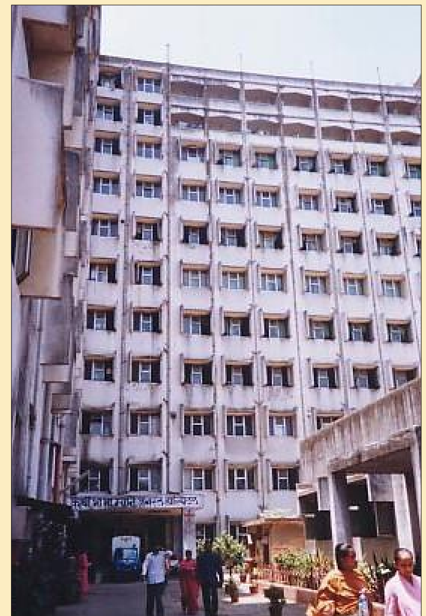
PROCESS DOCUMENTATION OF TRAINING OF TRAINERS AT DILAASA



PROCESS DOCUMENTATION
OF
TRAINING OF TRAINERS

Dilaasa-Crisis Centre for Women
K. B. Bhabha Hospital
Bandra
Mumbai.

Centre for Enquiry into
Health and Allied Themes
Mumbai.

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DILAASA

CRISIS CENTRE FOR WOMEN

A joint initiative of CEHAT and the Public Health Department-
K.B. Bhabha Hospital, Bandra.

Department No. 101, Opposite Casualty,
Near Surgical Ward, K.B. Bhabha Mun. Gen. Hospital,
Bandra (W), Mumbai.

Resource Persons

- Ms Manisha Gupte
- Ms Radhika Chandiramani
- Ms Renu Khanna

Acknowledgement

The training of trainers at *Dilaasa* is an experiment towards sensitizing the public health system and institutionalizing training within the hospital system. We would like to thank all the key trainers for participating enthusiastically in the training sessions. We would like to thank our consultants Ms Aruna Burte, Dr Kamakshi Bhate, Ms Manisha Gupte and Ms Renu Khanna for giving us feedback on the first draft of this report. We would like to thank Ms Purnima Maghnani for language editing of the report.

We are grateful to the Ford Foundation for its support in this endeavour.

Foreword

Violence against women is global phenomenon. The statistics on crime against women are shocking. It is disheartening to note that even in the 21st century the women in our country and the world live in such fear. It is important that efforts be made to help women in violent situations.

Women suffer health problems because of violence. The Brihanmumbai Municipal Corporation recognized the role that the Health Department must play in helping such women. Therefore it started the *Dilaasa* Crisis Centre at K.B. Bhabha Hospital, Bandra, West for Women in collaboration with an Non Governmental Organisation, Centre for Enquiry into Health and Allied Themes (CEHAT). The CEHAT has trained the hospital staff on the issue of Gender, Violence against women and the role of health professionals in responding to women survivors of violence.

This book gives a detailed documentation of these training sessions. It also contains a section of reference material that can be given to participants. I am sure this will be useful to all those who want to start work on this issue.

Shri. S. J. Kunte

Additional Municipal Commissioner(Western Suburb)
Brihanmumbai Mahanagarpalika

From the desk of

The Director-Medical Education And Public Health

Domestic Violence is not even considered an issue of concern in our country. To address this issue, the efforts have largely been that of a few concerned individuals and organisations. However the health consequences of violence have been largely neglected. In such circumstances, the participation of the PUBLIC HEALTH DEPARTMENT along with CEHAT, an NGO, is deeply appreciated.

It is encouraging to see that "HEALTH" is looked at holistically and not restricted to only curative services.

This documentation would be a landmark in paving the way for training health care providers in responding to domestic violence. This document carries information on the dynamics of domestic violence, screening and referrals, as well as strategies in becoming effective communicators

Dr. (Shri.) S. G. Damle

Joint Commissioner Medical Education and Public Health
Brihanmumbai Mahanagarpalika

Note From

The Executive Health Officer

Domestic Violence is a Public health concern, but it has not received much attention by the health care profession. The Public Heath Department of the BMC took up the challenge and started a crisis centre for women facing domestic violence at K. B. Bhabha Hospital in collaboration with CEHAT, a health research organization. I congratulate the Medical Superintendent and the staff for having made this a successful experiment.

This is the first time in India that a hospital has taken up the cause of women facing domestic violence. The project began by training the hospital staff to respond to women who come with health complaints due to domestic violence. An effort is being made to change their perspective of looking at their role as curative to holistic. This document presents in detail the training sessions that were undertaken to train the hospital staff on gender and violence issues.

I am sure that this document will be useful for planning and conducting training sessions for staff from other hospitals.

Dr. (Shri.) R. M. Kathuria

Executive Health Officer
Brihanmumbai Mahanagarpalika

Preface

Being medical superintendent of the hospital and at the same time being the project director for a social issue has been a challenging task for me. Integrating the issue of Domestic Violence as a public health issue within the hospital system was a challenge.

In-depth interviews with staff and their perceptions toward domestic violence has helped us to decide on subjects of training, which were required to sensitise the staff to Domestic Violence as a health issue and also to prepare them as trainers. This training report contains all chapters from Domestic Violence as a health issue, gender and violence, Role of health care professionals in responding to Domestic Violence and communication skills.

Being the medical superintendent, the issue of concern was whether this training will be sustained. In an organization like the hospital where there is floating staff. Because therefore it was necessary to make sure that there is regular training of new staff as well as old staff. Some key trainers from the hospital itself were chosen. While selecting the participant for key trainer's training, I had to take the advantage of the managerial system of hospital, where sister in-charges are managers of the ward and Medical Officers are managers of the entire department. These managers of the hospital will take the responsibility of training the staff in the department and see that this issue is integrated in the system. I also selected the Medical Record Officer, as he is the one who will see that documentation for survivors of Domestic Violence is done sensitively. Choosing the appropriate persons for training has created an environment in the hospital where we can see definite change in attitude of medical and para medical staff towards this issue.

My concern as project director to see such kind of change, and as medical superintendent to sustain it, is fulfilled to quite an extent. Hence I can now present this training report which will help the other hospitals to take on this issue and integrate it in their hospital system.

