child. This leave is sanctioned after consulting the woman.

Protectionist approach

This approach recognizes difference, but views the person or group that is socially unequal as being weak and in need of protection. It denies equal opportunity and access in the name of protection, thereby perpetuating discrimination and the status quo. The critique of such an approach is that discriminated people do not need protection. For example, a female journalist may not be sent for late night party press coverage because she is a woman. But when it comes to choosing the editor, the one who did all the work will be nominated, thus eliminating the woman from the race. Such a protectionist approach does not address the issue at all.

Equivalence approach

This approach states that people do not need equal rights, but rather equivalence in rights according to the roles and responsibilities that they perform at home and in society. Such an approach may justify women's lesser wages because socially men are expected to earn for the family. Roles and responsibilities decided by gender create discrimination and giving rights according to these roles and responsibilities perpetuates discrimination.

Substantive/Corrective/Equitable approach

This is the fairest of the approaches because it does not treat those who are socially unequal as though they were equal where laws and policies are concerned. It in fact recognizes differences in order to remove disparity, disadvantage and discrimination. Such an approach also brings in temporary measures of positive discrimination in order to make the playing field even.

This approach places obligation on the State to correct the environment that discriminates against certain people and provide these people with opportunities for advancement. Hence it has greater possibility of reaching equality of opportunity, access and result. It upholds equity as a process to achieve equality which is a legal standard and a cherished goal.

One example was of creating more schools for the girl children. However it is not enough to build schools and assume that girls will be able to use it. The substantive approach would recommend that there be toilets for the girls, make sure they don't have to do too much work at home, provide tuition and give free education. Similarly it would be unjust to compare a urban girl who has a room to herself, hot food served at her beck and call with a boy who works in the farm and gives the same exam.

Women's reservations are implemented for the same reason. Positive discrimination is a part of our constitution. Hence the much debated issue of reservation also needs to be looked at in the same light. This is why 33% seats in the Parliament are reserved for women. As a result, at least 1/3rd of the parliament would constitute women. The rest remains open, giving men and women an equal chance to compete. The South African constitution has regulated that no gender will be represented more than 70% in parliament. Hence there is no bias with respect to gender.

Another example is related to food: if it is decided that every person should get two rotis and vegetable for lunch, it appears to be an equal approach. However, it needs to be closely examined as to whether it will meet the requirement of a pregnant woman, lactating mother, labourer, farmer or a child under two.

The equitable approach is the closest to recognizing discrimination and embracing diversity.

Session 1.6 Human rights and Rights based approach

Duration: 1.5 hrs.

Objectives:

- To learn about the history of human rights
- To be introduced to International Human Rights treaties
- To develop an understanding about Needs-based and Rights-based approaches.

Methodology:

Lecture

The session explores human rights - their origin and source through a group exercise where the trainer will present the participants with two sentences in order to explain the difference between needs and rights:

1) Munni needs education

2) Education is Munni's right.

Content:

The session will begin with the trainer explaining Needs and Rights and the difference between the two. Certain rights are acquired by birth/inheritance such as property right whereas certain rights are given by law such as voting right, getting a salary for a job etc., whereas some rights are given by religion/culture such as daughters having the right to reside in the natal home only till they are married. There are certain legal and social rights such as a woman's right to maintenance, right to live a violent-free life on her own, right to equally use natural resources. If a patient is admitted s/he has a right to health care information. The important thing is that rights have to be legally codified. On the other hand, food, clothing, shelter, job, education, clean environment is a 'need'. Needs are those which only when fulfilled will the person be able to survive. Thus the needs of a woman who comes for health care after an episode of violence are protection from violence, justice, medical support, emotional support and her rights are justice, right to live in marital house as well as natal house.

Difference between the Needs-based approach and Rights-based Approach

The trainer will further elaborate the difference between the needs-based approach and rights-based approach. In a need based approach, needs may or may not be met; for e.g., a child who wants a watch may get it only if the family budget allows so. Needs may fluctuate - they can be arbitrarily decided or withdrawn; for e.g., if a family faces an economic crisis, they may remove the child from skating classes/ music classes but cannot withdraw the child from school if he/she is between 6-14 years of age. Needs are identified by the provider – a client-patron relationship is established.

There are no consequences to the provider if needs are not met. Non-fulfillment becomes crucial only when needs of a large section of society are affected. For instance, no problem would occur if a poor patient dies due to lack of oxygen cylinder at the hospital, but if this occurs frequently then problems would arise and the hospital would be questioned.

In a rights-based approach, rights are enforceable by law, are not arbitrary but are according to established principles and standards. Rights are negotiated and the bearer of rights has a say. It is fulfilled because there is a 'right'. It is dynamic and open to expansion. For example, the Centre can expand compulsory education from 6-14 years to 0 to 20 years, but cannot reduce it to 8 to 12 years. There are consequences in terms of accountability to mechanisms and remedies for claiming rights. The right holders have to face consequences if services are not provided. *Morchas* can be carried out; PILs can be filed against them. Even violation of a single individual's rights is considered 'wrong' in a right-based approach. The difference is further elaborated by giving another example that if a government centre does not have drugs and the response is 'they will come later' then it reflects a need based approach whereas if the lack of facilities is questioned then it is stemming from a right based approach.

Sources of Rights

- International Human Rights Law such as CEDAW, Convention on Rights of the Child, etc.
- National constitutions / bill of rights form the basis of all laws/acts and define the letter and the spirit of the law.
- National law - Laws could be Central or State based. Health is a State subject and family welfare a Central subject. State laws cannot violate national laws which in turn cannot violate national constitution.

- Customary Law - An example was when Maneka Gandhi demanded the right to property, Indira Gandhi refused on the ground that Sanjay Gandhi was a Parsi and so the Hindu Undivided Family Act does not apply. However, Maneka Gandhi's lawyer argued that Sanjay Gandhi was married according to Hindu rights and cremated as a Hindu, so she would have a right to property.
- Case Law - An example of positive judgment of Supreme Court in a case stated that if the couple is married, the child is considered the couple's (from that husband) unless proven otherwise and the onus to prove paternity of the child is on the father. Similarly emergency medical care is a right under the right to life.

Converting a Need into a Right requires

- Identifying the need and whether it is individual or collective; a survey may be needed.
- Getting a group consensus.
- Staking a claim with the appropriate authority.
- Lobbying and advocacy on the inside and putting people's pressure from the outside for the State to take cognizance.
- A bill may be drafted at this stage. Monitoring by NGOs and people's organisations is essential.
- An act, law or policy may come into being.
- The redressal and remedial mechanisms have to be put in place for the right to become justifiable.
- By now, another need may be felt by a group, and the circle of creating rights continues.
- Being conscious that the current right keeps alive the spirit of earlier rights and does not impede them.
- Consistently pushing for the expansion of the content of earlier rights and for the creation of new rights.

Essential 'players' in the rights-based approach

1. **The rights holder**
   It is often the State. Note that it is not called the rights "giver". This is because no one can "give" anyone their rights. The State merely "holds" a citizen's rights which are *his hers*. At times, parents are child's rights holder.

2. **The duty bearer**
They can be individuals or groups or the citizen to whom the rights are entitled.
3. **The provider**
They are those responsible for fulfillment of the right. It could be the State or non-state actors. In case of the right to health care, the hospital set-up is a rights provider.
4. **The redress mechanism for justifiability and accountability**
The redress mechanism is necessary in case a right is violated or un-fulfilled. It is the only way to ensure justice.

Interestingly, the rights holder, provider and redress mechanism are all part of the State and therefore all three responsibilities are carried out by different branches of the same system. So one arm of the State might violate a right and another might provide redress.

Difference between rights and Human Rights

'Human Rights' are fundamental rights neither created by governments nor by international treaties. They are universal, intrinsic and self-evident and are the rightful entitlement of all human beings. They are deemed essential for all human beings to lead a life of dignity and fulfillment. They need to be incorporated into a legally binding agreement if they have to be protected, enforced and monitored.

'Rights' can be created by formal law or a constitution or may be based on custom and tradition. To be able to claim rights, they have to be codified through law and policy. Violations have to be addressed and remedies claimed through institutions and procedures of redress. Rights can be temporarily limited when there is a political emergency or curtailed for reasons of culture and tradition.

Strengths of Rights-based Approach

A Rights based approach states that Rights are dynamic – they can be expanded and universalised, but never reduced or permanently withdrawn. For example, in 1987, there was a ban on sex determination in the state of Maharashtra. This ban was then universalized to the rest of the country in the form of the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 and amended to the Pre-conception and Pre-natal Diagnostic

Techniques (Prohibition of Sex-Selection Act (PCPNDT Act), 2003. Once a right is in place, the State is obliged to fulfill it, failing which redress mechanisms must be adopted. This makes the State accountable and propels it to ensure that violations do not occur.

Limitations of the rights-based approach

It could become apolitical. It has been criticised by progressive movements such as Marxism and Feminism which believe that it does not deal with re-allocation of resources and does not address the removal of structural violations. In this sense, it can end up being reductionist and not deal with the real issues. For example, when one's Primary Health Centre (PHC) is working properly, is stocked with medicine, but fails to see the larger picture that essential drugs are not manufactured in the country and irrational drug therapy is practiced. Similarly, one right may be pitted against the other; for example, the right to abortion is pitted against the right to abort handicapped fetuses. The disability movement is raising the point that people are born handicapped but disability is socially constructed, such as when buildings do not have ramps, wheelchairs are not available or materials are not available in Braille.

Even in rights discourse, women's rights remains a blind-spot and has not received due attention. It is ironical that birth registration and death registration are made compulsory but registration of marriage is not. Registering marriages would control deception of women by men who are already married and will make known the age at marriage. It took seven years of pressurising by CEDAW for the government to make registration of marriage compulsory.

Unless enabling conditions are created, true entitlement of rights may not happen. It may not always involve community mobilisation or politicisation. The people being affected by a right are not the ones being mobilized. For example, a petition to disallow marriages for HIV positive people was filed, but none of the people taking part in this were HIV positive. Hence the ones bringing about change are not always the ones whom the change will affect.

In order to adopt any approach; we need to understand its nuanced applications. The rights based approach has several advantages; however, it also has its limitations which must be recognized.

Principles of State Obligation

- **Respecting** rights require States to refrain from interfering directly or indirectly with a right. It would mean State giving money to rape victims as it failed to prevent the occurrence of crime under the right to protection.
- **Protecting** rights requires States to take measures that prevent third parties from interfering with rights. Thus if a murder happens, it is State vs. the murderer.
- **Fulfilling**, providing and promoting rights requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards full realisation of rights. An example would be starting PHC, training the staff.
- **Enabling conditions** have to be created for people to access and enjoy their rights. Along with starting schools, providing community crèches, mid day meals thus creating enabling conditions for girls to enjoy their right to education.
- The State is also obliged to **remove impediments** in people's access and enjoyment of rights. It would mean removal of child marriage in order for the child to realize his/her full potential and in accessing and enjoying her rights.

The trainer will then explain the concept of **Due Diligence.**

When a human rights violation or crime occurs, whether the State has exercised enough due diligence pertaining to:

- Prevention
- Investigation
- Prosecution and punishment
- Compensation

It is not the severity of punishment that is a deterrent, but the surety of punishment that reduces violations or crime.

State obligations towards human rights

The State must prove that it was *unable*, rather than *unwilling* to safeguard the rights of its people. Inability quoted on the basis of inadequate resources cannot continue forever. Progressive realisation of rights is the obligation of every State. Currently, education and health come under directive principles with the vision that with increase in resources they

would become fundamental rights. The State is answerable for its acts of commission as well as its acts of omission with respect to human rights.

State obligation towards realising human rights

The immediate obligation is that of non-discrimination. The obligation of *means, conduct* and of *result* impliesequality of opportunity, access to that opportunity and of result. The provision of maximum available resources, progressive achievement of rights, international obligations and making non-state actors answerable are all obligations of the state. .

The Human Rights Framework and International Human Rights Law

A brief history of how Human Rights came to be is explained. The concept of human rights has been evolving for centuries. In India, the spectrum of spirituality is rather vast. At one end are the Saints and Sufis from the *Bhakti Sampradaya* who spoke of universal brotherhood and at the other are the Pundits and Mullahs. Whatever the form, every religion and saint has propagated love for God's creation. Christ has taught to forgive and to do unto others what you want others to do to you. Islam means peace. Greeting of *salam* means that 'I guarantee you peace' and responding by *salam valikum* or *valikum asalam* means 'I too guarantee your peace'.

The French and Amercian Revolution brought in word 'liberty, equality and fraternity'. Like the concept of Human Rights, the idea of who a human being is, has also been evolving for ages. The American Declaration of Independence was applicable only to propertied white men - direct contradictions to slavery, but since the slaves were not recognised as humans, this contradiction did not seem to matter.

The legal quoting of human rights came about only in the 20th century as a result of the two World Wars. After the First World War, the League of Nations was formed. After the Second World War, the horror of Nazi atrocities underscored the need to come up with some human rights guarantees. As a result, the League was dissolved and the United Nations was established which came up with the Universal Declaration of Human Rights (UDHR) on 10th December 1948. Every year, 10th December is celebrated as Human Rights Day around the world.

The Human Rights framework has been criticized by various groups which range from the Marxists and feminists to religious and cultural fundamentalists. The Marxists felt that there was no emphasis on resource distribution while the religious and cultural fundamentalists

rejected it because they called it a 'Western concept'.

There is an over-emphasis on the legal and UN/State directed procedures which makes it difficult for human rights to be accessed and enjoyed by the most marginalized sections of society. However, the human rights framework has been constantly expanding to include the rights of hitherto discriminated groups. The earlier generality, neutrality or negative construction of rights has also been corrected through the formation of newer treaties, declarations, platforms for action etc.

Attributes or principles of human rights

- **Universal**: Human rights are applicable to all, just by virtue of being human. Having said this, one should also keep in mind that although Human Rights are universal, "one size does not fit all". Some people are at a greater risk of being violated than others.
- **Intrinsic**: One need not prove citizenship to avail of these rights, except that one is born as human.
- **Inalienable**: An Indian citizen has voting rights in India but not in Bangladesh. However, human rights cannot be snatched away from anyone at any cost and remains intact even when one crosses borders.
- **Indivisible**: All these rights apply to everyone.
- **Inter-dependent and Inter-related**: Just as one type of discrimination is dependent on another, so are human rights. If a person's rights are violated in one respect, they are likely to be violated in other areas too. Similarly, human rights violations in one part of the world will affect people in other parts of the globe. Intersectionality operates in human rights too. One right strengthened or eroded impacts the other.
- **Non-hierarchal**: No human right can be prioritized over another; the right to life cannot be said to be higher than the right to health.

Areas of International Human Rights Law

International Humanitarian Law: This law is related to war crimes. All war criminals are tried under this law. Trafficking is now emerging as a category by itself because of the increased incidence of this crime.

Sources of International Law

- Treaty Law (Closed or Open): It is also known as Conventions or Covenants
- Customary: A customary law is not necessarily approved of in writing, but is followed because it is an accepted custom. For example, the Universal Declaration of Human Rights is not a treaty, but it is binding on all nations.
- Judicial Decisions: These are decisions which are made by the International Criminal Court in Hague and can be quoted as precedent. If some type of verdict is passed several times, a treaty may be formulated along its lines.

Processes and Outputs

In order to acquaint the participants with terminology used in Human Rights Law, the trainer will discuss the following terms:

- **State party** is a State that has ratified the Treaty.
- **Treaty Body** is the Expert Committee that monitors the implementation of the human rights Treaty.
- **Concluding Comments** includes recommendations made by the Committee to individual state parties after reviewing their periodic reports.
- **Shadow / Alternative reports** are usually submitted by NGOs to the Committee, independent of the government report. Shadow reports have the opportunity to give a picture different from what the Government portrays, hence making the implementation of the treaty more effective.
- **General Recommendations** are interpretative comments on the specific articles of a Convention or Treaty.
- **Declarations or Reservations** - State parties are allowed to make reservations to an article of a Treaty on the basis of its inability or unwillingness to comply with that provision. However, no part of the treaty can be bracketed as such for an indefinite period of time. The reason that reservations are allowed is because if not, most countries will not sign the treaty.
- **Optional Protocol** may be an addition to the Treaty or may be a monitoring and complaints procedure. It has to be ratified separately and only by those State parties that have already ratified the main Treaty.

UN standards on International Human Rights Law

- The UDHR - a comprehensive instrument that combines all rights, not legally binding, but has achieved the status of customary international law and therefore, morally binding.
- Treaty Laws are binding on State parties:

    1. ICCPR: International Covenant for Civil and Political Rights
    2. ICESCR: International Covenant for Economic, Social and Cultural Rights
    3. CERD: Committee on the Elimination of Racial Discrimination
    4. CEDAW: Convention for Elimination of all forms of Discrimination Against Women
    5. CAT: Convention Against Torture
    6. CRC: Convention on the Rights of the Child
    7. Convention on Migrant Workers and their families
- Declarations are not binding.
- International conferences, Plan / Platform for Action are not binding.

How does a treaty (convention or covenant) come into being?

- Drafting the legal document and mobilizing support in the UN General Assembly
- Signing the Treaty
- Ratification by minimum number of nations needed: Ratification of a treaty need not be immediate. For instance, India ratified the CEDAW only in 1993 although it was signed in 1979. This is because ratification requires the State to change its domestic laws according to the provisions of the treaty. In India, the Protection of Women Against Domestic Violence Bill was undertaken by the Government because of its obligation to provisions of CEDAW. Also, the number of nations that are required to ratify the treaty is not constant. CEDAW, for example, was to be ratified only by 25 nations – 1/3rd the number required by other treaties.
- Once ratified, the treaty comes into force.
- At the national level, ratification implies that the provisions of the Treaty will be converted into domestic law.

Session 1.7 Understanding Violence

Duration: 1.5 hours

Objectives:

- To break the silence around violence, and begin talking about it.
- To understand power and control as the cause of violence within relationships/groups/ communities.

Methodology:

Exercise: Participants will be asked to choose one person from the group who they feel comfortable with. They are given 15 minutes to share with this person, two incidents – an act of violence inflicted on them and one that they had inflicted on someone else. They are cautioned about sharing anything that will make them uncomfortable later. No one would be required to share the incident in front of the group. However, if someone does decide to go public with their experience, the others are requested to maintain confidentiality and not discuss the same elsewhere.

Content:

The session will start with an exercise followed with discussion on the responses. This will be followed with explaining various acts of violence, why it is important to be able to recognise violence and how violence in society is shrouded in notions of shame and honour. Participants are likely to share incidents where they have shouted or beaten their children or siblings as acts of violence committed by them and incidents like being harassed by seniors as acts of violence on them. There is a lot of discomfort at the beginning, as participants will ask "what does violence mean", "does it mean beating", "but I have never committed any violence" and so on. The trainer should ask them to define it as per their understanding and recall incidents.

- Most acts of violence are committed by those who have more power against those who have less or no power. One can usually get away with violence because often it is impossible for the victim to resist or question the act. The perpetrator can also be confident that the

violence will not be reported, and even if that happens, very few will be able to question his/her act.

- In a few cases, violent acts can also occur as a reaction to constant exploitation and abuse. This has to be understood in the context of what the person has gone through in the past. Usually among women, the reaction to such treatment is often directed 'inwards' meaning that she will refuse to eat, or may think of committing suicide. She may also vent her frustration on someone who is more vulnerable than she is - such as beating up her young children.

- Violence occurs when a particular group or person in society is discriminated against - especially minorities. By minorities, one means all those who do not get their fair place in society and live on its margins. Such minorities could be religious groups, tribal groups, dalits, the poor and women - especially single, deserted, widowed or divorced women, homosexual men and lesbian women, people whose belief systems or political convictions are different from the majority, and so on. This means that a large section of society has to put up with violence. A game of divide and rule is used to justify violence by labelling people who are different, as abnormal. One should not fall into the trap of allowing someone's rights to be violated just because s/he is different from the dominant group. Some day one will become a victim oneself if such violence is allowed to continue.

- Violence creates terror. For example, if a woman is raped in a school or college, it scares all other women in that institution, often resulting in the immediate termination of education of many other girls. The consequences are borne not only by the victim, but also by many other girls. For the individual who is constantly subjected to violence, the damage can be lifelong.

- Violence occurs when a person or a party within a relationship is vulnerable or dependent on the other - children, women, elderly people, physically or mentally challenged people, a junior at work, younger siblings and so on.

- The home is considered a safe haven. However, we find that the most terrible kinds of violence are committed here. Studies have shown that most women who die

under suspicious circumstances die within the home, that women are mostly beaten by family members (husbands, in-laws, natal family members, grown-up children) and that most women are raped by men they know and trust. Thus, it is unfair to confine women within the house with the excuse of protecting them; in fact, it is at home where most of the violence against them occurs.

- Domestic violence (violence by family members) is considered normal by most societies and so no one interferes when a husband beats or kicks his wife. People also believe that what happens inside the house is no one else's business. This is not true. People have human rights, both inside and outside the house. In no place should these rights be violated by anyone.

- Violence does not occur just because someone possesses superior physical strength. A strong person does not beat up his boss who may be physically weak; neither does an angry man beat up his superior. When a man drinks alcohol, he does not go around beating anyone he sees. However, the man can easily beat up his wife or children because he does not fear any consequences. Therefore, violence should not be justified on the grounds that a man was drunk or was upset about something.

- Because family members inflict most of the violence that women face, it is not possible for the latter to speak about it openly. One is taught since childhood to protect family honour and to do nothing that can harm the family reputation. Often women protect their abusive husbands in their dying declarations. One needs to question the belief system in which the woman is expected to protect the same family that tortures or kills her. One has to stop using such terms like honour, and start using the concept of rights. If a woman is raped, one has to realise that her human rights and dignity were violated, not her (or her family's) honour. This change in attitude will enable one to see violence against women as a public issue and not a private one. It will also help to bring out violence from the four walls of the house into the public domain, such as the hospital, the police station, the courts, women's organisations and so on.

- Violence does not occur only among the poor or among certain communities. It occurs all over the world among all classes, races and religions. It is easier to identify the

violence in poor homes because they do not have the private space to hide it from others. In rich homes, women are reluctant to talk about the violence in their lives because they feel that they would lose their social status. This does not mean that violence against them does not take place. One has to give up one's class, caste, and religious biases pertaining to violence against women. Violence occurs, not only in 'their' homes, but in 'our' homes too.

- Violence should not be used to resolve conflicts or to punish anyone. Sometimes people say that it is fine for a man to beat his wife if she commits a mistake. Does a woman have the same right over her husband? Therefore, here one is not talking about the mistake but about the power relation between the man and the woman. As long as the house, the fields, and other assets belong to the men in the house, they will always be in a position to use violence to keep the family under control. Whether it is the man's fault in a particular situation or the woman's, it is the woman under the threat of being asked to leave the house. Since she has nowhere to go, and does not have the economic independence to walk out, she is forced to accept such violence from the family.

- Being angry or having a fight is different from being violent. One has the right to feel irritated or angry about something and to argue over differences. However, there should be mutual respect among people when they raise points of difference. Insulting, humiliating, ridiculing, being judgmental, or marginalising someone just because one thinks differently is not the way to resolve differences. All the above listed acts inflict emotional violence on the other person and make it impossible for her/him to raise different viewpoints in the future. Once someone is silenced, s/he becomes vulnerable to violence in the future. A person who gets used to humiliating people, is in danger of becoming violent.

- The trainer can conclude saying that it is not easy to speak about violence. Even when we know each other here and confidentiality is offered, it was not easy to share painful experiences.

Health care providers can contribute to the process of ending violence by being sensitive to social problems. The participants are urged to link their personal life to what is happening in society at large; only then will it be possible for them to empathise. They are asked to steer

clear of being judgmental towards women from a different caste, class or community and to not fall prey to the common biases that society harbours. As care-givers, they are required to try and understand a woman's situation and empathise as best they can.

The facilitator concludes the discussion by reiterating that bringing about change requires us to implement these principles in our own lives and talking about it with colleagues can make a difference. Remember that there is no limit to the amount of effort that we can make to eliminate violence as a whole.

Session 1.8 Masculinities and Men's Involvement in VAW

Duration: 1.5 hrs.

Objectives:

- To introduce participants to the concept of 'masculinities' and understand its role in violence against women
- To introduce participants to the MASVAW network in Uttar Pradesh that seeks to involve men on the issue of VAW.

Methodology:

Lecture, discussion and film screening

Content:

- Masculinities are a way to explain men's behaviour, power and responsibilities, in relation to women as well as each other. A man's 'Masculinity' is demonstrated through the fact that he does not cry, is brave, independent, protective and can roam around freely. It is also demonstrated through the role that he is required to play – that of a bread winner, warrior, bearer of property, decision maker, protector of women, care giver to elderly parents, etc.
- There have been various frameworks of understanding masculinity. Masculinity has been understood from the point of 'biological destiny' – that men are different by nature and that their biological characteristics give them a masculine advantage. For instance, 'biologically, men have a greater sexual urge'. The other framework is the cultural or social constructionist perspective which states that masculinities are a result of how boys are socialized to be 'men', that they are dictated by social and cultural norms. The third framework of understanding masculinity is as a discourse of power – that masculinity is what gives entitlement to power.
- Masculinities are of multiple types and hence are referred to in the plural rather than singular. Some forms of masculinity are prized, honoured and desired above others. Some forms of masculinities are dominant, while others are subordinate or marginalized. Aggressive behaviour, including physical violence, is important to the presentation of the dominant or hegemonic masculinity.

- A study by the International Center for Research on Women conducted in Rajasthan in India identified the 3 Ps that characterized dominant masculinity based on roles that a man is expected to play: Provider, Protector and Procreator. This could also be in relation to one's family and to one's country – protector of one's motherland, for instance.
- Kaufman identifies the 7 Ps of violence as:
- Patriarchal Power: The organization of patriarchy is such that it allows and expects men to be violent in order to retain power
- Sense of entitlement to Privilege: It is not just the need to retain power that leads men to be violent, but also their sense of entitlement to privilege. For instance, a man may hit his wife if there is less salt in the food because he wants to keep her in control, but also because he considers it his privilege to have good food on the table when he is home.
- Permission: Violence by men against women is permitted and hence goes unpunished. Laws to enforce it are lax and people are reluctant to report it as it is considered a private matter.
- Paradox of men's power: Men may be violent and aggressive, but their socialization to suppress their feelings and the need to conform to the dominant masculinity also results in them being very insecure.
- Psychic Armour of Manhood: Dominant masculinity demands that men do not express emotions and appear invincible.
- Psychic pressure cooker: Men are required to suppress all feelings and redirect them into anger which explodes.
- Past experiences: Experiences of having witnessed violence perpetrated by one's father on one's mother teaches men to be violent. Self-experience of violence, for instance bullying, too can instill a need to be violent just to survive.

How is masculinity related to Violence?

One way of proving one's hegemonic masculinity is to act aggressively and even violently toward what is regarded as feminine, women, homosexual and/or "nerds". Violence occurs not just against women, but also on men from under-privileged groups, if norms of behaviour are violated; for example, violence against homosexual men. Violence occurs on women when they deviate from norms of roles and behaviour. For example, honour killing when girls decide to marry out of their caste. Women are seen as symbols of family/community prestige and an attack on them is considered an attack on the masculinity of the men in their community. Thus, in times of conflict/riots women are targeted, to take revenge on that family/community.

What does working with men entail?

The fact that masculinities are plural and dynamic means that they can be reconstituted more positively. This needs to take place during the time when we are socialized into being 'men' and 'women'. There are some organizations and networks in India that are addressing these issues. They are working with young men to change their perspectives towards women, to question the 'norms' and to create a new type of masculinity – one that values equality.

MASVAW – Men's Action for Stopping Violence Against Women, is a campaign started by a group of concerned men and boys who collectively felt responsible for this situation and decided to bring about a change within themselves and in other men and boys in North India (Uttar Pradesh & Uttarakhand). MASVAW was started with the objective of increasing awareness among men about different forms of violence against women. It motivated men and boys to denounce violence and made them feel collectively responsible for reducing abuse that is perpetrated by them. Their aim was also to provide new role models for young men and boys and reconstruct a non-hegemonic masculinity.

What about working with abusive men?

There have been programmes in the West that require abusers to go through 16-day counselling programs to address their issues with 'anger' and 'aggression'. But the effectiveness of these programs is questionable. Men often use these programmes to get out of serving jail time. It is very challenging because how does one work with an abusive man unless he is willing to 'unlearn' his violent behaviour. Involving men would mean that they would have to relinquish their position of power and hand over power to women – why should anyone want to do that? There is a misconception that men are violent because they may have a mental health problem and once that is fixed through counselling, all will be well. This is not true – differences in power - not mental health problems - give rise to violence.

2. Understanding VAW, Health Consequences and Role of HCPs

Module 2:
Understanding VAW, Health Consequences and Role of HCPs

Session 2.1 Understanding forms and dynamics of abuse

Duration: 1.5 hrs

Objectives

- To enable participants to understand various forms of Violence against women.
- To examine common myths around VAW.

Methodology:

Group Discussion for understanding forms and dynamics of abuse – taking a look at myths surrounding violence against women.

Group Exercise: Form sub-groups and ask each one to define one of the following:

Group 1: Gender-based violence
Group 2: Violence against women
Group 3: Domestic violence
Group 4: Sexual Harassment
Group 5: Child Abuse.

Content:

Different forms of Violence:

Gender-based violence: It is an intentional indiscriminate behaviour on a person by another person (male/female) or group in powerful position. Gender-based violence need not be inflicted by men upon women but could also be by men on other men who do not conform to gender stereotypes.

Violence against women: Any act which a woman is forced to undergo without her consent or her willingness. It could be:

Physical – Beating /slapping /kicking etc.

Mental – Dowry, son preference etc.
Emotional – Labelling, ignoring her decisions.
Sexual – Rape (marital), touching private parts without her consent.
Economical – Control over money, dependence.
Verbal – abusive words, sarcasms.

It also includes State violence by armed forces on women as well as Communal Violence in the form of riots, fights where women are targeted. All these have shades of power, control, and intention.

Domestic violence: Violence done by those people living under one roof intentionally on each other is domestic violence (DV). It is inflicted by those in powerful positions on those who are in weaker positions.

Sexual Harassment at workplace: Any unwelcome sexual advance, requests for sexual favors or other verbal or physical conduct of a sexual nature, when it interferes with work, is made a condition of employment, or creates an intimidating, hostile, or offensive work environment is sexual harassment.

Child Abuse: An act done intentionally, physically, psychologically, emotionally, sexually, directly or indirectly, verbally or non-verbally, by known (mostly) or unknown person on the child from birth to 12 yrs of age is child abuse.

Violence by the health system: Some examples include

- Family planning programs target mainly women. Women are often coerced into sterilization and are given incentives to undergo the same. The choice of contraceptive is nearly always decided by the health care provider and the woman is not given an option.
- Women are routinely beaten while in labor and insensitive remarks are passed by health care providers. A woman giving birth to the 3rd or 4th child is blamed for having too many children.
- Women are often unable to access health facilities because of unfavorable timings, inability to travel to the hospital/Primary Health Centre alone, etc. The health system however, chooses to call this "inadequate utilization of facilities by women", thereby putting the onus on the women.

- Most health care providers are not gender-sensitized and cannot appreciate women's social and cultural restraints.
- Medical decisions are very often imposed upon the woman because she is considered unfit to make her own choices.

Society is rife with certain beliefs and stereotypes around violence against women. Domestic violence is viewed as a private matter or attributed to alcoholism; possessiveness and suspicion are viewed as an expression of love; sexual violence is understood as being the result of provocation by the woman - these are false beliefs or myths around the issue, perpetuated by the media and society at large. This session will involve examining these myths, eliciting reactions from participants and engaging in discussion.

The session will start with a discussion on various myths surrounding violence. Each myth will be presented as a statement and participants will be asked to react to it

Myths surrounding Violence against women:

"Violence against women is a private matter."

Violence is not a household's or a woman's issue, but a public/social issue.

"He loves me that is why he hits me."

This myth has an element of 'possessiveness'- that woman is a property of man, especially her husband. Possessiveness is manifested in ways such as telling her not to take up a job, not to pursue education. Women feel this is out of sheer love and affection. If the abuse is physical it is apparent, but when it appears in such subtle forms of 'possessiveness' it becomes more complex. A closer look at the cyclic episodes of violence points out that he hits her, but he also dresses the wound, apologises, thus making her feel that he loves her but it is actually a form of control.

"It's the poor and the illiterate who beat their wives."

The poor lack space and violence among them is therefore more visible and out in the open. Educated people, having more knowledge, know how to hit, where to hit, so that the injury or marks are not visible and others will not come to know. Thus their status remains protected.

"He hits only when he is drunk."

Even if he is drunk, he hits only his wife; not his boss or neighbours. He uses it as an excuse to abuse.

"Women provoke violence." / "Women provokes, so faces sexual abuse."

When women do not conform to gender roles, they are hit. It needs to be understood that women have very little space to assert their autonomy and self determination.

"Women are women's enemies."

In the context of gender roles, the mother–in-law becomes an agent of patriarchy. A woman's identity is associated with some male figure. If she is the mother of a girl, she is not counted as a mother and is considered so only if she bears a son. A woman's status is attached to men in the family. Her identity is attached to whose wife she is. Society is very unaccepting and uncomfortable if she does not carry symbols of marriage. When the son gets married and a daughter-in-law comes into the family, she assumes the status of mother-in-law and has much more power than the daughter in law. Now the daughter-in-law is expected to do everything in the house.

"He hits because it must be my mistake."

Often when a woman is hit she is questioned, "What did you do?", "Do not irritate him again". It is so easy to make women feel apologetic of their very existence. This indicates how strongly gender roles and norms are internalised within us.

"If she goes out she will face violence."

It implies that she deserves violence as she has broken rules. Various proverbs and songs are ways to transfer not only tradition, but also gender norms and behaviour such as *'Dhol, pashu, shudra, nari sab hain pitne ke adhikari'* which means a 'Drum, animal, untouchable and women- all rightfully deserve to be hit.

"The man is sad or mad rather than bad. He is emotionally disturbed, so he is not responsible for his actions."

Men in our societies are not socialised to handle emotion, sadness and stress. It is not considered acceptable for a man to cry. Hence it is believed that he relieves his stress by beating his wife. Rather than disapproval, he gets sympathy. There is also a notion that if a man is abusive, he may be mentally ill. However it is important to note that most mentally ill persons are not violent.

"His father beat his mother, so obviously he will hit his wife"

"Problem families" might be a predisposing factor because the son learns from what he watches his father do; however, this behaviour is not static and unchangeable. It cannot be condoned. There is also an element of self-determination and choice – a man can choose not hit, even though he saw his father inflicting violence.

"She needs the violence/ she is addicted to it/ it is a way of showing love."

Since men are not socialised to shower positive attention on their wives, many women believe that negative attention in the form of violence is better than indifference.

"It is their culture."

Several cultural practices throughout the world which are manifest in society are harmful to women and are tantamount to violence. As a result, women in these societies have also internalised this violence. The want of a male child to perpetuate a lineage results in sex selection. Social ills such as dowry and domestic violence are also accepted in the name of preserving culture. In the tribal areas, "witch-hunting" is commonly seen which targets powerful, independent women who challenge gender roles.

These women are considered "deviant" and are put to death by stoning or hanging. All these practices are detrimental to women and cannot be condoned.

"It cannot be that bad, or she would have left the man."

There are several reasons for why women do not leave their abusive homes. Many of them feel the need to keep their homes intact for the sake of their children. Also, the stigma associated with being a separated or deserted woman in society is too great for most to handle. Several women have no other means of support and are economically dependent on their husbands. In most cases, the woman does not even get support from her natal family. This does not negate the fact that the woman is being abused. It just means that she has no choice but to stay on.

Cycle of Violence:

I got flowers…
We had our first argument last night, and he said a lot of cruel things that really hurt me. I know he is sorry and didn't mean the things he said,because he sent me flowers today. I got flowers today. It wasn't ouranniversary or any other special day.

Last night he threw me into a wall and started to choke me. It seemed likea nightmare, I couldn't believe it was real. I woke up this morning sore andbruised all over. I know he must be sorry 'cause he sent me flowers today.

I got flowers today, and it wasn't mother's day or any other special day.Last night, he beat me up again - it was much worse than all the othertimes. If I leave him, what will I do? How will I take care of my kids? Whatabout money? I'm afraid of him and scared to leave. But I know he must be sorry because he sent me flowers today.

I got flowers today. Today was a very special day. It was the day of myfuneral. Last night, he finally killed me. He beat me to death. If only Ihad gathered enough courage to leave him, I would not have gotten flowerstoday.....