I would like to thank our Additional Municipal Commissioner Shri. S. Kunte, our Joint Commissioner Education and Peripheral Hospital, Dr. S. G. Damle and Dr. Kathuria, our Executive Health Officer, Chief Medical Superintendent, Dr. W.S. Bhatki for their support. I thank Shri. Ravi Duggal, Co-ordinator CEHAT and Ms. Padma Deosthali, Co-ordinator of *Dilaasa*, for constantly helping me in every step.

I thank all key trainers for undertaking the training and taking up the responsibility of training the rest of the hospital staff. I thank the staff of *Dilaasa* too.

Dr. Seema Malik
Project Director-*Dilaasa* and Medical Superintendent-KBBH

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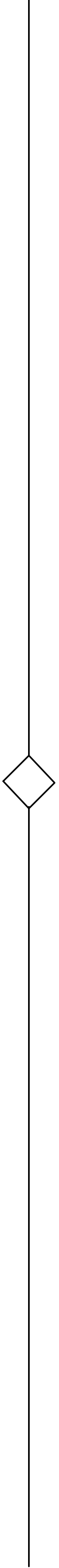


Introduction

Domestic violence is a global phenomenon. It cuts across boundaries of class, caste, religion, race, and education. Domestic violence, or violence within the household, can be physical, psychological, or sexual in nature. The 'home' is considered a safe place, therefore violence inside the house is often never discussed. Women experiencing violence are therefore left with no choice but to endure it silently. Any act of violence causes physical and/or psychological trauma and for treatment a woman usually approaches the health system. However, the health system is not geared to respond to her needs!

In spite of the fact that domestic violence affects a woman's physical, and/or mental health adversely, doctors are trained to only treat the physical injuries. The emotional support that the woman needs is entirely missing. One of the main reasons for this is that doctors do not think that it is part of their job at all. They see it as the job of the police. Secondly, doctors too feel that it is a personal issue, and therefore they should not be involved. Lastly, they are not trained to probe into the history of violence. Women rarely take recourse to filing a police complaint, as violence within the household is an accepted behaviour. It is only when the violence escalates beyond tolerance levels that women approach formal agencies for help. In such circumstances, the current incident only gets investigated, as there is no documentary evidence of such incidents having occurred earlier. Women activists have found that in the cases filed in the family courts cruelty by husband is the major reason given by women for separation and divorce. However, these women normally do not have any documentary evidence, in the form of medical records, to support their claims. This makes their battle more difficult. Doctors are perceived as non-threatening, and the patient has immense faith in them. Therefore, it is more likely that a victim of violence will confide more readily in the doctor. The doctors can play a critical role in responding to domestic violence faced by their patients in a number of ways; (1) Screening and identification, (2) Documentation of the abuse and resulting injuries, (3) Referral to support agencies.

Hospital-based studies do indicate that a large number of women are approaching public hospital with health complaints arising from domestic violence. With the objective to make the public health system more responsive, CEHAT (Centre for Enquiry into Health and Allied Themes) a research centre of Anusandhan Trust , and the Public Health Department of the Brihanmumbai Municipal Corporation have joined hands and started *Dilaasa*—a crisis centre for women—at K.B. Bhabha Hospital, Bandra. The goal of *Dilaasa* is to ensure that every incident of violence against a woman gets recorded, and she receives emotional support. The woman may or may not seek police/legal action, but the record will help her whenever she decides to take action. Women coming to the casualty and the Out Patient Department (OPD) will be screened by doctors for domestic violence and will be referred to *Dilaasa* for social and psychological support.

There was a need to first sensitise the hospital staff to gender and violence issues before starting the centre. We requested three individuals, namely Ms. Manisha Gupte, Ms. Radhika Chandiramani, and Ms. Renu Khanna, who have the experience and expertise on gender, health and violence, to help us train the hospital staff.

Ms. Manisha Gupte is the co-convener of Mahila Sarvangeen Utkarsh Mandal (MASUM), a rural women's organisation. She has been a part of the women's movement and has been actively taking part in research, training, and activism on issues related to health and sexuality.
Ms. Radhika Chandiramani works with TARSHI on sexuality and reproductive health. She is a qualified clinical psychologist.

Ms. Renu Khanna is the founder member of SAHAJ, has long-standing experience as a trainer on gender, violence and sexuality issues and is currently collaborating with the BMC on the Women Centred Health project that aims to sensitise the health system on women's health and improve quality of care at the primary level of the health care delivery system of the BMC.

The *Dilaasa* team had an extensive meeting with these three individuals during which we presented the hospital infrastructure, policies and procedures. While discussing the modalities of undertaking this exercise of sensitisation of the staff, we decided that instead of training the entire hospital staff (882 in number) on our own, we could select a small group from within the staff and the resource persons would train them as key trainers, who would then train the rest of the hospital staff. The medical superintendent then chose forty staff members who held permanent positions within the hospital, and were committed to their work. It was decided that they would be trained as key trainers for *Dilaasa*. They included doctors, paramedics, nurses, and some from the administrative section.

The resource persons expressed the requirement for a needs assessment of practices and perceptions towards Domestic Violence before commencing the training. A few studies were planned. One was an observation of the female cases coming to the casualty in order to understand the hospital's procedures with regard to women facing domestic violence, and the other constituted in-depth interviews with different levels of the hospital staff in order to understand their perception of violence against women and their role in responding to that violence. The team carried out both these studies and shared the findings with the resource persons. The resource persons incorporated the finding into their training sessions. The findings are presented here in the Needs Assessment section of this report.

During the meeting a detailed discussion on the content of the training sessions was held, and each one of the resource persons took up specific topics. The process of training the trainers took almost a year. Two groups of hospital staff (20 each) were constituted. Each group was composed of medical and paramedical staff. We could not form a group of only doctors or of only nurses as the hospital work would get affected. It was decided that training would be held once a month. The first training session for the two groups was held on 20th and 21st October, 2000, respectively. One of the groups named itself *Pragati* (Progress), while the other called itself *Prerna* (Inspiration).

Each group underwent seven full day training sessions. Each training session was documented by the *Dilaasa* team, and is presented here. The first draft of the documentation was discussed with the resource persons, and their feedback has been incorporated. The documentation of two modules was inadequate, and the resource person herself had to document the content of those sessions. The trainers administered pre- and post-tests to evaluate their sessions. We have compiled and presented them together in the chapter on Participant's Feedback.