Domestic Violence is not sporadic – it is ongoing, there is a definite pattern to it. Soon after an episode of violence, the woman is injured and is suffering (probably both physically as well as mentally). At this point, she may or may not seek help. The perpetrator, on the other hand, is afraid of what she will do. He knows he has done something wrong and feels guilty as well. He attempts to appease her so that she does not take any action. This phase is called the 'honeymoon phase'. The woman forgives him thinking that he is repentant.

Thoughts such as “He didn’t mean to hurt me”, “He is truly sorry”, “My love will change him” creep in at this point. That is the complexity of domestic violence - the victim and perpetrator are in a close relationship and she wants to forgive him. However, after some time, the quarrels and conflicts start again. This is the ‘tension building phase’ which is followed by another episode ofviolence and the cycle is completed.

As this cycle repeats itself again and again without any resistance, the severity of violence increases. The frequency of violent episodes also increases and the time taken for the cycle to be completed decreases. So the violent episodes are more frequent and more severe. If the cycle remains unbroken, the severity will continue to escalate and the woman will reach a point where she will suffer severe health consequences, even death.

As health care providers, we come in contact with the woman soon after a violent episode. At this time, it is important for us to understand her state of mind. She is confused because on the one hand she is hurt and on the other hand the perpetrator is apologizing profusely. She wants to believe that he will change and is likely to be persuaded. It is imperative that we intervene and provide her with adequate support. Give her the message that violence is not her fault and try to make her see the pattern.

Social support plays an extremely important role in successful intervention. When a married woman faces violence, she comes back to her natal home. She is welcomed home as long as she comes for a short while. Staying for a long period of time is not looked upon well. She is given messages like “You will have to bear this much”, “It will take some time for you to adjust but all will work out in the end”, “Don’t provoke him”, “You cannot come back to us; that is your house now”. With all this, she is sent back to the marital house. When she returns, the marital family knows that she has not received adequate support from her parents and so her status drops further. The violence becomes sanctioned by the natal family because they take no action and its intensity also increases. If she goes back to the natal family, the reception is even harsher than the previous time and her status drops again. She is caught in the cycle of violence as described earlier. This continues until she deteriorates steadily in a spiral manner which eventually leads to death. It is important for us to also understand at what point of this spiral she is in because sending her back to the marital home maybe unsafe. If she is extremely depressed, she might even attempt suicide. We also need to explain to the natal family the role they are required to play. The family is more likely to be receptive to us as health care providers.

Session 2.2 Health consequences of VAW

Duration: 2 hours

Objectives:

- To enable participants to analyse health consequences of VAW in different contexts.
- To enable participants to identify rights violations due to violence.

Methodology:

Form sub-groups and ask each one to read a case study (Tool 4) and answer the following questions:

- What type of violence against women do you see in this case study?
- What are the manifestations of patriarchy and masculinity?
- What are the connections to health/health consequences?
- Which human rights and women's rights are violated in this case study?

Give participants a copy of the UDHR (Universal Declaration of Human Rights)

Content:

The participants are then divided into sub-groups and each sub-group is asked to define one form of violence against women. The group exercise is followed with a lecture on various forms of VAW and its manifestations. The aim of case studies is to help the participants consolidate their earlier learnings; identify manifestations of patriarchy, violence and its health consequences and to view it within a human rights framework. The prevalence of VAW, direct and indirect consequences of VAW and basic elements of understanding VAW as a public health issue will be summarised through a PowerPoint presentation.

Tool 4: Case studies for understanding VAW as a health issue

Aruna

Aruna is a 25-year-old woman working as a nurse at a public hospital. She was recently engaged to her childhood friend. She is a hardworking person and is appreciated by all her seniors. She manages all her nursing duties with ease and competence. She is known to be strict with her team. A sweeper working in her ward is irregular and does not

follow instructions given by her. He is known to be difficult. She has already brought this up several times with the matron and the medical officer. One day when she asked him to take the patient immediately for sonography; he ignored her instructions. The patient therefore could not get the sonography done as the department closed after 1.00 pm.

Aruna was very upset with his irresponsible behaviour. She dashed out a memo against him. He was rebuked by the medical officer and the matter went up to the medical superintendent. The sweeper resented this and one day during Aruna's night duty, he caught her, choked her with a dog chain, raped and robbed her. She lost the power of speech, became blind, lost the use of her limbs and the control of her muscles, and suffered a kind of emotional disability, which is manifested in inappropriate laughter and bouts of screaming. Her memory and most of her other mental faculties were also severely affected.

Now more than 65 years old, she lies barely alive, in a semi-conscious state at the same hospital. Aruna's rapist, a sweeper in the hospital, walked a free man after a mere seven years in prison for 'robbery and attempt to murder', only because she was left unable to testify after the rape.

Tabira

Tabira is a 16-year-old girl admitted in the hospital for accidental consumption of poison. The hospital has a crisis intervention department where all women who are admitted for consumption of any poisonous substance are referred for counselling. This department provides suicide prevention counselling and also supports women facing domestic violence. When Tabira reached the department, she looked very depressed. To begin with, she told the counsellor that her parents are very good and that she has no problems and that she is happy. Meekly, she said that she had accidentally consumed phenyl. The counsellor then asked her directly why she had tried to harm herself by drinking phenyl. She kept quiet at first but then opened up. She told the counsellor that she liked a boy- Rohan, but her parents have found this out. They do not approve of the boy at all. Her mother now keeps an eye on her all the time, does not allow her to go out alone and saddles her with housework.

But she manages to meet Rohan when she goes to the public toilet and to fill water. Her parents have gone ahead and fixed her marriage with someone else. She tried to speak to her parents but they just would not listen. Since then, Rohan has not been behaving properly with her. He avoids her all the time. She is feeling hurt about it. She is also angry that her parents are being so unreasonable. She feels that if Rohan was with her she could find a way out, but his indifference is extremely painful for her. Today she called him, but he did not receive her call. She even sent a message through his friend that she wants to meet him, but Rohan refused to meet her. She felt hopeless then and is afraid that she will have to marry this boy who she does not like.

Kashmira

In the late evening, I was approached for a delivery. I was a bit taken aback as I was not aware of anyone due for delivery then. When I enquired, her uncle told me who it was. I was shocked as we had not seen this girl in the village for a long time. We were under the impression that she was with her aunt in Jammu. When I heard it was her, I knew there was something wrong. I wanted to refuse, but did not have the heart. I said my prayers and after bidding farewell to my family, left for the girl's house. One look at her and I knew we needed to take her to hospital; her delivery was going to cause a problem. I pleaded with the family, but no one was willing to listen. They pleaded with me to do whatever I could. After much arguing, I asked them to at least arrange a standby doctor. This too, they were not willing to do until I said that I was not going to deliver the baby without a doctor. Finally, they brought a doctor from somewhere. He was as scared as me. He also tried pleading with the parents to take her to the hospital, but they just would not listen. Her labour was long and difficult. We were worried. It was way past midnight when there was a knock on the door. The whole household went into shock. The girl was in pain. Her mother came over and tried to silence her by putting a pillow on her face. I was aghast. I snatched the pillow and threw it away. The banging on the door grew louder. Finally someone opened it or they would have broken it down. Suddenly, the room was filled with four men with guns. The doctor hid behind me. I was at the door and did not budge. I do not know what it was, but they did not try and move me aside. Maybe it was my age. They stood pointing the gun at me for I don't know how long - it seemed hours at that time. They finally moved back and motioned for the father and uncle of the girl to follow them. I do not know what happened between them, but after about an hour the militants left. We continued struggling with the delivery. The next

morning the girl finally delivered a healthy boy. She was lucky to survive. It was later that we got to know what the problem was. The girl was pregnant with a child of a militant who wanted it aborted. But the girl refused and her parents supported her. She was hidden in the house and the militants were told that she had gone to Jammu for the abortion. But someone had informed the militants of the delivery and they had come to kill the family. The family finally negotiated with the militants and paid them a huge sum of money to let them live and promised to get the girl married as soon as possible.

Rehana

Rehana is a 30-year-old woman living in an urban slum. Her parents got her married to a man who lived in the city so that she could escape the hard life and poverty of the village. Rehana took a long time to adjust to the highly-crowded slum, the lack of privacy and an extremely small home. She has two children. In the past fifteen years, Rehana and her husband have had to move from one slum to another, either because of demolitions or communal riots. Now they live in a predominantly Muslim neighbourhood because they feel safe there. Rehana now has to wear a burqa, which she never did before, and feels suffocated in it. To make matters worse, six years ago, her husband lost his job at the factory as it closed down suddenly. The money he received was used up to pay the heavy deposit on their present room. Her husband, who was a hardworking man, now has to go in search of daily labour. He feels frustrated and has begun to drink.

Rehana has been suffering from backache for the past two years, but she can get no rest. She also has white discharge. When she mentioned it to her husband, he told her to forget about it. Recently, she has been getting the sensation that there is something heavy between her thighs. Sometimes when she coughs or presses down hard during defecation, she feels that something is coming out of her body. She feels very scared about it and has taken medicines from a local dargah to fight off, what she believes, is evil spirits in her body. She finds it very difficult to have sex and suffers from severe pain after intercourse. Because she avoids sex, her husband has begun to get suspicious of her and says that she must be having another lover. He feels that she will leave him for a richer man.

Case study of Rehana is developed by Manisha Gupte, it is taken from Process documentation of training of trainers at Dilaasa, 2003, Module VII, Dilaasa & CEHAT.

Last night, Rehana's husband forced her to have sex. When she tried to move away, he caught hold of her wrist and twisted it. He also slapped her. After intercourse, Rehana started bleeding, which scared her husband. He promised to take her to the hospital if she promised not to disclose family secrets to anyone. This morning, Rehana, along with her husband, went to the nearest government hospital where they had to wait for two hours in the gynaecology OPD before they could get see a doctor. Her husband lost his day's wage because of this delay. When the doctor finally saw her, she could sense that he felt disgusted with her condition.There was another younger doctor who seemed more sensitive – even through the burqa he noticed the bruises on her wrist and made enquiries. But how could she tell him the truth in front of so many people? She said that she had fallen down. She also felt scared to tell the doctor about her husband's behaviour, because she felt they would give him up to the police. Would the police treat her husband as a terrorist or a criminal? The two doctors began to speak in English and she felt as though the older doctor was scolding the younger one. That further frightened her.

Rehana was told that she needed surgery, but who would take care of the children when her husband went out to work? The doctor was angry with her when she said that she had to go home. He wrote out some medicines for her. When she asked if she could get the drugs free at the hospital, he said that the government had now stopped giving free medicines and that she would have to buy them herself. Rehana left with the prescription, knowing that she had no money to buy them. She also knew that the doctor would be angry if she came back again without having taken the prescribed medicines, so she does not know where to go now.

Maria

Maria is a 36 year old woman who has not been married and who currently lives alone. She grew up living with her parents, maternal grandparents and a brother who is 15 months older than she is. Her grandfather was the only one identified by Maria as providing any nurturing and his death when she was 30 years old, was especially traumatic for her.

Maria has vague memories of her abuse starting very early in her life. The abuse included her mother becoming so furious when Maria would cry, that she would choke Maria and throw her against the wall. Maria has many clear memories of her parents screaming at each other and her mother constantly telling her how awful her father was and that she needed Maria's protection. It was not unusual for her mother to talk about killing him. In addition, Maria has many feelings associated with being sexually abused by her father, by a family friend, and by her grandfather.

Maria remembers her childhood as being scary and remembers feeling alone most of the time. At the age of 12, she often felt suicidal and knew that her "brain didn't work right". Her physical condition has been striking in that she has numerous physical problems and reports that for most of her life she has not felt well. These problems have included numerous precancerous moles, a ruptured appendix, collapse of the canal between the bladder and kidney, fibroid cysts and a fibroid tumor that caused her to have a hysterectomy. Although Maria has above intelligence, at age 6 she was diagnosed as learning disabled and has consistently had difficulty with verbal communication.

In spite of having a secure job as a technical writer, she reported that her life fluctuated between feeling suicidal and depressed, with intermittent periods of anxiety. She was able to make progress only when she was able to identify the splitting process that occurred during her childhood and realized that many of her adult symptoms were related to childhood traumas.

Naseem

Naseem aged 28 years, has come to the Casualty reporting assault by husband. She has injured her eye and reported blows in the stomach. She is nine months pregnant. Her husband hit her for not cooking food on time. The doctor registered a medico legal case and referred her to the labour ward. She was admitted after a sonography was done. Her husband works as plumber and his earnings are not enough. She has 3 daughters and 1 son. Her eldest child is 6 years old. She delivered a male child the next day. Her natal family, though very poor, was by her side. As per the hospital rule, any woman delivering a third child has to pay Rs.500/- as fine.

Naseem was asked to pay Rs.500/- as this is her fifth delivery. She is unable to pay this amount. Her father is running from pillar to post to find out whether this fine can be waived. Even the social worker said that she cannot help them. Her discharge from the hospital is withheld.

She is contemplating running away from the hospital, as she knows that this money cannot be raised. Throughout, she has had to listen to health care providers' remarks - "these people breed and waste hospital resources." "They don't understand that they should not have so many children when they are so poor." She is told that if she consents to undergo sterilization within one month from delivery date then the fine can be waived.

Sima and Saurav

Mr .K wanted the Principal of his children's school to certify that Mrs. K was a bad influence on his children, Sima and Saurav. He said Mrs. K was having an extra – marital affair and that separation from her was best for all them. Sima, the elder one was tidy and neat, punctual, brought books, etc. correctly to school, had the ability to perform, but seemed inattentive and lazy, and did not complete the school work.

She liked attention and care, but never asked for it. Saurav seemed insecure, did not trust anyone and was happy and relaxed when working alone, but anxious and aggressive in groups. Sima could recount all the fun experiences she had, carefully leaving out disturbing events at home. In her drawing, the father was conspicuously absent. Saurav too, refused to talk about events pertaining to home. Mr. K, 48, was an engineer; Mrs. K, 43, was working and they had been married for 14 years. For Mrs. K, the problem started soon after marriage and she experienced deprivation economically and emotionally; rejection, due to constant comparisons with the first wife; humiliation, as K insisted on her touching his feet with apology following any conflict; and his nagging, suspecting her of adultery. When she took up a job, the situation became worse. However, from the other side, Mr. K felt all the negative feeling that he felt, when Mrs. K became hysterical, tried to commit suicide, became physically violent and finally, became involved with another man. As violence in the family escalated, the children witnessed and were also subjected to it. Sensing the anger and hatred in the environment and also against them, they felt insecure, terrified, guilty and responsible. They were used by each parent

to tell tales about the other, feared punishment from either parent for their disclosures, felt tense and confused about what is right communication, and did not experience emotions fully because their spontaneity was stifled. Each parent forced them to see things as black or white, making them take sides. The children were often the subject of conflict as the parents passed around blame and responsibility for the way they were brought up. The violence was severe enough to incite embroilment with the police and the children were caught in all of this, in confusion, embarrassment, terror and rage. Eventually, Sima and Saurav increasingly took their mother's side and opposed the father, openly disrespecting him and protesting his increasing violence. The resilient Sima vowed to become a judge.

Session 2.3 Role of Health system and/or Health Care Providers in addressing VAW

Duration: 1.5 hours

Objectives:

- To enable participants to identify in each case study above, what the health system can do to address VAW.
- To identify and reflect on the barriers that HCP face in addressing VAW

Methodology:

Based on the case studies discussed in the previous session, the participants will be given 3 more questions to answer:

- What can the health system do to address VAW?
- What are the barriers that HCP face in addressing VAW?
- Fill in the Domestic Incidence Report based on the case study.

Content:

The session will start with an exercise whereby the participants will be asked to answer three questions based on case studies provided. This will be followed by a discussion explaining the importance of DIR (Domestic Incident Report) to the participants.

Session 2.4 Application of learnings

Objectives:

- Enhance skills in Observation, History-taking, Recording, Counselling, Treatment Plan

Methodology:

Role plays of four case studies: Child Sexual Abuse, Sexual Violence during communal riots, Rape in work place of adolescent, Domestic Violence

Content:

Group I – Muslim woman gang-raped during the Gujarat carnage a week ago.

Points for discussion:

It is not easy for a woman from a minority community in the course of riots to approach a police station as the latter often collude with the majoritarians. The husband should be asked to leave and history should be taken in privacy. Consent should be sought for examination and the procedure for examination should be properly explained. Women in the backdrop of communal violence may not directly say that they were raped. They may not even be willing for a police complaint, but the doctor must document it and provide her with treatment, care and counselling. Providers must know that during such riots, men have inserted swords into women's vaginas, thrown chilly powder and so on.

Group II: Adolescent girl was brought to the hospital by a mother who wants her daughter to undergo an abortion.

Point for discussion:

It is critical to have in-depth counselling as in case this abortion was conducted she would be under age; also if she continued her pregnancy, it would prove to be lethal. The pros and cons would have to be explained to her. There is also a need to refrain from suggesting marriage as an option, as the situation does not have the scope for it. Aspects of counselling should also ensure that medical follow-up takes place. She could be referred to a counsellor to deal with the emotional trauma of being raped by her employer.

Group III: 20 yr old woman, who has suffered 10% burns, is 4 months pregnant and is brought to the hospital.

Points for discussion:

It is important to probe sensitively to elicit history, especially the gaps in history. She could be asked what she had done during the day. This may lead her to the incident. Then they can check whether there is a gap in history. Patients who have attempted suicide may not reveal information even after three days. HCPs must never forget that their role is to provide medical care. Probing comes after that. They must leave the door open by telling her not to hesitate to come back if she feels the need to.

Group IV: Case of child sexual abuse, where the daughter is refusing to eat or talk to anyone and more so, her father.

Points for discussion:

One must recognise that speaking to children requires specific skills. Often they have no vocabulary to express what has happened, especially in case of sexual abuse. Using dolls has been found to be useful to elicit history. It is important to speak to the child alone, even in the absence of his/her mother. Referral to Child Guidance Clinic to mitigate effects of trauma should be emphasized and the safety of the child should be given prime importance.

Session 2.5 Visit to Dilaasa

Objectives:

- To see an example of how health system can address VAW
- To learn from the experience of health care providers who have been involved in the functioning of a hospital-based initiative on VAW.

Duration: 3 hrs

Methodology:

The participants are divided into three groups – each group interacts with one function of Dilaasa - administration, training and counselling services. Participants are asked to choose which group they would like to belong to, based on their area of interest. One group goes to the counselling centre and interacts with the counsellors. The second one interacts with trainers across five hospitals and the third one interacts with the administrators.

The groups are taken to the hospital where the crisis centre is located. They spend an hour with the concerned person – counsellor, trainers or administrators. They then visit the hospital departments and interact with the staff there. Each group discusses the following issues:

Counselling centre:

- Components/services being provided; linkages with other agencies
- Perspective with which counselling is provided
- Significance of location within the hospital - in what way does it increase access
- Linkages with other hospital departments
- Profile of women accessing services
- Barriers in accessing services
- Limitations and challenges
- What can you do at your level?
- Should counselling be part of health care provision?
- Do you feel counselling should be provided only by social workers/psychologists or all HCP?

Trainers:

- Why training should be ongoing
- Process of training- content, methodology
- Barriers from trainees in accepting VAW as a health issue
- Working around systemic barriers
- Finding different avenues to sensitise/orient staff
- Increasing visibility about the issue
- Signs/symptoms for screening by different departments.
- Experience of trainers themselves- how it has impacted their roles
- What they can implement at their level.

Administration:

- Why should administrators be convinced that this is a critical issue?
- Working around systemic barriers and ensuring training
- Being flexible to bring about change
- Increasing visibility within the hospital
- Bring in protocols/procedures to ensure that all women have access to services - ensure sustainability
- Involve all stake holders - unions, corporators/staff at all levels
- Safety of counsellors/staff and patients

Content:

Counselling centre:

- Components/services being provided:

Crisis counselling is different from most other types of counselling because it happens in a situation of crisis; the woman facing violence may have reached higher intensity of abuse. In such a scenario, the counsellor has to build rapport, provide her emotional support, assess her safety as well as provide alternatives to the current violent situation.

The first step in such counselling is to introduce one self and the functions of the department. After this the counsellor asks the woman if she would like to avail of any of these services. If the woman decides to talk, she is assured of confidentiality of the information that she shares with the counsellor. After this, the counsellor begins the journey of exploring the history of

abuse. In the process of counselling, it is important to understand how painful it is for a woman to recall such events of her life. Thus, while doing so the counsellor has to demonstrate empathy as well as reassure her.

At the core of the counselling, the counsellor has the understanding that the woman has struggled and tried numerous attempts - both, informal and formal - to reduce the violence that she faces. With this understanding, the counsellor explores these attempts made by the woman. Most women try to seek police support or natal family support. Such exploration helps the counsellor to identify the woman's coping mechanism. The philosophy behind exploring her coping is the firm belief that women have the capacity to address violence in their lives and she has come to the department because of a temporary breakdown of that coping mechanism.

While talking to her, it is important to assess her safety in terms of physical and emotional aspects. The latter essentially, is a way of exploring whether the woman has any suicidal ideation. It is also to explore if any such attempts were made in the past. Physical safety is assessed in terms of perceived threat from the abusers, threats of killing and whether she thinks that she can really be killed, are also explored. In case a woman is found to be unsafe, various alternatives which are feasible in her situation are suggested. There are situations where the woman is extremely unsafe and has nowhere to go. In such situations, if she has any health condition, she is admitted on the basis of a temporary shelter in the hospital. This would give her time to think about what she should do next.

- Linkages with other agencies

Shelter: Women in need of a place to stay are provided shelter, as domestic abuse often brings with it the lack of safety which prevents women from going back to the same house. Women are also often thrown out of the house and need such services

Police: Women are encouraged to make a police complaint, but most of the time, they are scared, and hence the counselling also has to dispel those fears. The counsellor can call the police station and state that such a woman will be coming to the police station and that her complaint be taken.

Lawyer: Women are provided information about laws, depending on the nature of problem that they are facing. They are also provided free legal services at the centre.

Community-based organisations and support groups: It is important to connect women to other organisations where they can meet other women. This builds a support system for her at her community level and provides her the opportunity to interact with other women who are probably in similar situations.

- Perspective with which counselling is provided:
  The counselling approach is feminist in nature. At the core, is the belief that violence is never the woman's fault; such abuse lies in the inherent unequal power relationships between men and women. Such messages are given in the course of counselling; such ideas help her reduce self-blame as women are often told that the violence they are facing is due to their fault or short-coming.

- Significance of location within the hospital - in what way does it increase access:
  Women can access the Centre under the pretext of going to the hospital. It is a less threatening place to access services. A large number of women suffer health consequences of domestic violence and access the hospital services. If they are screened at the hospital and services are provided here, it increases access of these women to such services.

Trainers:

- Why training should be ongoing
  There should be core groups of staff in the health system who can train their peers on the issue on an ongoing basis. The reason for this is two-fold. The first is that one-time training does not result in change in attitudes – it requires a more sustained engagement. Secondly, the staff in the hospitals is floating – several get transferred or there is rotation of resident doctors. In order to ensure that all staff is trained, training should be held routinely.

- Process of training - content, methodology
  The group of trainees should be a mixed group if possible. This helps to break the hierarchy of doctors, nurses and labour staff which exists in the system.

  Participatory methods such as role plays, games, etc. are used by trainers so that the session is interactive. In spite of such a methodology, it is often seen that the staff does not open up., It is the pro-activeness on the part of the trainer that would be able to help the staff to voice their opinion.

Avoid using the lecture method. Violence is something that everyone has experienced. People should be encouraged to think about their own personal oppression and vocalize and reflect on it. If we want attitudes to change, the engagement needs to be deeper than just lectures.

- Barriers from trainees in accepting this as a health issue
  There is usually a sense of boredom about the issue. Many people do not take it seriously. Sometimes, participants might joke about the issue. As staff members who are actively interested in addressing the problem of domestic violence, this might be disheartening to see. But do not be put-off. Learn to pitch the training at the level at which the trainees are. If there are trouble-makers, learn to deal with them. In a system which is so insensitive, one-time training will not change people's attitude. But orientation training should at least get them to think. Patience on the part of the trainers as well as constant communication has eventually helped the smooth running of the training programmes.

At times, those attending the training are completely expressionless making it difficult to comprehend whether they have understood or whether they are opposed to the concept itself. However, it is important for the trainer not to be disheartened by such a reaction. In fact, an added step must be taken to understand such a response and further dialogue with such a person.

Conducting training also requires team work. Some are involved in getting the required number of staff while others actually conduct the training.

During training, the hospital staff will voice their grievances. Allow them to voice their feelings.

- Working around the systemic barriers
  Organising training in the hospital is a challenge as adjusting timings, having adequate number of staff who can attend without affecting hospital duties requires planning. Additionally factors such as strikes by HCPs and opposition from the union and other influential parties on implementing a health care response is also a challenge.

It is important to have rapport with the hospital staff. Only then is the staff amenable to attending such trainings. It is also important to have personal contact with people; this

provides an opportunity to understand people's inconveniences and, if possible, rectify them for streamlining training sessions.

- Finding different avenues to sensitise/orient staff Strategies such as talking to staff in various wards about the different health consequences that they should screen for, what they could do for women who they identify as being abused, etc,. organising poster exhibitions, also create awareness at the level of the hospital.

Administration:

- Why should administrators be convinced that this is a critical issue?
  The role of administrator is crucial for implementation of such a programme or project. Sending staff for training, making changes in the documentation protocols (such as the medico-legal case register), access to medical records, providing space for services, training - all of this requires permission from administrators. If they are not convinced that this is important, they will not take the required steps for making all these things possible.

- Working around systemic barriers and ensuring training: Hospitals function round the clock and so deputing staff for 2-3 hours of training is not an easy task. Conducting the training after official duty and giving staff compensatory off for having stayed post duty is one way to deal with the issue Conducting orientations in smaller groups with staff from different departments ensures that the functioning of hospital is not affected.

- Being flexible to bring about change: this is important for administrators to understand. Any change requires time. Being rigid with rules and norms acts as a barrier in bringing about any positive change.

- Increasing visibility within the hospital: a new project or programme should be visible and the administration can play a role in identifying various means of making this happen - posters, placards, sign boards, appropriate directions - are some ways.

- Bring in protocols/procedures to ensure that all women have access to services- ensure sustainability: incorporating a new project into the daily report of staff helps in integration; otherwise, it will remain an experiment.

- Involve all stakeholders - unions, corporators, and staff of all levels: various stakeholders need to be apprised of the various activities of the hospitals. Support for a new idea may come from any quarter and therefore, information-sharing becomes important. For example, the nursing unions recognised the need for services like Dilaasa and even demanded that similar services be set up for their own members.

- Safety of counsellors/staff and patients: working against violence is not easy. The staff working at the crisis centre as well as the trained doctors and nurses who are helping survivors of violence may be threatened by the abuser and/or his family. In such times, the safety of staff becomes priority and therefore, informing the security and police at the hospitals about Dilaasa and the kind of work it does, is necessary.

Session 2.6 Comprehensive Health Sector Response to Sexual Violence

Duration: 1.5 hours

Methodology: Lecture and PowerPoint presentation

Content:

- Defining sexual violence: Often, the term sexual violence is understood only as 'rape', but in reality, there are several types of acts that fall under its ambit. Apart from non-consensual peno-vaginal intercourse, other acts such as fingering, anal intercourse, fondling of body parts, oral intercourse are also considered sexual violence. Both men and women may be survivors of sexual assault.
- Marital rape is categorically excluded from the legal definition of rape. It has been recognized for the first time in the Protection of Women from Domestic Violence Act, 2005.
- The reporting of sexual assault is extremely low. This is because there is a lot of stigma associated with it. There are questions raised about the woman's character; instead of questioning the perpetrator's action, it is always the survivor's actions that are questioned – why she was dressed a certain way, why she was out late at night, why she was out with a particular male. There is a lot of speculation about whether she is telling the truth, but few understand how difficult it is to report the crime.
- Medical textbooks too, perpetuate such myths. Modi's textbook on Forensic Medicine asks the doctor to ensure that a female attendant is present during examination because a woman who has 'alleged' rape on another man can very well allege rape on the doctor too. The presence of a female attendant is required for the comfort and safety of the survivor – but it is portrayed as a way of protecting the doctor. The textbooks also perpetuate myths like 'a well-built woman cannot be raped against her will'.
- Health care providers and health facilities routinely receive cases of sexual assault. They have both a medico-legal and therapeutic role to play. A comprehensive response of the health system consists of:
    - Obtaining informed consent
    - Provision of treatment and psychosocial support

- Documentation and collection of evidence
- Maintaining chain of custody
- Co-ordination with police and laboratory
- Referral to other agencies for legal or other help.

- Informed consent in cases of sexual assault is legally mandated by law. Consent is not merely a signature, but a process. The survivor must be given information about the procedures that will be carried out and their importance. Consent must be sought at three levels: 1) for treatment 2) for examination and evidence collection 3) for giving information to the police. The survivor may refuse one or all of the above and this choice should be respected.
- Survivors may come with the police or by themselves directly to the hospital. Sometimes, they may not want to file a police case. While the law recognizes voluntary reporting, health facilities have still not changed their practices and an Medico Legal Case (MLC) is compulsorily made.
- Even though HCPs are aware of the needs of a rape survivor, their response does not emerge as rapidly as it should. Often, it is seen that health care providers get caught up in medico-legal formalities and neglect care for the survivor. Treatment must be given priority. Sexual assault can have many consequences such as pregnancy, transmission of HIV or other STIs, injuries, mental health consequences such as Post Traumatic Stress Disorder (PTSD).
- Emergency contraception, STI prophylaxis, Tetanus Toxoid injection, HIV testing are basic aspects of treatment that should be provided.
- In an examination of sexual assault, documenting the history of the incident is of utmost importance, but this is often not stressed upon. The survivor may be scared or ashamed of revealing the acts that were performed, but sensitive probing by the doctor can help them speak about the episode. It is crucial to document all details of the episode and all types of assault that were perpetrated. This will also help the doctor to ascertain the kind of evidence to be collected.
- While documenting examination findings, often doctors comment on old tears of the hymen and laxity of the introitus (admits one/admits two fingers). These are irrelevant to a case of sexual assault and should not be documented.

- A lot of doubt is raised over the absence of injuries in cases of sexual assault. The doctors may actually say that there was no rape because of absence of injuries. But it must be remembered that most survivors of sexual assault do not show injuries.
- While collecting evidence, only evidence relevant to the assault must be collected. If there was no oral intercourse, collecting an oral swab is irrelevant. Also, if women report after 72 hours, have bathed and washed themselves, the
  samples need not be collected as the evidence would have been lost.
- Evidence must be dried and sealed. If this is not done, it may decompose and will be rendered useless. The dried and sealed samples should be dispatched to the police as soon as possible, but while it is in the hospital, it must be kept under lock and key so that it is not tampered with.
- A copy of the documentation done should be provided to the survivor as a matter of right.
- It is common practice for the police to ask the doctor to opine on whether rape occurred or not. A doctor cannot comment on this and must refuse to answer such questions.
- Emotional support to survivors of sexual assault is crucial as it can prevent the development of long term mental health consequences. Validating the woman's experience, addressing her feelings of self-blame, shame, involving the family so that they may support her, are all components of emotional support that nurses or doctors can provide.
- Above all, it is crucial that the experience of coming in contact with the health system does not re-traumatize the woman beyond what she has already been through.

3. Communalism

Module 3: Communalism

Session 3.1 Formation of identities

Duration: 3.5 hrs

Objectives:

- To develop an understanding of the concept of communalism
- To understand how identities are formed.
- To understand the linkages between certain aspects of identity being valued and lead to communalism.

Methodology:

Ask the group the following questions. Write responses to each question on a chart/board:

- What are the different aspects of identity?
- What are the aspects of identity that are acquired by birth?
- What are the aspects of identity that are acquired by birth but can be changed?
- What part/ aspect of your identity are you proud of?
- How do you classify people as 'we' and 'they'?
- Do you feel afraid and insecure of people categorised by you as 'they'?
- Do you have feelings of anger, repulsion and/or hatred for people categorised by you as 'they'?
- Do you feel that either you or somebody should teach a lesson to people categorised by you as 'they'? If yes, how?
- Of the people you categorise as 'they', whom do you consider as your enemy? How can any danger or harm from them be avoided?

The session begins with the above exercise. This exercise takes the participants through a process to understand formation of identity. The exercise is followed by a discussion in which myths are examined and the concept of communalism is explained.

Using the above questions, there is a guided discussion to understand the relationship between identity and violence. The process of progression from distinctness to identity, to pride, to misunderstanding, to bias, to chauvinism, to hatred and finally to violence is discussed.

Content:

- **Formation of Identity:**

Stage 1 - Recognising Identities:

Most of us characterise ourselves with certain aspects like name, surname, nationality, profession, tribe, region, religion, language, relationship (such as wife, son), could also be achievements, social status, caste, political ideology or sexual orientation. These essentially define any individual's personality. The participants are asked to list the characteristics that they use to describe themselves. The following emerge from the discussion:

- Some aspects are biological – they cannot be changed
- Some are acquired and hence can be changed.
- Some are individual, i.e., distinct to oneself
- Identities are multiple and not singular
- They are dynamic/changing and not static
- Some aspects can come in conflict with each other

Stage 2 - Pride and superiority associated with identity:

There are some things that an individual is proud of. This also demonstrates that some of these identities are far more important than the rest, for each of us. When participants are asked to identify those identities that are most important to them or the ones that they feel proud of, some responses could be being an Indian, male, woman, mother, Gujarati. This stage is called the second stage of identity - when pride is associated with identity. However, it also has elements of rigidity in it. At this stage, the identities tend to become monolithic, static and singular.

Stage 3 - Misunderstandings and biases:

When a sense of pride comes in to forming an identity, it becomes easier to create a divide between "them" and "us" and we tend to put "them" into another box. Each one of us has identities of "us" and "them". Participants are encouraged to draw out a long list. Some responses are: being a Hindu, vegetarian, married, doctor, feminists, educated, cultured, upper caste, class etc.

Stage 4 - Chauvinism, hatred:

The rigidity further sharpens, and there is scope for biases to creep in. This is also the time when people who are labeled "they", are termed as inferior, majority, bad, uneducated, not cultured, not worthy of trust. This then becomes the fourth stage identity formation.

Stage 5 –Violence:

The fifth stage is when people in the "they" category get termed as enemies, often due to some characteristic that they possess or some 'wrong' that they have done. Most often these are biases, but no efforts are made to find out more about the source of these biases. This comes from a sense of superiority that leads to feelings of irritation, hate, suspicion, dislike, insecurity, competition, and jealousy. We think that "those" people should be taught a lesson. This leads to thinking about what can be done to terminate them, trap them, alienate them completely, harm them, neglect them or convert them into people like "us".

Summarising the exercise:
Having taken a close look at how identities are formed; it shows us that feelings of communalism are rooted deeply in all of us. We need to be aware of this lest it take the form of violence.

The process of identity formation and hardening that plays out in an individual's mind and in society is the psychological basis of communalism. An attempt to understand this process will make us realise that it arrests the progress of individuals and societies. It eliminates peace, foments violence and war.

All of us have a variety of identities and this is not inherently a bad thing. But if we artificially start imposing uniformity over everyone with a certain identity, disregarding all of their other identities, it eventually leads to communalism. Instead of trying to impose uniformity, we have to learn to celebrate this plurality. We have to strictly avoid pride, misunderstanding, bias, chauvinism, hatred and violence.

- **Examining the myth that all people of the same religion have the same cultural characteristics**

  It is often believed that people who belong to a particular religion are the same and by extension have the same aspirations. This forms the basis of communalism. This, however, is a myth. Muslims in Kerala have more in common with Hindus in Kerala than, say Muslims in Uttar Pradesh. They speak the same language – Malayalam, wear similar clothes, and cook similar food. In Malabar Kerala, among the Navwayath Muslims, the "nikaah" is considered complete only when the bride and the groom walk around the fire.

- **Religious Identity vs. Religious Morality**

  Rituals, religious books and religious men are the three signifiers of religious identity. They are the 'external' expression of religion. At the 'internal core' of religion lies religious morality. All religions have different religious identities – Christians read the Bible, Muslims read the Quran, Hindus read the Gita. If you look at these external factors, what strikes you immediately is the difference. But when you look closer, you realise that there is more in common among these religions.

Consider three moral principles and try to identify the religions:

- *Vasudhaiva kutumb kand* –the entire universe is one, all persons on earth are part of our family. This is from Hindusim.
- A man, whose neighbour sleeps hungry, will never enter heaven. This is Islam.
- Love thy neighbour as much as you love your own. This is Christianity.