This training programme led to the formation of a core group of 12 key trainers (from the group of 40) who volunteered to conduct training sessions for the rest of the hospital staff on an ongoing basis. The core group then met regularly and developed a three-hour orientation module. They conducted six sessions, which were documented. We then had a review session with Ms. Manisha Gupte where the key trainers expressed their concerns about handling these discussions on gender and violence. The resource person had a thorough discussion with the group on this issue, and on ways of handling various questions. The module was then revamped and has now been finalised after testing it with a number of groups.

We hope that the documentation of the process of training hospital staff as trainers will be a useful resource for those endeavouring to sensitise the health system.

NEEDS ASSESSMENT

I. OBSERVATIONS AT CASUALTY

II. IN-DEPTH INTERVIEWS WITH HOSPITAL STAFF

I.

Observation at Casualty

(EMERGENCY DEPARTMENT)

OBJECTIVE

- To understand how the Casualty operates, in terms of the roles that the different categories of staff play.
- To understand the existing system in the Casualty, in terms of the procedures related to patients with suspected histories of violence.

METHODOLOGY

Members from the team sat in the Casualty everyday, for 15 days. We spoke to the staff on duty and took them into confidence. Our role was to "observe" only. It was difficult to maintain this role, as the staff and relatives accompanying the patients approached us directly, either to just share their pain or to seek advice. We had to struggle hard to restrict our role to only observation, but were forced to interact only on some occasions.

LEARNING

- The police constable who is on duty 24 hours/ day registers cases of suspected violence in the Emergency Police Register (EPR). He registers only those cases that are admitted to the hospital. The information recorded in the EPR includes date and time of incident, name and religion of the patient, address, and type of complaint. The police station nearest to the place of incident is contacted and police personnel from that station record the patient's statement. The patients who are treated at the Casualty but not admitted to the hospital, are not registered with him. They are expected to go to the nearest police station to register their complaint.
- A number of non-emergency patients do come to the Casualty. The perception of doctors is that they tend to come to the Casualty because they do not wish to stand in a queue at the OPD. At the Casualty, the doctors do examine these patients immediately and treatment is given at once, but with some amount of grumbling, as they feel that because of such patients they cannot properly attend to "serious" patients.
- Medical care is provided immediately to all patients coming to the Casualty Department. What is of concern is the staff's irritation and annoyance with patients who are not seriously ill. This is of particular importance, as women facing domestic violence need not necessarily exhibit serious ailments or signs of injury.
- Another observation is the obvious reluctance of the doctors to elicit information from women with suspected histories of violence. They do not feel that it is part of their calling. They see it as the job of the police. The doctors too carry the common perception that domestic violence is a personal issue and that they should not probe into it. They do not seem to recognise it as a public health concern.

II.

In-depth interviews with *Hospital Staff*

OBJECTIVES

- To understand the perceptions of violence against women among different levels of the hospital staff and their role in addressing this issue.
- To understand the existing systems in the hospital with regard to cases of violence.
- To find out if hospital staff feel the need for a hospital based intervention, such as a Crisis Centre to help women victims of violence.
- To find out what roles hospital staff are willing to play in relation to such a centre.

METHODOLOGY

We selected our samples from the female wards, namely: the Medical, the Surgical, the Orthopaedic, the Gynaecology, and the Antenatal and Post-natal Care units (ANC/PNC). We also selected the Casualty Department, as this is the place where all cases of violence are registered. We did a random sampling of the hospital staff in these departments. The others included in the sample were a social worker, one policeman and the records officer. We took a total sample of 40 people for the interviews, but were able to complete only 31. A few refused to give an interview, and others avoided it.

The final sample consisted of:

Doctors[1] **:**11 **(**4 MOs, 3 lecturers/honoraries, 2 RMOs, 2 CMOs); **Nurses:** 8 **(**Sisters in charge of the above mentioned wards); **Staff nurses** (2) from Gynaecology and ANC/PNC; **Ayahbais:** 4; **Maitranis:** 2; **Social worker:** 1; **Police constable:**1; **Wardboys from Casualty:**2; **Dresser from Casualty:**1; **Records officer:**1

The sample consisted of 14 men and 17 women.

We gave each person a written note on the purpose of the interview along with a short introduction to the Crisis Centre. We explained to them that the information they shared would remain confidential. We also explained to them that we had taken a random sample. Only with their consent did we proceed with the interview.

FINDINGS

The entire hospital staff gave the impression of being casual and matter of fact about the whole issue of violence against women, irrespective of the category or department to which they belonged. Moreover, the atmosphere at the hospital seemed to be clinically oriented and governed by the duties officially laid down. Beyond that, very few individuals went out of their way to explore the issues that underlay a case, and even fewer seemed to do something about it. Each one was clear about his or her role vis-à-vis a patient, which was limited to providing medical treatment in the hospital. Violence was perceived as a social issue by most. However, most acknowledged that it did have health consequences.

---

1 MO Medical officer, RMO- Resident Medical officer, CMO-Casualty medical officer.

Two significant observations were made: (1) the staff perceived domestic violence in a communal perspective, observing it more among the Muslims than among the Hindus, and, (2) staff blamed the women for the battering they received.

ISSUES OF CONCERN

1. Hospital staff identified the health problems of women specific to the wards they worked in. Cases of violence were not cited even by those in the Surgical and Medical wards where such cases are admitted (for example, burns and poisoning cases).

2. Violence was not recognized as a health issue by most of the staff. It was mostly seen as a social issue, at the most having a psychological dimension. Despite probing, all that could be established was the link between physical violence and the physical health consequences.

3. The types of cases of violence cited by the staff were burns, poisoning, assaults (fractures, CLWs, abrasions, etc.), assaults reported as falls, rapes, desire for male child leading to repeated pregnancies / abortions, stabs, bullet injuries, etc.

4. Their perception of the causes of violence were: Demand for dowry, alcoholism, bigamy, infidelity, unemployment, indebtedness, desire for male child, infertility, failure in love, scolding, failure in exams leading to consumption of poisonous substance.

5. Attitudes towards violence among staff:

   Victim blaming: There is a feeling that women are beaten as they may have provoked their husbands or their in-laws.

   "Don't you feel that sometimes a woman has driven the other person to assault her? Ok he is a drunkard, so when he drinks he assaults; you just can't label him for that."

   Women exaggerate their complaints in order to make their case stronger.

   "Many pregnant women complain of being beaten in the abdomen because it makes their case with the police stronger. How come that every pregnant woman gets beaten in the abdomen? However cruel the man be, will he beat his pregnant wife?"

   Women should endure the violence.

   "Our generation was different. We stayed on how much ever our husbands beat us. These days, even if they have 3 to 4 children, they leave them and go. They get another man and leave... They should bear the beating."

   It's not our job.

   "When patients come, doctors take history, but nothing more. What will they do by asking why they were hit? They are only interested in the treatment."

   "They never talk. We don't ask. That is their problem. They should solve it."

   "We generally do not probe into it. We don't take any statement about it, or enquire about who did it and why did it happen." - Doctor.

   Apathy and insensitivity

   "When the patient suffers and there is frothing, the staff says, 'You fight at home and come and harass us... Why didn't you take the whole dose and end your life.'- Administration

   Reluctance to intervene, despite the felt need to do so.

   "We usually don't ask, but if they are beaten we should be asking them. However, we get scared. What if they give us one story and the police a different one?"

Something should be done.

"Husbands who have done this should be given some punishment."

"Yes, they can come to the hospital but they must say something... They must tell the police, who can give "dum" to the husband (that is, warn the husband), and then something can be done."

Biases

There seems to be a feeling that domestic violence is more prevalent among the Muslims and the Bhaiya community.

"We see that wife beating is more common among the Muslims. They have lots of children also. Among Hindus, it is not so common."

Women "may not be physically assaulted but they may be forced to have another child when they don't want one. Husbands' consent is required for the sterilization operation. When women object they are harassed and given more work." - Administration (female)

Boredom

"No, no, who is going to do it here? Here nobody talks. If there is a case, then I do not know, but if the woman says that her husband has done it then he lands himself in the lock-up. I have got bored seeing all this." -

Inherent contradictions

"We don't usually ask,..but if they are beaten we should ask. But we get scared. What if they give us a different story and give the police a different one"/ "They never talk. We don't ask. That's their problem. They should solve it."

"Girls should be educated and made independent before they are married."/ "Working women are aggressive and do not adjust with the family."

"There was this case of a thin, lean woman who was battered by her drunken husband. I told her that how could a drunken man do this, you should not have taken this hands down. This was at 1.30 in the night. At 4.30 a.m. I was woken up by her husband. She had gone home and beaten him up. After that I stopped doing all this." - Doctor

PROCEDURES IN THE HOSPITAL

- Burn and rape cases are seen as serious cases. In a burns case, if the incident has occurred within three years of marriage, it comes under the Dowry Harassment Act. Further, most of the burns cases are transferred to the Kasturba Hospital, as Bhabha Hospital does not have a special burns ward. Only in cases where the prognosis is poor are they kept here.

- In rape cases, seven samples are sent to the forensic laboratory in Kalina, and a four-page form has to be completed. However, as there is little social support, many cases just die their own death. Only when somebody fights on behalf of a rape victim, justice is sought.

- In poisoning cases, the stomach-wash report is sent to a laboratory in Kalina. The police is supposed to collect it within 14 days. In the existing system, poisoning cases are referred to the psychiatrist for evaluation. Some doctors say that they also refer women with mental health problems like depression, cases of trauma because of burns, or where the woman keeps coming back for the treatment of the same ailment.

- Cases that come to the Casualty are examined by the CMO. The injuries that come to the Casualty, whether reported as accidental or deliberate, are entered as Medico Legal Cases (MLCs). The police procedure in case of MLCs depends on the admission status of the patient. If the patient is admitted, then the police constable (PC) on duty records a brief statement, without going into the history. The PC then notifies the inspector at the police station under whose jurisdiction the case falls. The officer from that police station then comes and takes the statement in the ward. Those MLCs that are not admitted, the initiative has to be taken by the injured to get his/her statement recorded at the police station.

- In cases of pregnant women, accidental falls, (even those occurring at the time of filling water), are recorded as MLCs. This is done to protect the doctors "so that if something happens to the baby, the doctor should not be blamed for it", says a sister. As a precautionary measure, they are sent to the labour ward for a sonography.

- The role of the hospital social worker is mainly viewed as an arranger for monetary help, or helping with the adoption of babies of unwed mothers. It has also become evident from the interviews that social workers are seen as part of the management. Further, the municipal setting has its inherent bureaucratic hurdles and poor accessibility. The doctors are concerned about the cost of medicines. They find it difficult to help patients. Moreover, the system can provide monetary relief of about 20 per cent, which is not much of a help to poor patients. The existing procedure to procure such relief for a patient is itself very cumbersome and frustrating, and is often used more effectively by people with contacts, especially with local corporators.

- In cases of unwed, destitute girls, the hospital admits them in the ANC ward till delivery. They are referred to the social worker post delivery for the adoption of the baby, and shelter.

IMPRESSIONS

- We found that it was only the nurses and just one or two doctors who had really gone beyond their role of health providers to help women who were victims of violence.

- There was no distinct difference in responses from male and female staff.

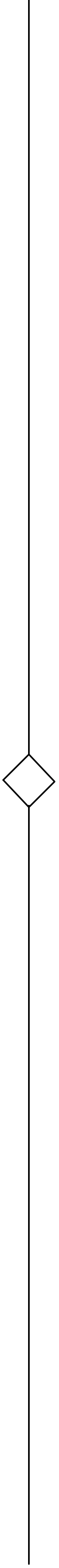
- We had not taken religion as a variable for selecting the sample, which is a limitation of this study. Therefore, all the respondents are Hindus since they are the majority.

- Except the female labour staff, the rest of the staff willingly gave us information.

- The staff did feel the need to help women victims of violence. However, they were neither able to identify the needs of such women nor appreciate their role in helping. They showed willingness to refer such cases to the crisis centre, once it opened.

- Some of them, especially doctors and nurses, showed interest in the training that we proposed to conduct and said that they would like to be part of it.

These studies are part of the formative research done by the Dilaasa team in the initial phase of the project. We would like to acknowledge the contributions of : Dr Amar Jesani for providing guidance and support through the research process, Ms. Tejal Barai Jaitly for data collection, data management and writing for "Indepth interviews of hospital staff" and Ms. Rekha Kale for data collection for "Observation at Casualty".