All three are saying the same thing – they are not at odds. So the moral values of all religions are the same. The basis of difference is religious identity and that is what communalism bases itself on.

- **What is communalism:**

  As discussed previously, communalism uses the difference in religious identity of people to divide them. This is usually done for political gains. When we think of communalism, the first thing that comes to our mind is 'communal riots'. But this is only the tip of the iceberg. Communalism actually runs very deep because we value our religious identities so much. It is the building of this identity between the riots that is actually the root cause and must be studied more than the riots themselves.

When communal riots take place, it is not Hindus or Muslims or Christians who die. This will vary with the place. In India, Muslims may die in riots, in Pakistan it may be the Hindus, in Bangladesh it might be the Christians – the commonality in all is that it is usually the poor who die and the rich who orchestrate riots. In general, we agree that the ones who are victims must be protected. But when riots happen, our hatred towards these groups is so great that we do not make efforts to protect them and the rich who cause the riots go scot-free. That is why we need to inspect the notions that we harbour about communities – how do these come about?

- **Social Reality vs. Social Common sense**:
  There are some beliefs that people hold which are not true. This is not just a simple case of misinformation, but that of deliberate mis-guiding common man to create division in society. Today we feel that Muslims are aggressive, fundamentalist, violent, revengeful, have many wives, have many children, have a communal unity among themselves, are under-developed and are terrorising the world. When we ask "Why are they violent?" the answer that comes from somewhere is "Because they are taught, and because they eat non-veg." What is factual is called social reality. But these myths that we harbour about other people – this is social common sense. There is a need to differentiate between the two and be aware of the information that we consume.

- **Certain myths related to religious minorities are addressed such as:**
  Destruction of temples by Muslim rulers: It is often said that Mahmud Ghazni looted Somnath temple and this is used by communal forces to justify breaking of mosques as revenge. The fact is that plunder of temples was done by kings irrespective of their religion. Temples were where the wealth of the kingdom was kept. For instance, the Marathas plundered temples in Tipu's sultanate. The Srirangapatnam temple was destroyed by the Marathas. Attacking temples was a way of humiliating the other kings.

In medieval times, Hindus and Muslims kept fighting with each other: The fact is that a large number of courtiers, Rajas and Zamindars were Hindu and the existing social structure was not disturbed. Communalism tries to project that all Hindu kings who fought against the Muslim empire were national heroes – Shivaji, Rana Pratap, and Guru Govind Singh. But many of them 'allied' with Mughal rulers. For instance, Rana Pratap's son Amar Singh allied with Jehangir. In the fight between Akbar and Rana Pratap at Haldi Ghat, it was Raja

Mann Singh (and the general with him was Shahzaada Salim) who went from Akbar's side to fight Rana Pratap (the general with him was Hazim Khan Sur). Some of the nine jewels of Akbar's court were Birbal, Tansen, Raja Todar Mal. Rahim and Ras Khan have written some of the well known "dohas" of Lord Krishna. All these go to show that history is often twisted to support divisive forces.

Islam spread at the point of a sword: The fact is that conversion was not the aim of the kings who conquered. Once they had conquered, there was no need for them to convert their subjects. The formation of the Muslim community took place in India in various stages. First, it emerged along the Malabar Coast where traders came from Arabia. Many people took to Islam after interacting with them. Then the Turkish invasion brought a larger influence of Islam. But the main conversions came from the poor low-caste untouchables who despite being formally part of the Hindu fold, faced severe oppression and repression from upper castes. If Islam were to spread through Muslims, it would have been the highest in Delhi; but it is only 13% there, 25% in Kerala and 80% in Kashmir. Swami Vivekanand said that it is wrong to assume that Muslims converted people at sword point- rather they embraced Islam to save themselves from the exploits of the landlords.

Missionaries are converting everyone rapidly to Christianity by coercing poor people in the villages: If Christians were involved in converting people then they would be the ones with the maximum population. As per the national census statistics, in 1971 their population was 2.60%; in 1981 it was 2.44%; in 1991 2.34% and in 2001 2.30%.

Muslims marry many women: Men marry multiple women because it is considered a show of power. This is true of men from different religions. Some Hindu men "keep" more than one wife but do not marry them legally the way Muslim men do.

Muslims are violent and they are terrorists: The psychology is that fear and insecurity leads to increased aggression. People respond to a situation in an aggressive manner when they feel that their security is at stake. In Mumbra – a suburb of Mumbai city, the Muslim population about a decade ago was 80,000. In 2001, following the riots, the population increased to 7 lakhs with Muslims migrating for security reasons. These are all tactics that communities use to protect themselves. In this day and age, there is a political reason why Muslim violence is

constructed as 'terror' and other violence is not. But the fact is that all fundamental religious forces do indulge in violence. Gandhi was assassinated by Nathuram Godse, a Hindu; Indira Gandhi by Sikhs; Rajiv Gandhi by LTTE members. Terrorism takes place irrespective of religion. In recent times in India, there has been a spate of blasts orchestrated by the RSS. But we do not call it 'Hindu terror'.

Session 3.2 Manifestations of communalism and Role of HCPs in responding to/countering them

Duration: 3 hours

Objectives:

- To understand the different forms of communalism and discuss each of them through case studies.
- Understand the role of health care providers in countering communalism

Methodology:

Group discussion using case studies of real incidents covering a range of issues such as inter-caste marriage, caste violence, and communal riots. The main emphasis is on the inter-linkages between gender-caste-class-religion.

Content:

The biases against various communities/groups will emerge; therefore the facilitator should have data related to discrimination and violence based on caste and religion.

Case Studies:

The participants are divided into groups. Each group has a case study. They have to respond to the following questions:

- Which stage of the formation of identity does one see here?
- What are the types of violence & its health impact?

Case study 1

Short, stocky and balding, Babubhai Rajabhai Patel can pass off as a normal, middle-class trader. Only, he is not one. Babu Bajrangi, as Patel likes to be called, says he runs an NGO, Navchetan Sangathan. Sitting in his 'office' in Ajanta Ellora Complex in Naroda in Ahemdabad, Bajrangi is surrounded by images of RSS ideologues - K.S. Hedgewar and Guru Golwalkar, a map of Akhand Bharat and his own photographs with politicians or in public meetings. Bajrangi claims to be a social worker. "I rescue Hindu women who are lured by Muslims. I hate such marriages." As soon as Bajrangi gets to

know of any such union, he kidnaps and sends the girl back home and beats up the Muslim boy. "It's fun. Only last week, we made one such man eat his own shit thrice." he says. Bajrangi's operation is ruthless and effective. He claims to have 'saved' 725 Hindu women this way. And what about the law? "What I do is illegal, but it is moral. And anyway, the government is ours." Perhaps that is the reason that Bajrangi, chief accused in the Naroda Patiya murder case (during the Gujarat carnage), is out on the streets and not behind bars. "People say I killed 123 people." says Bajrangi with a grin. Did you? "How does it matter? They were Muslims - bloody Pakistanis. They had to die. They are dead."

"The government is ours." Few will doubt Bajrangi's claim. Not Muslims for sure, for they know Bajrangi might be more extremist than most, but he represents a mindset that is widespread: the mindset of the Gandhinagar government's ministers. The mindset of several Hindus across Gujarat, from the waiter to the auto-driver and the middle-class is severely affected.

Points for discussion:

The labeling of all Muslims as 'bloody Pakistanis' and extreme hatred towards that group comes from making a divide between 'us' (the Hindus) and 'them' (the Muslims/Pakistanis). Bajrangi couches this hatred however, in what he calls 'social work'. The impact of such communalism on women is depicted. The marriage of a Muslim man with a Hindu woman is seen as an affront to the Hindu male's manhood. Women, who are believed to carry the honour of the community, hence, do not have the choice to choose their partners. However, Babu Bajrangi depicts this as 'rescuing' of Hindu women and considers himself a social worker.The State is complicit in the violence as it does nothing to stop it. In fact, Babu Bajrangi openly claims that what he is doing is illegal but is confident that no action will be taken against him because the government itself believes that what he is doing is right.Though not all are overtly Bajrangis, this sense of hatred towards Muslims exists at a subconscious level in most individuals. That is why, even though one may not be actively involved in violence, one does not do anything to stop such violence.

Case Study 2:

Hating Muslims Is A Natural Thing In Gujarat - Ganesh Devy

Some years ago, Habib Tanvir wanted to come, stay and work in Vadodara. He did not find a house for six months. Eventually, he went back. Some of us tried to find him a place to stay, but nobody was willing. My own landlord at the time, a perfectly decent man otherwise, refused. I have a young Muslim associate who has been pursuing post-graduate studies. After the 2002 violence, I suddenly noticed that he was having a problem trying to form his sentences while speaking. He used to write clearly but I saw that his writing too was breaking up. In fact, he was not able to write. This was a typical case of aphasia, which is a condition of loss of speech and articulation caused by external trauma. Gujarat is probably the only state that has a sizeable Muslim population but no Urdu paper. I wonder if there is something to it, a state of collective aphasia. I often wonder how it must feel to be a Muslim in Gujarat. I shudder to think what it must require to live at the wrong end of so much hatred, contempt and threat. Do they have a strategy of reaction? Is something in the process of evolving? I do not know. Sahitya Akademi Award winner, Devy is founder-director of the Tribal Academy in Tejgarh, Gujarat.

Points for discussion:

This case study demonstrates the infiltration of communal attitudes into the police forces as well as the government. Collusion of the government and the police ensures that during times of riots, it is the Muslims who lose life and property and that they are the only ones who get arrested. When the law turns a blind eye to those like the Sangh Parivar, it is able to function with utmost impunity which furthers the communal divide.

Case study 3:

One Day In The Life Of a Sullen Town

In pursuing a news report on an incident of 'moral policing' in Muzaffarnagar, Shyama Haldar comes upon a place blistered by its own nature. Omkar Singh, co-ordinator of the Muzaffarnagar branch of the Sanyukt Hindu Sangharsh Samiti (SHSS), is insistent that the truth of the May 27 Incident at Nandi Sweets be established with public finality.

"We aren't terrorists, you know; we aren't thugs," he says. "That's right, we're all

cultured people, educated, got our own businesses," avers SHSS local president, Sanjay Agarwal, between sips of midday tea at Singh's garment store in the town's Sadar Bazar. "You want proof?" asks Agarwal. "In the last six months alone, we have rescued 80 Hindu girls who had gone with Muslim boys. Of these, 60 girls were graduates - some of them M.Com., some B.Com., some B.A., some M.Sc. And the boys - 60 boys - labourers, whitewashers, scrap dealers, fruit sellers, and house painters - can you believe this? A girl of good family, studying for her graduation: would she go with a labourer, a house painter? This is the new jehad. This is what we are trying to make our community aware of. That's what the sanghathan is for - to make Hindus strong, to make them alert."

Points for discussion:

The intersection of gender and communal identity is depicted. The impact of wanting to preserve one's community has a direct bearing on women's freedom, forcing them to fall in line with the communal ideology. Agarwal refers to the alliances between Hindu girls and Muslim boys as the 'new jehad', as if to say that the Muslims are waging war against Hindus by influencing their girls. The reaction of Hindus to this, hence, is also a religious one according to him.

Case study 4:

If some had hoped that the national and international condemnation would make Gujarat's communal rabble-rousers (with Modi as their cheerleader) pull back from their extremist agenda, this has not happened. In fact, the polarisation has intensified across the state in the last four-and-half years. If it was difficult before the riots for a Muslim to find a house to rent in Hindu areas, it is now impossible. Sophia Khan would know. A leading women's activist in Ahmedabad, she has had to undergo significant changes in her personal and professional life since 2002. To begin with, the polarised atmosphere in the city led Khan to shift her residence to Juhapura, the city's large Muslim area, although her office remained in the upmarket Hindu locality of Narayanpura. Sophia's identity had remained a secret in Narayanpura because the office had been rented in the name of a Hindu trustee of the NGO she runs. A month ago, when neighbours in her office complex came to know of Khan's faith, she was asked immediately to pack up and depart. She tried to put up a fight, but gave up in the face of constant harassment. "Imagine, they were not even willing to let me use the lift," she says. Khan moved

her office to a flat in Juhapura, but with that, came a new complication. A Hindu employee who was working with Khan was pressured by her family to resign, for they did not approve of her going to a Muslim area. She is grim as she intones: "My house is in a Muslim area. My office is here now. My only Hindu employee is resigning, and my work revolves around Muslims. This is exactly how they want to push an entire community into a corner."

Most cities and towns in Gujarat are completely divided into Hindu and Muslim areas; a street corner, a divider in the middle of the road, a wall, or just a turn acting as border. If it was difficult for a Muslim to find a house in Hindu areas before the killings, it is impossible now. The segregation has spread to other realms as well, leading to absence of contact and interaction between the two communities and breeding stereotypes and intolerance. The most visible realm is the fewer number of mixed schools in Ahmedabad which have a fair number of Hindus and Muslims. Discrimination on religious lines, coupled with the desire of parents to send children to schools where there are 'more of our people' has further boosted this trend. Pankaj Chandra, professor at Indian Institute of Management, is worried. Brought up in the composite Ganga-Jamuni culture of Allahabad in Uttar Pradesh, he says, "My children may graduate from school without knowing a single Muslim. Imagine how easy it will be to build stereotypes then."

Points for discussion:

The build-up of communalism during times of peace is again depicted in this case study. Isolation of Muslims from Hindus by pushing them into ghettoes and even dividing schools along these lines is all part of the process of distancing 'them' from 'us'. This creates fertile ground for breeding stereotypes and deepening the division between communities. Women belonging to the minority community often face harassment in different forms; there is restriction on where they can go when they live in such isolated conditions. The hatred and alienation occurs often at times of peace but then people do not view it as unethical. Not discrediting such a process also means that we are essentially contributing to it.

Case Study 5:

The appeal issued by the Karnataka Komu Souharda Vedike (Karnataka Forum for Communal Harmony), a coalition of 200 organisations working to stem the tide of

communalism in Karnataka also clearly states: "Ananth Kumar, the BJP MP from Karnataka, had declared in 2002 that the Bababudangiri was the Ayodhya of the South. Against the backdrop of the Gujarat riots in 2002, the implicit reference was to transform Karnataka into Gujarat. That today has received a boost in Bangalore and Dakshin Kannada district and is beginning to turn into a horrendous reality. Clear targeting of the Muslim community through physical attacks, looting of their shops, stoning mosques, restaurants and businesses owned by Muslims was in evidence throughout. Though curfew was imposed, the police refused to intervene in several instances, and when they did, Muslims were specifically arrested. The home minister of the state, M.P. Prakash, brushed aside the incidents by saying that communal voices exist within the police forces as well and there was little that the government could do about it. What adds to the alarm is that the recent spate of violence follows years of communal tension created by the Sangh Parivar in the entire coastal belt. Under the excuse of upholding the ban on cow slaughter, the Sangh Parivar have repeatedly taken the law into their hands over the years. They have attacked Muslims, stripped them, paraded them naked, beaten them up, harassed women and looted their shops - all in the name of religion. Despite this history of communal tension that existed in the district, the police and the state government have not taken any serious action. Though cases have been filed in police stations, hardly have any resulted in the convictions of the accused persons, further endorsing the communal nature of the police. "The appeal has been quoted in such detail to underline what has become the pattern and the norm. The Sangh Parivar has been with impunity, imposing this pattern and norm, which has today contributed to the creation of a well organised network and structure for the production of communal violence that can start its work and put a pause to it as and when it likes.

Points for discussion:

This case study demonstrates the infiltration of communal attitudes into the police forces as well as the government. Collusion of the government and the police ensures that during times of riots, it is the Muslims who lose life and property and that they are the only ones who get arrested. When the law turns a blind eye to those like the Sangh Parivar, it is able to function with utmost impunity which furthers the communal divide.

Cast Study 6:

Protest against burning the works of Dr. B.R. Ambedkar at AIIMS on 29th September 2006

To protest against the burning of Dr. Bhim Rao Ambedkar's literature by doctors of the AIIMS, 15 Dalit organisations plan to hold a demonstration outside the main gate of AIIMS (opposite the Safdarjang Hospital gate) at 12 noon on Friday September 29, 2006. The act of burning, demonstrates the fact that even educated doctors can be so insolent towards the constitutional ideals of social inclusion, social cohesion and protection of human rights through affirmative action. Please consider joining the protest and support the cause of inclusion - Rajni Tilak

Points for discussion:

This case study invariably touches a nerve of 'merit' among health professionals, particularly doctors. The first reaction is usually that Dalits have already benefited from reservations and should not be allowed access to them any further. Reservations are often construed to be unfair to upper-castes or the 'open category' students. This myth is addressed by pointing out that even today, lower castes are employed in class IV category employment and the heads and senior ranks are largely upper-castes. Further, those few who may have progressed economically are also often reminded about their Dalit status by the rest. Hence it is not so easy to get rid of the caste system.

It points out that health professionals are largely unable to comprehend the purpose of affirmative action although ironically, they are perceived to be the most educated. Much noise has been made of caste-based reservations but nobody raises any protests against the large number of private medical colleges that admit students based on the paying capacity of the students rather than on merit. No one questions this kind of class-based reservation.

Case Study 7:

Dr. Arjun Appadurai, anthropologist in his book, Fear of Small Numbers

The idea of majority and minority are intimately connected. The two arise together. And in the book, I observe that the idea of majority and minority in India emerges out of a procedural consideration having to do with minority opinions in key administrative

committees under British rule. The idea of minority opinion did not arise in the first place out of national enumeration of population, but from this other administrative and procedural root. But soon after this administrative concept came into play, the idea of minority and majority began to apply to core social groups and began to be institutionalised in the census. Sure, there is a rise in the anti-Muslim sentiments across India. What has been especially worrisome is that this anger has been adopted by the middle class, the educated and the professionals across India. The very classes and groups who would have been ashamed to express strong radical religious sentiments in the 1950s and 1960s are proudly pro-Hindu today. We must not just ask what Hindutva is about, you must also ask the question how it has changed in the last few decades. In the 1950s and 1960s, many middle class, educated professionals talked as if India's secularism belonged to everyone, and was not a favour handed out by Hindus to other groups. In the 30 to 40 years since the high period of Nehru's secularism, the other trend in Indian politics, the pro-Hindu strand, has become prominent. For me as an anthropologist, it is painfully obvious that it has become culturally respectable to run down and suspect the Muslim community. You can now publicly question the political loyalty of the minorities, you can publicly question Muslims at all times, Christians at various times and Sikhs intensely in the 1980s, as you recall. Fortunately, the tide of anti-Sikh sentiments has turned, and their loyalty is not questioned now.