MODULE - I

DOMESTIC VIOLENCE - An Orientation

DATE	OCTOBER 20TH AND 21ST, 2000 (One-day session for two groups)
TIME	11.00 A.M. TO 4 .00 P.M.
TRAINER	MANISHA GUPTE RADHIKA CHANDIRAMANI (Participant Observer)

OBJECTIVES

- To get the group to break the silence around violence.
- To introduce the concept that domestic violence is a public health issue.
- To share information about *Dilaasa* as a hospital-based project.
- To motivate the group to become key trainers.

INTRODUCTION

i) Getting to know each other

As the trainers did not know all of them, the members of the group introduced themselves individually. The two trainers also introduced themselves and told the group about the role that they were expected to play in the setting up of *Dilaasa*.

The name *Dilaasa* means 'empathetic and comforting support'. *Dilaasa* is not there merely to solve people's problems but to create a support structure in which the victims can find answers to their own troubles. The project was started as a cooperative venture between CEHAT and the Bhabha General Hospital of the BMC. This was a novel experiment to see if an NGO could work from within a government structure, rather than from outside it. The CEHAT team would help set up the structure, as well as provide training and research support. However, they would move out of the hospital after three years, and *Dilaasa* would be permanently integrated in real terms within the hospital, as it would then be managed and owned by the hospital staff themselves.

ii) Rationale for selecting 'key trainers', and role expectations

After this brief introduction, Manisha explained to the group the entire process of selecting 'key trainers' from within the hospital. The key trainer group consisted of doctors, matrons, nurses, social workers, para-medical staff (occupational-therapist and physio-therapist, clinical psychologists) as well as non-medical staff such as a librarian. All the key trainers had been identified by the Medical Superintendent, the criterion for selection being the high motivation level of the individuals. These key trainers were expected to go through a series of perspective and skill-building exercises in the first year, after which they would train the rest of the hospital staff.

iii) About the methodology

Everyone was requested to use the language that they felt most comfortable with - Hindi, Marathi, or English. The methodology of the entire training would be participatory - using discussions, role play, case-studies and games, as training methods, rather than using traditional methods such as lectures. The trainer would be more of a facilitator than a 'teacher'. No judgement would be passed on anyone for his/her belief system. The group would be open to new ideas and would be encouraged to challenge our world-views, and would maintain the right to disagree with each other on any issue. Everyone, including the trainers, would be ready to learn from each other. Cooperation, rather than competition, would be encouraged.

LEARNING TO TALK ABOUT VIOLENCE

- This part of the session was conducted through an activity. The group was presented with a box of chits. On each chit was a name that matched with some other chit in the box. Each one had to find her/his partner from within the group. The names that matched were, for example, diabetes and pancreas, or anaemia and iron.
- The participants enjoyed shouting out their own names and searching for their partners. This exercise was used as an icebreaker, initially to get the group to interact freely with each other as well as create a relaxed environment conducive to discussing violence. The nurses were the first to break the ice and the doctors followed. The male doctors seemed to feel a little left out and stood on the fringes for a while, but the nurses and matrons walked up to them and peeped into their chits to find the match. This game temporarily suspended the hierarchy of rank and set the tone for the day in which all participants would feel equally free to speak their minds.

The process documentation of this session has been done by the resource person herself.

- Once everyone had found his/her partner, each pair was given 10 minutes to share with each other the following details: an act of violence that had been committed on them, and one that they had committed on someone else. Within each pair, these experiences were presented by one partner on behalf of the other. The group was cautioned not to share any such incident that they might feel uncomfortable about later on. Since the presentation of the incident was going to be in public, the group was also reminded that protecting the confidentiality of the shared incident was not possible. At the same time, the group was requested not to discuss the incidents outside the room in any way that would reveal the identity of the person or to use the information against anybody later on.
- One or two participants were unable to share any incident with their partner. This fact was gracefully accepted. Two participants said that no such incidents had taken place in their lives. The others had talked about incidents, mainly related to the workplace, and at times related to their homes. At the workplace, when people spoke about the violence committed on them, they mentioned harassment by superiors, discrimination, overwork, favouritism, and so on. At home, the group mentioned being scolded by parents or siblings in childhood, alcoholism, and beating by father, grooming by parents that was gender-biased, feeling blamed for the death of a loved one, control of earnings by husband who was uncooperative and suspicious, not being allowed to meet one's own grandchildren, and so on. People also spoke of emotional pressures, such as feeling overburdened physically, psychologically, and financially, as acts of violence committed on themselves.
- The list of acts of violence committed by oneself on others was mainly related to the domestic realm. The list mentioned taking out one's frustration on children, beating a younger brother in childhood, neglecting one's child, inability to care for a daughter because of work, scolding and nagging children, fighting with one's spouse because of differences of opinion regarding the care of a daughter who is depressed, and so on. At the workplace, people spoke of not being able to concentrate on their work because of other pressures and then feeling guilty about it and not being sensitive to patients in the hospital because of overwork.
- The trainer then tried to sum up what was shared. She spoke of comfort levels that one felt while talking about violence. Talking as victims precipitated feelings of anger, humiliation and pain, whereas talking as perpetrators made them feel uncomfortable, reluctant, guilty, and relieved as well. She drew the group's attention to the fact that when one felt inhibited to talk about violence in general terms, then how could one expect women who are victims to confide the violence in their lives in a big hospital setting unless one made it accessible and approachable, comfortable, trustworthy and caring.

UNDERSTANDING VIOLENCE AGAINST WOMEN

The trainer used the earlier discussion to draw the attention of the group to the following facts:

- 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 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 frustrations 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 as well. 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, people physically or mentally challenged, 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 husbands in their dying declarations. One needs to question the belief system in which 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 one 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.
- It is not true that violence occurs 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's 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 one has the right to argue out one's differences. However, there should be mutual respect among people when they raise points of difference. Insulting, humiliating, ridiculing, being judgemental, 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. Once one gets used to humiliating people, one is in danger of becoming violent oneself.

- Violence is an act committed to put down someone, to silence her/him, to keep someone under control, and is carried out with the intention of hurting or humiliating her/him. The victim loses self-confidence and feels helpless and lonely. Violence breaks her/his spirit. She/he begins to hate her/himself and even begins to think that she/he deserved that treatment. This is true of people who get tortured, as well as with women who live in violent homes.
- Violence need not be only physical; it could be emotional, verbal, financial, sexual, social or political. It could also be a combination of all these. For example, women are often raped during a communal riot. This could be done with the intention of insulting men from the other community or religion. Neglect is also a form of violence, especially if the other person has no access to resources. This would include keeping a wife or child hungry, taking away money from the wife, and so on.
- One is often told that women are women's worst enemies and that it is the mother-in-law who harasses her daughter-in-law the most. As mentioned earlier, violence is an act of silencing someone who is powerless. In the case of the mother-in-law, she is more powerful than the daughter-in-law. Why? Because she is the mother of a married son. Is it possible for the mother of a daughter to beat, insult, or kill her son-in-law as easily? Therefore, what matters is whether you are the mother of a married son or a married daughter. Your status increases in the first case and decreases in the second. Women rarely get power on their own - it is only through men that they gain or lose power. If a woman is not married, has no children or has no son, or does not live with her husband, she loses power in society. If her husband is the earning member in a joint family, she has more power in the joint family, whereas if he is unemployed, her status falls. Because women have no power on their own, they stick to the men in their lives, sometimes at the cost of sacrificing their other rights, their health and their life. One needs to teach them to stand up for their rights too.
- Often people ask why we only talk of violence against women. They say that women are also capable of violence and that men too can be victims of it. Certainly, this can happen in some situations and one has to be sensitive to any man who has suffered violence - whether it is physical, verbal, emotional, or sexual. We at Dilaasa have opted to work with women who suffer violence because of several reasons. Firstly, the proportion of violence against women is much higher than that against men. Secondly, women are conditioned not to speak about domestic violence or rape. This results in these crimes being unrecorded and unquestioned. Thirdly, men have more access to resources, such as private doctors and lawyers, as compared to the women in their homes. This is why we need to stand by those who do not have such access. Fourthly, even if women as well as men can be capable of perpetrating violence, the material consequences of it are far greater for women than for men. Women live under the threat of being thrown out of the house, of losing custody of their children, of losing social status, of not having the privilege to marry again, of being disinherited by their fathers, brothers, husbands, or sons, or even being killed by the family. Fifthly, as long as assets and resources belong to men in society, women will continue to be more vulnerable to violence than men. We need to change this system that encourages an imbalance of power between the sexes, and which breeds discrimination. One way of doing that is to work with women who have suffered violence in their lives and create confidence in them so that it is possible for them to think of a better life and fate. We plan to do this in Dilaasa.

WHY IS VIOLENCE A PUBLIC HEALTH ISSUE?

The trainer asked the participants this question and a lively discussion emerged. She facilitated the discussion and rounded it up by mentioning the following issues:

- Violence results in injuries, bruises, fractures, burns, vaginal tears, psychiatric problems, miscarriages, and so on. This happens to many women. Therefore, it is not a personal matter limited to a few individuals in society. Studies have shown that the health consequences of violence are horrifying, and exist all over the world.
- One of the largest killers of women in the reproductive age group in India is violence. Burns, poisoning, knife assaults and abetting suicide are some of the ways in which women are killed within the family.
- Violence results in long-term physical and psychological ill health. The health effects range from low-birth-weight babies to anaemia, from depression to suicide, from vague bodily complaints to severe illnesses such as pelvic inflammatory diseases, from repeated abortions to chronic pain syndromes, from unwanted pregnancies and unsafe abortions to HIV/AIDS,

from pregnancy complications to maternal mortality, from memory loss to heightened anxiety, from fear of sexuality to low self-esteem... The list is endless.

- Ill health and disclosure of illness increase the element of violence in women's lives. Women with tuberculosis, mental illness or HIV/AIDS are likely to be thrown out of the house, and therefore they are reluctant to disclose their disease to their families or get their illnesses diagnosed. If a woman has white discharge, she may be accused of sleeping with other men; if she repeatedly falls sick, she may not get medical attention. Thus, women are more vulnerable to illness because of their low status in society, and low access to food, rest, and recreation. This, in turn, increases the probability of violence in their lives. A vicious circle is thus set in motion.

- Women's access to health care is very limited. A married woman has to depend on her husband and mother-in-law to accompany her to the hospital, to make decisions regarding her treatment, and to pay the bills. A woman's access to grievance redressal, such as the police and the courts, is even lower. The consequences of speaking out are very grave for a woman, and therefore to survive, she has to stay silent. On the other hand, this very silence ultimately kills her.

- Even if a woman's bruises or fractures do not match her account of the accident, such as falling down the stairs, the doctor will rarely ask questions to probe the incident or seek answers to the discrepancies in what the woman says and what she suffers. No one wants to be involved in other people's personal lives. Most health professionals want to avoid being called into the courtroom as an expert witness. Often, the professionals themselves have traditional ideas about domestic violence, and they may have unresolved issues in their own lives that block their sensitivity to such cases.

- People in the health care delivery set-up are not trained to look at domestic violence. Often doctors are not aware of how to preserve evidence in the event of a rape, or how to present forensic evidence in a gender-sensitive manner. They are not taught to look for clues that may reveal domestic violence, or to see beyond their specialities when women come to them. Therefore, a gynaecologist and psychiatrist will look at the woman independent of each other, rather than as a team. A multi-disciplinary approach is extremely necessary to understand the complex picture of violence, especially domestic violence.

WHY *Dilaasa*?

- The trainer revisited the fact that women, especially if they are living in violent homes, are afraid to talk about their problems. They may have many fears - will the doctor believe my story? will my husband get to know? will confidentiality be maintained? what will the consequences be? will the police take away my husband? where will I live if he throws me out? will my brothers understand? do the doctors and nurses think that I deserved the treatment? do they think I'm stupid for putting up with it for so long? how can I talk in such a crowded room? will the male doctor take advantage of my domestic problems? how can I show the bruises on my inner thigh to anyone? how can I talk about the knife cuts inside my vagina.... Let us imagine ourselves in this situation. Would we be able to talk unless we were sure of receiving support?