Point for discussion:

Participants may feel that it is the Hindus who are in minority if the world scenario is concerned. Hence there is also a feeling of security in numbers. It is important to point out that emphasis on religious identities makes one fall into such a trap. It is important to understand that essentially our identities are multiple and dynamic. Any process which does otherwise has to be viewed with skepticism and best rejected outright. Globalisation has also had its effect where the markets have so much to offer but the capacities of each to buy may differ, hence insecurity is increasing and people are moving towards religion or community which creates false sense of security.

Case Study 8:

Sitting next to Prema, was a woman who looked a little worried. Prema asked, "Where are you going?" She answered, "I am getting off at Lonavala."Do you stay at Lonavala?" Prema probed. The woman continued, "No. I have kept my elder daughter in the boarding school. Now she is finishing school this year. The Father has called me to discuss. They are telling me, if my daughter wears the cross, she will be helped to further continue her education. They have asked me to make that decision and have called me. I have no problem. It is so important that they are looking after her so well. I am supporting my family alone. My husband has long deserted me. My employers with whom I work suggested this school."Prema was sharing this episode with her friends when they were discussing the issue of right to conversion.

Points for discussion:

This case study brings out the common misconception held about Christians – that the missionaries use education and other amenities in order to convert people to Christianity. The myth can be questioned by pointing out that if Christians were so preoccupied with conversion, how the population could remain only 2.3% over the years. Moreover, people also send their children to these schools because they offer various facilities and they have every right to take advantage of these.

Case Study 9:

"Why are they burning-looting the shops and why are the riots happening?"

A standard VIII child asked this question to his parents. The schools were closed for weeks on end and the child was getting restless. His father, a manager in an MNC, answered: Look, they do not want to follow the laws of this country. They want separate laws for their community. This cannot go on. Therefore, people are angry and they are expressing their anger. After the Shah Bano case they are trying to change the laws of this country. One does not know whether the child was satisfied. His mother, a lawyer, was looking on. This conversation took place in the aftermath of the Babri Masjid demolition on 6th December 1992.

Points for discussion:

The case study shows how the seeds of communalism are being sown in such a young child. The child's mother may have a different opinion but she is not able to express it.The Shah Bano case is often used to point out how the Muslims in India are not willing to abide by the laws of the country – that they want their own laws (personal laws). In the Shah Bano case, a woman who had been deserted was asking for maintenance which was to be granted to her under the secular Indian Code. However, a religious fundamentalist group within the Muslim community felt 'threatened' and agitated that it was in violation of the Muslim Personal Law. In the name of secularism, the then Congress Government gave in to their demands by passing the Muslim Women Act which denied her the right to maintenance. This was looked upon as an effort to appease the Muslim Community and garner their votes. The opposition used the case as a way to demonstrate how Muslims in India wanted different rules/laws and this is what got ingrained in people's psyche. In the given case study, the demolition of the Babri Masjid is actually justified by the father on these grounds.Further, it should also be pointed out how the fundamentalist forces within the Muslim community were able to take away a woman's right to maintenance with the passage of legislation. This clearly demonstrates the impact that communal ideology can have on women's rights.

Case Study 10:

On 4th September 1987, the murder 'Sati' of Roopkuwar happened in Deorala, Rajasthan. Here is a reaction of (Late) Rajmata Vijayaraje Scindia (Former vice present, BJP member, national executive). In quotes:

"Real sati is very rare. Jo sati ho chuki hain, unke khilaf ek shabd bhi na bolo. (Do not say anything against those who have become "sati"). I cannot hear it. I feel that it is something found in Indian women. Chahe woh achha, bhala, galat, salat, jo bhi hai. Woh unki bhavna hai. (It is their sentiments and I do not care if it is a good, correct or wrong practice). Social workers parliament mein aur bahar bhi, jab kuchh milta nahin, to koi vishay utha leti hain. (Social workers have nothing to do so they just pick up some issue inside the Parliament or even outside). 700-800 saal se puja ho rahi hai Sati rani ki, aur ye kahte hain ki puja chhod do. Are bhai, kahin nari ki puja ho rahi hai, to hone do. Usne dikha diya ki woh kahan pahunch sakti hai aur usme kitni intensity hai." (Sati rani is being worshipped for more than 700-800 years and these people want it to be stopped. If a woman is being worshipped by someone, let it continue.

Women have proven their mettle in all ways today).

Points for discussion:

This case study again demonstrates the intersection of gender with communal identity. Brutal and ruthless practices like Sati which have been outlawed for decades because they are a violation of women's rights still continue. However, these practices are upheld by communal forces as a mark of honour and women's 'power'. Any encroachment on them is considered an assault on religion and culture. The custom is kept alive by deifying women who immolate themselves and erecting temples in their name. Our politicians instead of deriding this, actually end up encouraging it under the guise of "protecting culture".

Case Study 11:

They met during the anti-caste campaign of the 1970s. Their association turned into friendship and culminated into marriage. Disapproval of parents, especially his, did not bother them. Their common friends were very supportive. Once married, she had to face his family, as they stayed with his parents. She was asked to use a separate plate by his mother as it challenged her ideas of purity and untouchability. This was something she did not expect. She was revolted. She was deeply hurt. Her husband did not protest this openly. He was baffled and remained silent. He tried to explain to her how the notions of purity have gone deep down to her bone marrow. She was not convinced. She thought that he was unable to understand her hurt because he belonged to the upper caste. Eventually they set up separate home. But this hurt and sense of injustice continue to haunt their relationship. Down the line she lapses into episodes of depression.

Points for discussion:

In the given case study, the couple has opted for an inter-caste marriage. Both the husband and wife have been part of the inter-caste marriage and clearly the step to enter into such a marriage is a progressive one. However, there are still several hurdles – like the mother-in-law's casteist treatment of the daughter-in-law. This was a struggle for the woman. In this case, although the husband was able to see and understand the violence, he was not willing to protest against his mother and instead explained away the behaviour of his mother as something that was deeply ingrained and could be changed. She felt that he was not able to empathise with her and this reflected in their relationship. The case-study demonstrates how women bear the brunt of

the inter-caste marriage as well.

The manifestations of communalism have an impact on health. As health care providers, it is important to understand these dynamics so as to approach care and treatment accordingly. For instance, in the case study involving inter-caste marriage, the situation has led the woman to a state of depression. This will, no doubt, have an impact on her physical health as well. Communal riots and violence creates an atmosphere of fear and suspicion. This affects access to healthcare. The healthcare provider can at such times, approach care and treatment sensitively, with an understanding of the manifestations of communalism, maintaining objectivity and ensuring thorough documentation.

4. Counselling

Module 4: Counselling

Session 4.1 Counselling-principles and skills

Duration: 1.5 hrs

Objectives:

- To develop an understanding of the concept of counselling
- To impart skills required to communicate with women patients who report violence

Methodology:

Participants are asked to recall an experience where they spoke to someone about a problem that they were facing. They are told that they do not have to share the actual incident with the group but only reflect upon the experience. They are given 5 minutes for this task. The facilitator later asks the participants to state the qualities that they looked for in their confidante, what the person said and how they felt after talking to him/her.

Lecture using Power Point Presentation: Present the principles of feminist counselling, process of counselling including the different stages.

Demonstration: An ideal counselling session is demonstrated and there is a guided discussion on the qualities of counsellor and opertionalisation of principles of counselling.

Content:

The session starts with an exercise in which each individual reflects on what the qualities of a good counsellor should be and what principles govern counselling. A historical context to the feminist movement is provided followed by discussion on the application of the principles from the movement in counselling. The process of counselling, discussing each of the stages is done through a power-point presentation. This is followed by demonstration of an ideal counselling session in which the participants are asked to observe different stages and how the principles were translated into practice.

- Qualities of a counsellor:

The individual exercise helps participants to list out the qualities that they look for in people who they entrust with their problems. Some of the things that participants mention are: patience, non-judgmental, being discrete, reassurance, turning negative to positive, and keeping the person with the problem at the centre. These qualities are then connected to the principles of counselling.

- Principles of Counselling:

The over-arching principles of counselling are presented - uniqueness, acceptance, confidentiality, self determination/autonomy, being non- judgmental. Specific principles as drawn from the women's movement are discussed in detail, with examples relating to domestic violence:

Uniqueness: Every individual is unique. The woman's problems cannot be approached with the attitude that it is common and happens to everyone. Understand the uniqueness of every woman's story.

Confidentiality: The information shared by the woman should not be discussed. If discussion is necessary, her permission should be sought before doing so.

Self-determination or autonomy: The process should be geared towards giving the woman decision-making power. She should make her own decisions. Her decision must be respected even though the counsellor may hold a different view.

Non-judgmental attitude: The counsellor must not judge the woman or her decisions, because each woman comes from a different position and value system. For instance, if a woman says that she does not want divorce but wants maintenance, the counsellor must try to understand her background and not criticise her decision. Similarly, if an unwed mother approaches the HCP for abortion, the HCP must not take a moralistic stand on the matter.

- Historical framework:

The concept of 'feminist counselling' is introduced by placing it in a historical framework, describing the circumstances in which it emerged. Feminist counselling in the Indian context draws from the 'speak out' groups during the 1980s, where women openly discussed their problems. The message that violence suffered by a woman is not her fault was sent out by

the women's movement. The movement challenged traditional psychology which views violence and its consequences on women's mental health as something that is intra-psychic. Violence is not a result of different personalities. The cause of violence lies external to the woman suffering from it It stressed that there was a common reason behind violence against women – the power differentials between men and women which put women in a subordinate position. This system was perpetuated through patriarchy. Violence was used as a weapon to keep women in their place, so that they did not challenge the status quo.

The principles as drawn from the women's movement are:

Personal is political.
One has to realize that the problem of domestic violence cannot be looked at or addressed in isolation. The roots of the problem – gender and patriarchy – are seen not only in the family where violence occurs, but in other social structures as well. Therefore, any effort to eliminate domestic violence must understand linkages in the personal and socio-political spheres. The women's movement stressed that counselling cannot be dealt with in isolation, without explaining this link. This also helps women to understand that this is not happening to her alone, but to many other women as well.

Relationships are egalitarian.
Feminist counselling aims to reduce the hierarchy between the counsellor and the counsellee. Never look upon a woman as someone who is weak and powerless. The counsellor should understand that there are inter-linkages between the life of the woman and the counsellor's own, since both of them are part of the same patriarchal society.

Women's perspectives are valued.
Respect the woman as an individual. Know that she has a certain value system she subscribes to, that you may or may not agree with. Nevertheless, she has the autonomy to adhere to her own beliefs.

Every woman's experience will be unique and must be valued as such.
It is important to understand where the woman stands on the power ladder in her family. Every woman's situation will be different and it is not possible to apply tailor-made solutions to problems. Uniqueness must be valued.

• Feminist counselling rests on these principles:

Firstly, every woman who comes out for any external formal redress is a whistleblower for patriarchy.

Secondly, we recognise that domestic violence cannot be dealt with in isolation and therefore, an understanding of the complexities of caste, class and community is essential while counselling.

Thirdly, the problem of domestic violence cannot be ignored to initiate any social change on behalf of the toiling, dispossessed, exploited and disadvantaged in society.

Lastly, efforts at preventing domestic violence are necessarily linked to the broader struggle of freeing society of all types of violence, i.e. class, caste and community.

- Stages of Counselling:

This is followed by understanding how the principles are operationalised in the process of counselling in domestic violence. The trainer goes on to discuss the four stages of counselling – emotional, analytical, practical and social. These four stages do not always follow the above sequence; they are often rearranged and overlapping.

1. Emotional:

The first stage of counselling involves building trust with the woman. Non-verbal communication through careful listening, eye contact and body language can give the woman tremendous emotional support. Her emotional state is gauged by trying to locate her position in the cycle of violence. Observing her body language will also help the counsellor to read her condition.

2. Analytical: The second stage requires the counsellor to understand her situation and help her reflect on what is happening in her life.

Empathy not sympathy:

Showing sympathy towards the woman is patronising and depicts a hierarchy between the counsellor and counselee. The counsellor must keep in mind that the woman who approaches her has probably been facing violence for a while and has coped with it. She is seeking formal support at this point because she has temporarily lost touch with her coping mechanisms and has chosen to fight against the injustice. Every woman who goes out and seeks help openly

is a whistleblower for patriarchy and must be valued as such. Never look upon her as a weak, unfortunate victim.

Create trust not dependence:
Providing the woman with empathy instead of sympathy will help the woman realise that she is still in control of her life (as opposed to thinking that the counsellor has taken over). This ensures that she does not become dependent.

Make a judgment but do not be judgmental:
There was a time in the women's movement when it was believed that the woman must be identified with at all costs, so much so, that the counsellor completely puts herself into the mindset of the counselee. Over the years, it has been realised that assessing the woman's location in the power ladder (within the family as well as society) is essential to gauge her mindset. However, there is a thin line between judging a woman and being judgmental, which the counsellor must be aware of.

Violence is counterproductive:
A lot of women approach the counselling centre with the expectation that the counsellors will threaten the abuser and "teach him a lesson". In such a situation, try to take her out of the retributive mindset and encourage her to channel her energy in a positive direction. Violence as a method of retribution should be discouraged. Legal redress, however, should not be looked at as a negative method of retribution. Pursuing the course of law is not violence, but a method of seeking redress for the woman. According to Gandhian philosophy, the only real way to bring about reform is through changing mindsets. However, until that happens, we have to make use of law to protect women's rights.

Working on common biases:
Although the counsellor is required to be non-judgmental, she adheres to a certain world-view which may be different from the woman's. She needs to be cautious so that she does not use her position of power and say something that reflects her inherent biases. Just like the counsellor, the woman also comes in with certain biases which may sometimes be manifested in her political affiliations. Very often, she will want to use this contact to get back at the abuser. She must be told about the means that such organisations use, to achieve their goals and must be allowed to judge whether these are acceptable or not. Since women are part of society, they too

will carry some biases which must be dealt with. This can be accomplished by putting forth an alternate view point and allowing her to introspect.

Analyze but do not advise:

The counsellor's job is to make the woman aware of her rights and help analyze her situation. She can put forth the various alternatives that the woman has, to improve her condition, but leave the choice of action to the woman. The survivor knows best what consequences she can or cannot cope with and will choose a course of action accordingly.

Deal with negative emotions:

Make sure that the woman does not fall prey to feelings of self-doubt, self-pity, self-blame or self-harm. These negative emotions take a toll on her energy which can otherwise be utilized more constructively.

Emphasize positive coping mechanism:

Remind the woman that so far, she has managed to cope with her troubles single-handedly, without anyone's help. Value her for it and emphasize her strengths.

At this stage, the counsellor should also convey to the woman that no situation is hopeless while at the same time stating limitations explicitly. Arrange all the information provided by the woman to make it a coherent story.

Always ask open-ended questions during counselling and avoid asking "why" as a rule. Reframe the question to avoid the "why". Asking 'why' erroneously puts the onus of action/inaction on the counselee.

3. Practical

Suggesting the various courses of action available to the woman in a given situation is an important role of the counsellor. Based on the analysis, a plan of action must be drawn in a realistic manner. As per her needs, the counsellor could provide information to file a written complaint and make her aware about laws and legal procedures. A counsellor must understand basic police, legal and medical procedures and hospital procedures too, when working in the hospital. The client could also be referred to other institutions and support groups to broaden her support system. Sometimes, expert advice may be required from a lawyer on legal

matters or psychologist/psychiatrist for mental health assessment. A database of referrals should be maintained. Dialogue with the abuser could also be established through joint meetings.

4. Social

The woman's problems at a personal level are connected to social systems that everyone is a part of. Explain this to her. Help her connect her life to the social reality at large. Encourage her to join groups or organisations that work on women's issues so that she can meet other women like herself. Also, understand that elimination of violence requires ridding society of all forms of oppression; all social problems are linked and need to be worked on. Most importantly, keep the principles of the women's movement in mind:

Never justify other forms of oppression based on various discriminations.
While being woman-centered see to it that human rights of others are protected.
Always uphold the democratic process.

A demonstration of an ideal role play is carried out following these principles and participants are invited to discuss their observations.

Health care providers can contribute to the process of ending violence by being sensitive to social problems. The participants are urged to link their personal life to what is happening in society at large; only then it will be possible for them to empathise. They are asked to steer clear of being judgmental towards women from a different caste, class or community and not fall prey to the common biases that society harbours. As care-givers, they are required to try and understand a woman's situation and empathise as best as they can.

The trainer concludes the discussion by reiterating that bringing about change requires us to implement these principles in our own lives and talking about it with colleagues can make a difference. Remember that there is no limit to the amount of effort that we can make, to eliminate violence as a whole.

Session 4.2 Practising counselling skills

Duration: 1.5 hours

Methodology:

Role plays: Case studies that include narrations of women experiencing domestic violence are given to the participants. They are asked to do a role play of each situation, performing the roles of health care provider, victim and counsellor. After the role play, the victim, counsellor and health care provider (in that order) are asked to share with the group their feelings in playing the role expected of them. The other participants provide feedback. They are asked to reflect on how the case was handled, whether the important messages were conveyed and whether the principles were adhered to. Each role play is enacted for 10 minutes followed by a discussion of 20 minutes.

Content:

Each group is asked to demonstrate counselling for 10 minutes. On completion, each group member is asked to share his/her feelings. Start with the person, who played the role of victim/ survivor, then the counsellor, and so on. Ask the others to provide feedback. Each role play should be debriefed in terms of conduct/qualities of counsellor, messages given, impact of the counselling and suggestions for improvement.

Group A:

Seema is 24 years old woman married for a year. She has studied till the X standard and works in a private company earning Rs.2000/- a month. Her husband owns an auto. Seema is 2 months pregnant. She has consumed phenyl and has come to Dilaasa before her discharge from the hospital. Her natal family admitted her. Her parents are very supportive. She expects emotional support.