- *Dilaasa* is about creating this support for women, so that they can speak out. Speaking out is the first step towards questioning the violence in one's life. Therefore, one has to create an environment where women will speak out. For that to happen, one has to learn to listen. Listening is not the same as hearing. Listening is about understanding, believing and empathising with what a victim or survivor of violence has to say. The next stage is counselling. This will include the skills of active listening, of finding out what the woman wants, of working with her rather than on behalf of her, of not making decisions for her, of not passing judgement on her actions, of ensuring confidentiality, of creating confidence in her about being able to handle her own problems and her life, and so on. All these skills will be imparted to the key trainers and to relevant persons in the hospital over the next one year. We also need to work on our belief systems, question some of our attitudes, increase our comfort levels about sexuality and other issues related to women, and grow along with the women who come to us for support. While the formal training will last over a year, the learning process will go on forever, because we have to constantly learn and update ourselves about new issues and concerns.

- At the level of the hospital, we need to create a system of multiple referrals so that a woman who needs urgent help will not be neglected, and that the hospital sees violence against women as a complex, rather than a fragmented, issue. In the beginning, we will concentrate

on the Casualty wards and on the medico-legal cases, but we will soon move on to other relevant departments, such as, Psychiatry, Gynaecology, Obstetrics, Paediatrics, Burns, Orthopaedics, and so on. After that, we will gear up the out patient department (OPD) to look at 'general' problems and find the links to domestic violence if it exists in the woman's life.

- It is not possible for a single organisation or hospital to tackle a multi-dimensional problem such as domestic violence. We need to establish a strong network with other groups working on this issue - crisis shelters for women, legal support groups, helplines, counselling services, women's organisations, the police, and the courts. We will draw support from each other and pool our skills in such a way that women's access to the relevant services will be maximised and expedited.

The following services will be offered within *Dilaasa*:

1. Emotional and social support
2. Legal support
3. Referral to a shelter and other agencies, if required
4. A 24-hour emergency shelter within the hospital

BECOMING KEY TRAINERS

The trainer then asked the group if they were interested in continuing with such sessions and whether they felt the need for participating in the training of the hospital staff. The group's response was extremely enthusiastic. Some participants mentioned that they had come to the training only because they had been directed to do so, but after this day's orientation, they were enthused and convinced that they should participate in *Dilaasa's* activities. Some others said that they had always felt helpless when women came to the burns ward and died without telling the truth, but now they felt they would be able to do something about it. A few people said that in the beginning they could not understand how they were concerned with the issue of violence, but now they had started seeing the connections between their work and domestic violence. In fact, this understanding would help them wherever they worked - the Casualty, the library, the administration/accounts, the various wards, and in the OPD. The male participants were unsure of their role as trainers, but they would be happy to participate in Dilaasa's work to the extent they could. The entire group expressed the need for continued and intensive training to be able to carry forward the training process, and requested the *Dilaasa* team to work out duty hours with the hospital management.

The key trainers would attend sessions in two groups, so that hospital duties would not be adversely affected. The two groups were formed and they were encouraged to name themselves. Through an exciting process of selection and elimination, the groups came up with the following names: Prerna (inspiration) and Pragati (development or enhancement).

MODULE - II

GENDER

DATE	NOVEMBER 27TH AND 28TH, 2000 (One-day session for two groups)
TIME	11.00 A.M. TO 4.00 P.M.
TRAINER	MANISHA GUPTE

OBJECTIVES

- To create awareness about the difference between sex and gender.
- To sensitise participants about the manifestations of gender.
- To create awareness about patriarchy and power relations.

PROCESS

The trainer did a short recap of the earlier session on 'Domestic Violence–An Orientation', and asked the participants if they had any questions or comments on that session. After a short discussion, she explained the entire agenda of the sessions on Gender and Sex.

The first session began with a game. The participants were asked to form a circle and the trainer read out the following statements one by one. Some of these were related to biological sex and the others to social influence. The participants were requested to step inside the circle if they felt that the statement was related to biological sex, and step outside if they felt it was related to social conditioning.

The statements used in this game were 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 get bald, as they grow old.
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 at marriage.
22. Women bear children.
23. Men earn more than women do.
24. Women's names change after marriage.
25. Women breast-feed their children.

The process documentation of this session has been done by the resource person herself.

The game generated a lot of laughter and arguments. Half way through the game, heated discussions took place. It was observed that the participants agreed on statements related to anatomical traits of men and women, but had a range of different views when it came to statements on social conditioning. The most amusing statement turned out to be 'Women have long hair'. A number of participants jumped inside the circle, suggesting that this was a biological trait, and were teased to no end by others!

The game was followed by a discussion on each statement. The discussion brought out that primary and secondary sexual characteristics were the only 'real' differences between men and women. The trainer reiterated that except for the fact that women bore children and breastfed their new-borns, there was no big difference between the sexes. The rest were socially created. Sometimes one feels that some characteristics are specific to men or women. Gender becomes such an integral part of one's life that one cannot often differentiate between a biological trait and one that is socially constructed.

In the **second session**, the trainer used the following situations to explain how gender shapes our lives. She got the entire group to participate in the questions and answers asked below:

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 go to visit them in the hospital. They are wrapped in cloth from below the neck. Can we make out the sex of the children? No, because the sex of infants can be found out only through differences in their external genitals. So, when can biological difference show that Munna is a boy and Munni is a girl? Only at puberty, when secondary sexual characteristics develop. However, in reality, do we need to wait so long to find out the difference? No, because the clothes they wear, the hair they keep and the way they behave are different for both from early childhood. Many believe that this difference in behaviour between boys and girls is 'natural' because it comes so early. Therefore, let us look at another situation to explore whether this is true.

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? She doesn't. 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, and 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? We decide that. *'Because'* Munna is a boy, he is expected to wear a shirt and not a frock. Where do these expectations come from? They come from society, not from the children's natural desires. Therefore, society determines the way in which boys and girls dress up, the manner in which they keep their hair, and so on. Next, 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, not to... not to... not to...The list never ends. This social influence is called the social construction of gender. This begins around the age of one, and by the time the children are two or three years old, they get to know their gender. Later on, when they notice their own external genitals as well as that of others, they get to know of their biological differences. As the children grow up, gender begins to play a bigger role in their upbringing. Let us see how that happens.

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, bats and balls, planes, guns, mechano 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 with the kitchen set for Munni. What are the ramifications of these presents for the children?

SITUATION 5

Munna plays with the bat and ball. Where is this game played? Out in the open, away from home. Therefore, Munna gets a chance to go out, to learn to cross a road, to learn to negotiate with children of his age (or even older children, when they snatch his toys); he gets 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 they begin to involve him in decision-making too.