Narration:

My husband constantly pressurizes me to have sex. He does not understand me emotionally. I could not bear the situation and in a fit, I consumed phenyl. My husband informed my parents and they brought me to the hospital. I was feeling very weak since a month or so. My husband had spent the money kept aside for my sonography. My mother arranged for the same. The results showed that I was pregnant. On the

same night my husband wanted sex. I was too tired. It was 4 in the morning. He created a row. My father-in-law joined him and began calling me names in public. The neighbours gathered. I could not bear it. I did this in desperation. I think I do not want to go back to my husband. Our views do not match. My husband and his family keep insulting me. Even my having a permanent job was an issue. He did not tell me how much he earns. He is not suitable for me. Even his own relatives ridicule him. I do not like it. I think he is borderline intelligent. I have tried my level best. He has been hitting me on any pretext. Once he demanded sex when there were other relatives in the same room. When I protested, he hit me so hard that I almost fainted. My mother took me to a doctor the next day. Neither my husband nor his relatives were bothered. I am very sure we are not suitable for each other. His people are pressurizing us so that I resume staying with him. I do not want to go back. I am feeling very weak and sad. I will take a month's leave from work and stay with my parents. Just tell me what I should do later.

Points for facilitation

- Establish rapport so that Seema knows that she can discuss about her life without fear of being judged. Explain to her that all the information will be kept confidential
- Acknowledge the challenges she is facing with her husband that led her to attempt suicide
- Appreciate her efforts such as maintaining her job, ensuring her independence
- Acknowledge the intensity of violence and discuss that violence is not her fault .Explain the health consequences of consuming phenyl and discuss strategies to deal with suicide ideation such as contacting counsellors, going for a walk, calling up friends etc so that she is able to overcome those thoughts
- Discuss with her principles of relationship and that she should not feel compelled to continue a relationship if she does not feel like it
- Encourage her to reflect on next steps if she decides to leave the relationship. Help her think through these steps and maintain a follow up

Group B:

Bindiya is 18 years old and belongs to a tribal community in Kutch. She has come with her mother. They do not understand Hindi. They know only a few words and the rest is to be communicated in sign language. She has severe pain in the stomach. The PHC has told them that she is pregnant. The community has ostracized her. In their community,

young married women visit their husband's family off and on, but she has not visited him for the past 4 months. Therefore, her pregnancy is objected to and punished. She has come to the city to find out what is wrong with her. She knows that she has not slept with anybody. On examination, you find out that she has a huge tumor in her stomach. When you tell her the findings, she is relieved The tumor needs to be removed through an emergency operation. She is pleading with you to call the male members from the village and tell them that she is not pregnant.

Points for Facilitation:

- Prioritse the health of Bindiya by explaining the tumor and the importance of surgery .
- Discuss the wrong diagnosis by the PHC and clarify the reasons for severe stomach ache
- Discuss the implications of mistrust by the husband , his family and community on Bindiya with her and its impact on her psychological health
- Discuss principles of equal and healthy relationship so that Bindiya knows that she is not wrong and take away blame from her
- Contact the Panchayat through a formal letter from the hospital specifying health condition of Bindiya

Group C:

Bhama is a 40 year old woman who earns Rs.1500/- per month as a domestic help. She was married very young and has been married for past 25 years. She has two sons. Her first son contracted Tuberculosis and died soon after marriage, leaving an infant behind. His wife who also contracted Tuberculosis left and Bhama is looking after the grandson who is now 3 years old. Her second son is schooling, but does beadwork and earns Rs.600/- per month. Bhama's husband has treated her very badly. He is a casual worker who gets work occasionally and does not provide financial support. He used to beat her and lock her to prevent her from going out to work. She had three miscarriages, two due to beatings and one due to weakness. She also suffered from TB but was cured with treatment. When her elder son was ill, she could not provide for adequate treatment for him. Her grandchild also suffers from TB and fits. She has come to the Casualty department to receive treatment for head injury resulting from being beaten by her husband with a wooden staff. This is the first time she has made an NC at the police station after an MLC was registered at the hospital. She wants to know how her situation can be changed.

Points for Facilitation:

- Dicuss the intensity and severity of violence faced by Bhama and express concern about the increase in violence.
- Encourage her to register a cognizable offence complaint as recent episode could have become lethal. Understand the reasons for not recording complaints in the past
- Probe if she can stay at the hospital for a few days so as to recover from the physical trauma as well as get some time to think about next steps. Discuss if there is a neighbour of well-wisher who can care for the kids in her absence. If she is unable to stay in the hospital discuss steps for ensuring her safety as well as getting rest to recover
- Discuss government schemes for TB treatment for her grandson as well as treatment for epileptic seizures. Connect her to resources such as ration, balwadi and others for accessing care for her grandson and son.
- Appreciate her efforts for single handedly caring for grandchild, her child and retaining her job as all these were difficult given her situation of abuse.

5. Ethics

Module 5: Ethics

Session 5.1 Values, ethics and ethical principles

Duration: 3 hours

Objectives:

- To develop an understanding about ethics and rights framework.

Methodology:

Screening of vignettes from films and popular advertisements: This depicts doctor patient interactions, treatment of people living with HIV in popular cinema and coercive public health advertisements. These are used to start a discussion on "means" and "ends". Two questions, which form the crux of all ethical debates, are posed:

- What are ends that are to be achieved and are these justified?
- What are the means that are being used to reach these ends and are *they* justified?

Mapping moral values: This is an individual exercise in which participants are asked to make a list of their moral values from their personal, social and professional lives. These values are then collectively listed out and a discussion is generated around them.

Moral development and Moral reasoning:The facilitator gives the participants a situation for discussion:

Content:

The session starts with screening of vignettes from popular films and advertisements which triggers a discussion on what is ethical action. This is followed by mapping of personal, professional and social values.

Another individual exercise is given to demonstrate moral reasoning followed by a discussion on the various studies on moral staging of men and women. The theories and principles of ethics are discussed with examples followed by case studies which throw up ethical dilemmas for discussion.

Mapping of Moral Values: Based on the individual exercise in which participants are asked to list their values, the following key points emerge:

- Some values are common across all people such as honesty, integrity, loyalty , fairness etc
- Personal, professional and social values often overlap but sometimes they also differ – some people might be progressive in their professional lives but not so in their personal lives
- Values are dynamic – some people constantly re-evaluate their values and others retain values that they have internalised at a young age.

Moral Reasoning and Development:

The following situation is presented:

You are deeply attached to your partner, so much as to make any sacrifice for his/her wellbeing. The partner is very sick. Only one drug can save him/her, but it is very expensive and the drug company is not ready to lower the price.

- What would you do?
- Why?

- Participants typically suggest borrowing, stealing, begging, approaching charitable organisations and even selling an organ in order to cover the cost of the medicine which will save their loved one's life. In general, no one suggests killing another person to get the money. Also, no one suggests gathering like-minded people to rally for bringing down the cost of the medication. These two approaches to the problem represent the ends of the large spectrum of moral development.

- Two studies are discussed – one by Lawrence Kohlberg in the 1970s and the other by Carol Gilligan in the 1980s. In order to study how morals develop in groups, Kohlberg conducted a study. On the basis of his findings, he defined three stages of moral development – pre-conventional, conventional and post-conventional. Most of us are ingrained with the conventional method of thinking which is reflected in the responses to the question above. The first study on moral staging by Kohlberg took into account only men. Later, when the same study was conducted with women, it was found that they were one stage below their male counterparts. This was because women emphasised preservation of relationships.

- In the 1980s, Carol Gilligan conducted a study and used the term "moral voice" instead of orientations. Voices provide an idea regarding concerns and relations but are not meant to be right or wrong. She found that men's moral voices reflected justice, rights, fairness, impartiality, laws, etc. while women's tended towards caring for everyone's suffering, responsibility towards individuals, preserving emotional correctedness, etc.

- The feminist approach to ethics is a combination of both these voices. On the one hand, from a rights perspective, it calls for accountability of the perpetrator while keeping in mind the woman's voice towards caring for her family and relationships.

Principles of ethics:

Non-maleficence: These principles apply to the provider. When you are a counsellor, you are in a powerful position owing to the dependency of the client. You have to use that power with responsibility. The power that we have as providers, whether doctors, nurses or counsellors must be used only in the best interest of the patient. The woman is putting a lot of faith in you and assuming that you are giving her good advice. You have the power to destroy her. That is why psychologists need to have a very strong code of ethics. If a client asks you a question that you do not have an answer to, be candid enough to say that you don't know and that you will look it up. This requires for you to admit to your limitations.

Beneficence: Whatever you do should be for the good of the patient, maximizing her benefit. If your client wants to do something that can harm her, take care to inform her about safety measures that she can take to reduce harm. A good doctor is one who knows the side effects and can warn you about them. That is why you make a safety plan not just for actions but also for the consequences of those actions.

Autonomy: Offer the woman alternatives and let her decide. Ensure that whatever you do is with her consent. There was a time when we believed that doctors know best. Patients were never given a choice. Things are different now. When you talk about rights, you talk about the client's rights. What is your responsibility based on her rights? That is what ethics is about. You do not impose your decision on women because you understand that solving the client's problem is her own right. It is her life. Your role is to help her realise it.

Confidentiality: Confidentiality is a part of respecting the woman and her autonomy. The client gives you information because she trusts you. Thus you have a responsibility. Without her consent, you cannot tell anyone else about it. Counselling must happen in visual and auditory privacy. That was one of the reasons *Dilaasa* was set up in a hospital – so that no one in the family suspects that she is going to the hospital. Confidentiality is your responsibility.

Needs, Rights, Ethics and Law: How do needs relate to rights and rights relate to ethics?

Needs are relative. They depend on social development and access to resources. Since they are ever-changing, it is necessary to incorporate some basic needs into rights. Rights are expectations essential for the self-realisation of the full potential of human beings and for a just socio-economic order. Recognition of rights imparts ethical duties to the providers of these rights. Therefore, we will not respect our patients as individuals until we realise that they have rights. Again, all ethics cannot be converted into laws. However, if an ethic is not being followed, a law can be passed to enforce it as in the case of sex selection, where the PCPNDT Act was required as doctors were violating medical ethics by discriminating against females and propagating male preference.

Session 5.2 Identifying ethical issues and resolving dilemmas

Duration: 2 hours

Objectives:

- To discuss how our own biases/attitudes inform practice.
- To encourage participants to identify ethical issues and discuss ways of resolving them.

Methodology:

Group discussion using case studies: Groups are formed and each is assigned a case study. Each group is asked to discuss the questions raised at the end of the case study. The three case studies discussed are:

- Sadhvis, Sexuality and Societal morality – A Case of sexual violence against two Sadhvis; human rights of Sadhvis were violated by doctors, police and the media.
- Caring for the patient: Does it include lying for her?
- Patient reporting sexual assault at the hospital: ethical challenges.

Content:

The purpose here is to help participants raise ethical issues and challenges. The points for discussion are mentioned at the end of each case study.

Case Study 1: *Sadhvis*, Sexuality and Societal morality

In a medium sized city in India with two medical colleges, a religious sect was having a group of sadhvis undertaking religious as well as social work. This sect has a very sizeable following in the city. Some of these sadhvis were working among children in collaboration with an NGO for last two decades. One of the works of the NGO was to educate and rehabilitate street children in few Children's Homes established by them. Sadhvis of this sect were managing one of these homes for last five years. They had left their homes in their early age and fully dedicated themselves to religious and social work. One of them was 45 years and another 38 years old. They were very popular in the community for their dedication, caring nature and simple life-style. The children's home run by them had two rooms – one large room served as the dormitory to sleep at night and served as a space for educational classes during the day, for 21 children (all boys) housed

in the Home. The second small room had two cots and tables and chairs where these two sadhavis used to live. A door connected both the rooms, and both rooms had a door each, opening to the outside courtyard independently. At night the children slept in the dormitory, the room connecting the two rooms used to remain locked from the side of the sadhvis room and if any child needed their assistance, he had to knock. The young inmates were imparted basic education and skills – most of them started doing some work in the city or elsewhere using such skills by the age of 14 or 15 years and used to leave this Home. The sadhvis and the NGO used to maintain contact with them as these rehabilitated children looked at the Home as their own home and the sadhavis like their mother.

One day, at around 5:00 a.m., a small child needed assistance of the sadhvi. He knocked at their door several times, but did not get any response. Hearing the noise, the other children got up and they all knocked. The children went to the courtyard and knocked on the other door of the sadhvis' room, found that it was not locked, went inside, and found both sadhvis lying dead in a pool of blood. The children panicked and shouted for help, the neighbours came rushing. The news spread like wildfire in the town, the priest and other sadhvis of the sect gathered in no time. All of them were crying around the dead bodies when the police reached the scene. The police had a hard time getting all of them out, cordoning off the area and looking for clues. Both sadhvis had been stabbed but no weapon was found. A team of forensic experts also visited the scene of crime.

The next morning, there was a bandh in the city to pay respect to the deceased, and the newspaper ran the front-page story of the murder, and wrote with superlative language, articles on the dedication and popularity of the sadhvis, and above all, blasted the police for deterioration of the law and order. Speculations were rife about the involvement of a powerful underworld gang having political connections and the cause talked about was its attempt to get the Children's Home which had, with small building, courtyard and garden, large amount of land. The police said that they were on the trail of the murderers but they would be able to say more only after the post-mortem. The Chief Minister of the State gave a statement expressing sympathy with the head of the sect to which these sadhvis belonged, and severely pulled up the police chief for inefficiency and negligence. The post-mortem was conducted by early afternoon. On the second day after the murder, three of the four newspapers published in the city front-paged different stories on

the murder of the sadhvis. Citing a reliable source, they said that the autopsy had revealed they were not raped, but at the same time it showed that they were used to sexual intercourse and one of them was also suffering from a sexually transmitted disease. They also stated that perhaps police was investigating sadhvis' relationship with ex-inmates of the Home – the boys who grew up there and subsequently moved to some other towns; and also with some sadhus or priests of the sect who were frequent visitors of the Home and with the head of the NGO. These stories had indirect references to the licentious behaviour of the men and women who were supposed to remain pure. With the publication of these stories, the public outcry on the murder suddenly died down. Even the priests of the sect stopped giving statements, and in the next few days the furore was gone, the media shifted the story to inner pages and mainly reported statements of the police about the progress of investigation.

After about three months of the murder, a meeting of the sadhvis took place where all of them revealed that since the murder, their image in the community had gone down, people were regarding them as of loose moral character and they were finding it difficult to continue with their work. At that time, a lawyer, journalist and a doctor along with few other public-spirited individuals constituted an investigation team. These sadhvis provided them with a copy of the autopsy report and they went around for two weeks interviewing doctors who were involved in performing the autopsy, police officers, newspaper reporters and many others. It was discovered that apart from findings of injuries that killed them there were only two other positive findings. In both, the hymen was found absent or torn, and vaginas were patulous; and there was a small inaugural wart near the vagina of the younger woman. The autopsy report was dated seven days after the murder and the doctor, who did the autopsy refused to take responsibility of the kind of interpretation given by the media. He also said that at the time of autopsy his senior professor was present and he had taught five students from medical college on these bodies. The said professor had said some uncharitable things about women in general and the morality of sadhvis and sadhus in religious sects. The professor refused to talk to the team saying that he had not performed the autopsies. The team also discovered that a few years back, both sadhvis had undergone D&C at the public hospital due to some severe menstrual problems. The reporters of the newspapers claimed that they had written a truthful account of whatever was reported to them, but they refused to divulge their source.

When the investigation team released its report, there was furore in public. While acrimonious debates continued in the media, the followers of the sect who had kept quiet for so long suddenly felt that the sadhvis of their religion were deliberately maligned, and they protested. However, the murderers of the sadhvis were never found and the police closed the files.

Questions:

1. Did the doctors and reporters do anything wrong? If yes, what did they do wrong? Why did they do it? Were they correct in refusing to apologise?
2. Was it correct for a citizens' team to do its own investigation in this episode? Why? What are the rights and ethical responsibilities of the team?
3. What are the ethical obligations of forensic doctors?

Point for discussion:

- The post-mortem was delayed, the doctor made unscientific and derogatory remarks about the sadhvis while teaching his students. Doctors should have known that the hymen can tear naturally.
- The media was wrong in reporting information without thoroughly investigating the matter. They also focused only on the sexual history of the sadhvis rather than the murder itself.
- There was a need for independent investigations which required that permission from the authority be sought and that data be transparent. The investigation should have been conducted with caution in a systematic and unbiased manner. Even if the truth was unpalatable, there should have been readiness to publish. The report should have been thorough, else people would lose faith.
- The Sadhvis, children and society were the victims while the HCPs, journalists, politicians and police formed a chain of beneficiaries. When morality comes into the picture, the larger issue is forgotten. For e.g., a sex worker when raped is viewed as someone who invited the act due to her conduct disregarding that she was the victim of rape/ sexual violence.

Case study 2: Caring for the client: does it include lying for her?

A 30 year old married woman was facing extreme forms of violence from her husband, who was also very violent towards their two young children aged 2 and 4. In one of his violent spells, the husband burnt to death both children. The husband was arrested, and was facing long-term prison sentence for murder.

The woman was pregnant at the time of this incident. Her mother was the only local support she had. However, the mother was old and poor, without resources to support her and without the time to care for her pregnancy. So she was sent to a shelter for women. During her stay, the care givers at the shelter discovered that she suffered from epilepsy. They also found that the violent death of her children had deeply affected her and she was showing signs of mental health problems. There were doubts as to whether she would be able to take care of herself, more so after giving birth to the child. They concluded that she needed counselling support and also referral to mental health and medical professionals. She was therefore referred to the hospital-based crisis counselling centre that provides emotional and psychological support to women facing domestic violence.

During the course of counselling, she shared her grief, anxieties and insecurities. She was very concerned about the future of the child in her womb in the context of the violent death of two of her children by their own father. She told the counsellor that she feared the worst for her child and so wanted an abortion. Given her pathetic economic condition – including inability to support self, the social stigma of being wife of a person imprisoned, and her delicate mental health status, the counsellor was sympathetic to her demand. But her pregnancy was already more than 20 weeks, and at such an advanced stage of pregnancy the law did not permit medical termination. The counsellor explained to her that abortion was not a legally available option for her.

But the insecurity for her child was really disturbing her, so they explored another option of giving birth to the child but immediately giving it up for adoption. But the adoption laws in the country require the consent of the father of the child if it was born to a married couple. Despite extreme cruelty and criminality of her husband, the law still recognised him as child's father. With the history of violence and the death of her

children, she could not imagine involving her husband in a decision regarding their unborn child. Also with no way to support herself, she felt it was not right for her to give birth. But she was convinced that if the child gets adopted by a good family, at least it will have better life. She indeed liked such an option and insisted with the counsellor to find a way out so that she could give her child to an adoption agency.

The other provision within the adoption laws is regarding children born out of wedlock, in which case there is no need for consent from the father of the child. She thought this to be a good option for her to use. This also helped her to avoid the stigma that went with the name of her criminal and imprisoned husband. She felt that there was nothing wrong in stating that she was unmarried and that her child was born out of wedlock in order to be able to give up her chid for adoption. She was ready to state this to the hospital where the child would be born and also to the adoption agency which would accept the child.

She wanted the counsellor and the Centre to help in implementing this plan. In fact, given her poverty and helplessness, only the reference from the Centre would provide credibility to her story for the adoption agency.

The counsellor contacted the adoption agency, told and sold the story. The adoption agency agreed to pay for the delivery of the child in a reasonably good private maternity home.

Questions:

1. Should the abortion law of the country be more considerate about the need of women like the one described in this story and allow medical termination even in an advanced stage of pregnancy? Why?
2. Do you agree with the woman's choice of either abortion or giving away child for adoption? Explain.
3. Although the woman made a choice to lie, should the counsellor have accepted her request to lie on her behalf? What are the consequences of accepting or rejecting such a request to lie for her?
4. Was there an ethically less problematic way out available from this situation? Discuss.

Points for discussion:

- Abortion/ Medical Termination of Pregnancy (MTP) is available only under certain condition in India. The conditions are failure of contraception, congenital anomaly, or if the foetus is dead or poses a threat to the woman's life. The decision to abort must be that of the woman; but several factors keep women away from decision making.

- The issue of giving up the child for adoption also requires value clarification. Participants may feel that it is her responsibility as "mother" to take care of the child and so efforts must be made to institutionalise her, provide economic support and provide protection to her and the child. The concern is whether we can stand by a woman if she decides to give up the child in adoption, or pass judgments on "motherhood" if she refuses to keep the child.

- The point related to "telling lies" generates a lot of differing opinions. It may be good to ask participants if they always tell the truth and if not, then under what circumstances they lie. If to save one's own life lying is acceptable, why is it not acceptable in order to save the life of others? The consequences of the act fall on the counsellor who must therefore think about whether she is capable of tackling the situation. In future, the counsellor may be under pressure to disclose information and at that point the counsellor must be strong enough not to yield to pressure.

Case 3: Patient reporting rape: ethical challenges in investigating rape and pregnancy

A girl aged 14 years with recurrent soft tissue sarcoma was admitted to the female ward on 17th November 2006, operated on 20th November 2006 and was discharged on 22nd December 2006. Following suture removal on 26th December 2006, she was asked to follow up after 2 weeks. However, she did not follow up till 2nd March 2007. On 2nd March 2007 the surgeon ordered an ultrasound for a large abdominal swelling which determined that the girl was pregnant.

The girl told her parents that she was raped in the hospital while she was recovering after her operation in November 2006. The family complained to the hospital staff. Soon the news spread and a women's organization associated with a political party protested outside the hospital and demanded an enquiry. They demanded that all

the staff on duty be interrogated.

In its response, the hospital said that the girl was more than 20 weeks pregnant, so no rape occurred in the hospital. They also carried out tests to determine the exact stage of pregnancy from another hospital. A hospital report dated 6th April 2007 stated that the girl was 25.5 weeks pregnant. The hospital authorities spoke to the press on a daily basis about the chronology of her visits to the hospital. They also gave the ultrasound reports indicating the status of her pregnancy as 24/25 weeks, thus raising doubts about the alleged rape.

Then one day, it was reported that the police has been successful in finding the rapist who was actually her neighbour. The police received kudos from all for carrying out quick investigations and catching the culprit. What the police did is like this- they went to the girl's neighbourhood, picked up and interrogated young boys whom the girl interacted with on a daily basis. From amongst them, they arrested one boy who was friendly with her, on charges of rape. The so-called women's group went silent after that and the hospital authorities immediately washed their hands off and claimed that she was already pregnant when she was operated.

The hospital was concerned about her future line of treatment. In view of the recurrent disease, it was necessary to offer palliative radiation therapy to the patient. She was terminally ill but needed radiation not for her cure but for palliative survival. The radiation may or may not kill the foetus. So the dilemma faced by the team was whether she should be provided the treatment and whether she should she be allowed to abort her foetus although she was in an advanced stage of pregnancy.

The girl's family said that they do not have a case against the boy arrested by the police; the two had no such relationship. However the police did not pay heed and kept the boy in jail. The community was upset with the girl and her family for creating so much trouble for all of them, especially the young boys who were still being called to the police station for interrogation. The girl's parents were so upset and embarrassed that they decided to stop her treatment at the hospital and went to their village in Uttar Pradesh.

The girl later had a stillbirth. The DNA test was carried out and it did not match with that of the boy arrested by the police.

Questions:

1. Do you agree with the way the hospital handled the girl's complaint of rape?
2. Do you think that the police was right in interrogating the boys although there was no complaint against them by the girl's family?
3. Does her stage of pregnancy really matter vis a vis her complaint of rape?

Points for discussion:

- The hospital, instead of investigating the case of sexual assault and questioning the staff shifted the issue to identifying the origins of the pregnancy. This put the entire case on a tangent, whereby the girl's morality was brought into question and the incident of rape was forgotten.

- The girl never denied pregnancy – she was making the charge of rape in spite of the pregnancy. But the question is – can a pregnant woman not be raped? Is it not possible that there is no relation between the rape and the pregnancy?

- It must be remembered that reporting rape is not easy at all. It is much easier to say you are having an affair than saying that you were raped. Society points fingers, finds fault and takes moral stands on issues. A woman, who is away from the norm, is considered immoral and treated disrespectfully. In this case it was the 14 year girl who was considered immoral because she was pregnant and single. A person can be tortured by giving them a sub-human status; for e.g., when the police kill terrorists, it is accepted because of the label terrorist'; they are not considered human. The hospital was defending itself but using her morality to divert the issue.

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Annexures

Annexures

I. Essential Reading Material

I: GENDER

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IV: VIOLENCE AGAINST WOMEN AND ROLE OF HEALTH CARE PROVIDERS

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V: VIOLENCE AND ETHICS

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VI: COMMUNALISM

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VII: COUNSELLING

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II. Violence Against Women and Role of Health Care Professionals

Sample Feedback form

1. On the scale below, please indicate how ***useful*** you found the topics covered in today's training for your work as a health professional. *(Please check the box)*

Topics	**Not at all useful**	**Somewhat useful**	**Extremely useful**
Patriarchy			
Intersectionality			
Discrimination			
Equality			
Rights based approach			
Human rights			
Understanding Violence			
Working with men on VAW			
Violence against women			
VAW a Health and Human Rights Issue			
Role of Health care providers in VAW			
Applying learning to practice			
Inter-sectoral collaboration for addressing VAW			
Comprehensive health care response to sexual violence			
Understanding the Dilaasa model			
Medico legal documentation			
Communalism – Identity formation			
Communalism – Group discussion			
Counselling principles and values			
Counselling - application			
Ethics Rights and VAW			
Ethics – Principles and models			
Ethics - application			

2. How ***satisfied*** are you with the way in which the training was conducted? Please indicate your level of satisfaction on the scale below. *(Please circle only one number.)*

Topics	**Not at all useful**	**Somewhat useful**	**Extremely useful**
Patriarchy			
Intersectionality			
Discrimination			
Equality			
Rights based approach			
Human rights			
Understanding Violence			
Working with men on VAW			
Violence against women			
VAW a Health and Human Rights Issue			
Role of Health care providers in VAW			
Applying learning to practice			
Inter-sectoral collaboration for addressing VAW			
Comprehensive health care response to sexual violence			
Understanding the Dilaasa model			
Medico legal documentation			
Communalism – Identity formation			
Communalism – Group discussion			
Counselling principles and values			
Counselling - application			
Ethics Rights and VAW			
Ethics – Principles and models			
Ethics - application			

3. How effective were the resource persons?

   ☐ **Excellent** ☐ **Good** ☐ **Okay** ☐ **Poor**

4. What are the ***three*** things that you learnt in this today's training?
5. Please describe ***three*** ways in which you intend to put into practice the learnings from this training.
6. Please share additional comments, suggestion, or feedback about today's training in the space below. Feel free to use the other side of this paper as well.
7. Please mention what you did not like in training.

Today's Date: _____ **Name: _____**

तोड़ तोड़ के बंधनों को

तोड़-तोड़ के बंधनों को देखो बहनें आती है,

ओ देखो लोगों देखो बहनें आती है,

आयोंगी, जुल्म मिटायेंगी, वो तो नया जमाना लायेंगी ।

तारीकी को तोड़ेगी, वो ख़ामोशी को तोड़ेगी,

हां मेरी बहनें अब ख़ामोशी को तोड़ेगी,

मोहताजी और डर को वो मिलकर पीछे छोड़ेगी,

हां मेरी बहनें अब डर को पीछे छ़ोड़ेगी,

निडर, आजाद हो जायेंगी,

अब वो सिसक-सिसक के न रोयेंगी ।

तोड़-तोड़ के बंधनों .....

मिल कर लड़ती जायेंगी, वो आगे बढ़ती जायेंगी,

हां मेरी बहनें अब आगे बढ़ती जायेंगी ।

नाचेंगी और गायेंगी, वो फनकारी दिखायेंगी,

हां मेरी बहनें अब मिलकर ख़ुशी मनायेंगी ।

हां मेरी बहनें अब मिलकर ख़ुशी मनायेंगी,

गया जमाना पिटने का जी, अब गया जमाना मिटने का,

तोड़-तोड़ के बंधनों .....

कमला भसीन

ले मशालें चल पड़े हैं

ले मशालें चल पड़े हैं लोग मेरे गांव के,

अब अंधेरा जीत लेंगे लोग मेरे गांव के ।

पूछ़ती है झोंपडी और पूछ़ते हैं खेत भी,

कब तलक लुटते रहेंगे लोग मेरे गांव के ।

बिन लड़े कुछ भी नहीं मिलता यहां यह जानकर,

अब लड़ाई लड़ रहे हैं लोग मेरे गांव के ।

चीख़ती है हर रुकावट ठोकरों की मार से,

बेडियां खनका रहे हैं लोग मेरे गांव के ।

लाल सूरज अब उगेगा देश के हर गांव में,

अब इकटठे हो चले हैं लोग मेरे गांव के ।

देखों यारों जो सुबह लगती है फीकी आजकल,

लाल रंग उसमें भरेंगे लोग मेरे गांव के ।

बल्लीसिंह चीमा

रुके न जो झुके न जो ...

रुके न जो, झुके न जो, दबे न जो, मिटे न जो,

हम वो इंकलाब है, जुल्म का जवाब है,

हर शहीद, हर गरीब का यही तो ख्वाब है ।

रुके न जो ...

लड़ रहे है इसलिए की प्यार जग में जी सके,

आदमी का खून कोई आदमी न पी सके,

मालिकों ... मालिकों मजूर के, नौकरों हजूर के,

फर्क को मिटायेंगे, समानता को लायेंगे ।

रुके न जो ...

मानते नहीं है, फर्क हिन्दू-मुसलमान का,

जानते है रिश्ता, इंसान से इंसान का,

धर्म के .... धर्म के, देश के, भाषा और भेष के,

द्वंद को मिटायेंगे और एकता को लायेंगे ।

रुके न जो ...

छात्र युवा संघर्ष वाहिनी

इसलिए राह संघर्ष की हम चुने

इसलिए राह संघर्ष की हम चुनें
ज़िंदगी आंसुओं से नहायी न हो
शाम सहमी न हो, रात हो न डरी
भोर की आंख फिर ड़बड़बाई न हो ।

सूर्य पर बादलों का न पहरा रहे
रोशनी रोशनाई में डूबी न हो
यूं न ईमान फुटपाथ पर हो खड़ा
हर समय आत्मा सबकी उबी न हो
आसमां में टंगी हो न खुशहालियां
कैद महलों में सबकी कमाई न हो ।
इसलिए राह ....

कोई अपनी ख़ुशी के लिए गैर की
रोटीयां छ़ीन ले हम नहीं चाहते
छ़िंटकर थोड़ा चारा कोई उम्र की
हर ख़ुशी बीन ले हम नहीं चाहते
हो किसी के लिए मखमली बिस्तरा और
किसी के लिए एक चटाई न हो ।
इसलिए राह ....

अब तमन्नायें फिर न करें खुदकुशी
ख़्वाब पर खौफ की चौकसी न रहे
श्रम के पावों में हो ना पड़ी बेडियां
शक्ति की पीठ अब ज्यादती ना सहे
दम न तोड़े कहीं भूख से बचपना
रोटियों के लिए फिर लड़ाई न हो ।
इसलिए राह संघर्ष की हम चुने
इसलिए राह .....

वशिष्ठ अनूप

तू जिंदा है

तू जिंदा है तो जिंदगी की जीत पर यकीन कर ।
अगर कहीं है स्वर्ग तो उतार ला जमीन पर ।।
तू जिंदा है तो .....

ये गम के और चार दिन, सितम के और चार दिन ।
ये दिन भी जायेंगे गुजर, गुजर गये हजार दिन ।
कभी तो होगी इस चमन पे, भी बहार की नजर ।
अगर कही है स्वर्ग तो उतार ला जमीन पर ।
तू जिंदा है तो .....

सुबह ओ शाम के रंग हुए गगन को चूमकर ।
तू सुन जमीन गा रही है कब से झूम-झूम कर ।
तू आ मेरा सिंगार कर, तू आ मुझे हसीन कर ।
अगर कही है स्वर्ग तो उतार ला जमीन पर ।।
तू जिंदा है तो .....

हजार भेष धर के आई मौत तेरे द्वार पर ।
मगर तुझे न छ़ल सकी चली गई वो हर कर ।
नई सुबह के संग सदा मिले तुझे नई उमर ।
अगर कहीं है स्वर्ग तो उतार ला जमीन पर ।।
तू जिंदा है तो .....

हमारे करवां को मंजिलों का इंतजार है ।
ये आंधियाँ, ये बिजलियों की पीठ पर सवार हैं ।
तू आ कदम मिला के चल, चलेंगे एक साथ हम ।
अगर कहीं है स्वर्ग तो उतार ला जमीन पर ।।
तू जिंदा है तो .....

जमीं के पेट में पली अगन, पले है जलजले ।
टिके न टिक सकेंगे भूख रोग के स्वराज ये ।
मुसीबतों के सर कुचल, चलेंगे एक साथ हम ।
अगर कही है स्वर्ग तो उतार ला जमीन पर ।।
तू जिंदा है तो .....

बुरी है आग पेट की, बुरे है दिल के दाग ये ।
न दब सकेंगे, एक दिन बनेंगे इन्कलाब ये ।
गिरेंगे जुल्म के महल, बनेंगे फिर नवीन घर ।
अगर कही है स्वर्ग तो उतार ला जमीन पर ।
तू जिंदा है तो .....

शंकर शैलेन्द्र

तू खुद को बदल

दरिया की कसम मौजों की कसम,
ये ताना बाना बदलेगा ।
तू खुद को बदल, तू खूद को बदल,
तब ही तो जमाना बदलेगा ।
तू चुप रह कर जो सहती रही,
तो क्या ये जमाना बदला है ।
तू बोलेगी, मुंह खोलेगी,
तब ही तो जमाना बदलेगा ।
दस्तूर पुराने सदियों के,
ये आये कहां से क्यों आये ।
कुछ तो सोचों, कुछ तो समझो,
ये क्यों तुमने है अपनाये ।
ये पर्दा तुम्हारा कैसा है,
क्या ये मजहब का हिस्सा है ।
कैसा मजहब, किसका पर्दा,
ये सब मर्दों का किस्सा है ।
आवाज उठा, कदमों को मिला
रफ़्तार जरा कुछ और बढ़ा ।
मशरिफ से उठो, मगरिब से उठो,
उत्तर से उठो, दक्षिण से उठो,
गांवों से उठो, शहर से उठो,
फिर सारा जमाना बदलेगा ।

(हिंदुस्तान और पाकिस्तान की महिलाओं द्वारा एक वर्कशॉप में रचित कवाली)

इरादे कर बुलन्द

(मशहूर शायर मजाज की एक गज़ल पर आधारित)

इरादे कर बुलन्द अब रहना शुरू करती तो अच्छा था
तू सहना छोड़ कर कहना शुरू करती तो अच्छा था ।

सदा औरों को खुश रखना बहुत ही खूप है लेकिन
खुशी थोड़ी तू अपने को भी दे पाती तो अच्छा था ।

दुखों को मान किस्मत हार कर रहने से क्या होगा
तू आंसू पोंछ कर अब मुस्करा लेती तो अच्छा था ।

ये पीला रंग लब सूखे सदा चेहरे पे मायुसी
तू अपनी इक नई सूपत बना लेती तो अच्छा था ।

तेरी आंखो में आंसू है तेरे सीने में है शोले
तू इन शोलों में अपने गम जला लेती तो अच्छा था ।

है सर पर बोझ जुल्मों का तेरी आंखें सदा नीची
कभी आंखे उठा कर तेवर दिखा देती तो अच्छा था ।

तेरे माथे पे ये आंचल बहुत ही खूब है लेकिन
तू इस आंचल का एक परचम बना लेती तो अच्छा था ।

कमला भसीन

मत बांटो इंसान को

मंदिर, मस्जिद, गिरजाघर ने बांट लिया भगवान को
धरती बांटी, सागर बांटा, मत बांटो इंसान को
हिन्दू कहता मंदिर मेरा, मंदिर मेरा धाम है
मुस्लिम कहता मक्का मेरा, अल्लाह का ईमान है
दोनों लड़ते, लड़-लड़ मरते लड़ते-लड़ते खत्म हुए
दोनों ने एक दूजे पे जाने क्या-क्या जुल्म किये
किसका ये मकसद है किसकी चाल है जान लो
धरती बांटी .....

नेता ने सत्ता की खातिर कौमवाद से काम लिया
धर्म के ठेकेदार से मिलकर लोगों को नाकाम किया
भाई बंटे टुकडे-टुकडे में नेता का है मान बढ़ा
वोट मिले और नेता जीता शोषण को आधार मिला
वक्त नहीं बिता है अब भी वक्त की कीमत जान लो
धरती बांटी .....

प्रजातंत्र में प्रजा को लुटे, ये कैसी सरकार है
लाठी, गोली, ईश्वर, अल्लाह ये सारे हथियार है
इनसे बचो और बच के रहे, और लड़कर इनसे जीत लो
हक़ है तुम्हारा चैन से रहना, अपने हक़ को छीन लो
अगर हो शैतानी से तंग, खत्म करो शैतान को
धरती बांटी .....

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health

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