On the other hand, Munni plays with the doll and the kitchen set. Where is this game played? Inside the home, in the kitchen or in the corner of the living room. What is the script used when she's playing? "Feed the baby", "Kiss the baby, it's 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! In reality, we are inculcating in her the values of motherhood and wifehood. We are creating a future homemaker, instead of letting her play and enjoy her childhood. This is the reason why women are considered to be better parents. We sometimes also believe that women are naturally more gentle. This is not true. Gentleness (which is a good quality for both men and women) is expected more of a woman, so we train her to be like that. If a woman does not like to cook, or does not want children, or is not a good homemaker, she is ridiculed and ostracised. She dare not say that she does not like children, because she will be labelled 'abnormal'.

All this while one may be wondering why we are making such a fuss about toys. If the twins enjoy their respective toys, why should we read so much meaning into their play? What happens if the children refuse to play with the toys that we gave them?

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?" 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 take them 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? A look at another situation in their lives will throw some more light on this matter.

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 in a good restaurant. He has a decent salary. Munni's fiancé is a dress designer and designs clothes for a boutique. He also has a good annual income. The dowry from Munni's parents will help him put 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? What we assume to be 'natural' differences between men and women are actually gendered and based on economic returns. Women cook, clean, and mend—mainly for the family, free of cost; but men cook, clean, and tailor only when the returns are economic. Even if women are considered excellent cooks, they have no place in the food or hotel industry, where 'masculine' characteristics such as competitiveness, the ability to conduct negotiations, or undertake financial transactions on a large scale are involved. Women's lives thus revolve around the men in their families: obeying fathers or husbands and raising sons who will, hopefully, provide for them in old age. On their own, they do not own assets, nor will they have adequate access to resources such as education, health care or credit.

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 of course through religion and culture. It is not possible for us to work at all these levels, but we can at least make a difference wherever we can – within our homes, in the hospital with our patients, and in our workplace with our colleagues.

GENDER AND SEX

The trainer then spoke of the differences between biological sex and gender. Biological sex is what we are born with and gender is what is created later on. In fact, even biological sex is so gendered that we force every newborn into the strict category of 'male' and 'female' even though 13 per cent of all new-borns are intersexuals. Imagine a scene in a hospital like ours. As soon as a baby is born, everyone wants to know if it is a boy or a girl. The weight or height of the baby can be disclosed later, but the news of the 'sex' is expected within minutes. Before the 19th century, the religious authority (the priest, for example) conferred the sex of babies whose sex was ambiguous. Later on, lawyers took over. Then came the doctor, especially the surgeon. Not only could he announce the sex of the baby, he could also 'fix the problem' by using his scalpel. "The penis is too small, less than two centimetres. May be it is actually an enlarged clitoris, so why don't we just shape the external genitals as that of a woman?" would be the logic. Arguments took place on whether the baby was a true hermaphrodite or not. In fact, with the advent of surgery, intersexuals and hermaphrodites have been made to disappear because they are operated upon. Parents of intersexual babies are hardly given a chance to meet parents of similar babies, or to postpone the decision of changing the child's sex after puberty with his/ her consent or in accordance with his/ her wishes.

Soon after the surgeon, comes the geneticist who checks for X and Y chromosomes. Beware if someone has an extra sex chromosome! Then comes the endocrinologist, who checks for hormone levels. While this discovery may be important to some people, it actually suppresses the diversity of biological sex. We make intersexuals invisible by stigmatising them. What 'sex' are intersexuals supposed to write when every official form has only two sexes mentioned on them? We are so obsessed with gender roles that we actually change what is natural in order to fit them into socially-constructed stereotypes.

Having said this, and having resigned to the fact that most people belong to the two dominant biological sexes, the trainer elaborated on the differences between biological sex and gender. Biological sex remains constant over time, culture, religion, geographical regions, and so on. For example, it would be possible to identify the sex of a 5,000-year-old Egyptian mummy. An African woman and a Caucasian woman would have the same sexual characteristics. However, this is not the case with gender. Women will dress and behave differently depending on their culture, historical time, religion, caste, class, and age. Gender roles change for men and women over time. This is clearly evident in the changing roles of fathers and their attitudes towards their children. Two generations ago, children could hardly pluck up courage to face their fathers, leave alone have a conversation or an argument with them. Today we find fathers more interested in and engaged with their children. One often sees young fathers carrying their babies in their arms, or playing with their children, and sometimes even insisting that their daughters get a good education. This clearly indicates that gender perceptions change. Most importantly, it means that gender *can be changed*. This is heartening, because it is not biology that oppresses us but socially-constructed gender.

Gender is man made; it can be dismantled by us if we wish to do so. Therefore, rather than perform sex-determination tests to avoid giving dowry (which is gendered, based on greed, and the belief that men are superior to women), we should abolish the dowry system itself and let girls be born. We are not against any category of biological sex, but against the belief that one sex is superior to all others. Gender is the result of adding or subtracting social value to biological sex. We need to challenge this discrimination. In the long run, it is easier to change gender than to change biological sex, so why don't we begin work on this rather difficult (but not impossible) job right away?

In the **third session**, participants were requested to form two groups. Each group was given half an hour to discuss one of the following case studies:

CASE STUDY 1

Asha has been nominated by her organisation to give a welcome speech, as she has been very active in organising this important meeting. This is her first public speech and she has prepared well for it. Her husband is a *gram sevak* who works in a neighbouring village. After he leaves for work, their son begins to vomit and feels feverish. Asha has to cancel attending the meeting since there is no one to look after the child. She rings up the office and excuses herself.

Points brought out by Group 1

- Lack of communication between the partners.
- Asha had to sacrifice her career. This meeting was her first break. Because she let down her office at the last moment, it may not rely on her thereafter nor give her an important assignment that entails responsibility.
- She could have asked her husband to look after the son or she could have taken him with her.
- Had she been in a joint family, she could have left the son with some one.
- Household work and the care of children has always been a woman's job —unrecognised and unpaid.
- Women continue to struggle inside and outside the home, without supportive structures.

The trainer used the above case study to explain that even if Asha had lived in a joint family, or in a supportive neighbourhood, only the women from these structures would have looked after the child, not the men. Household duties are always considered a woman's primary responsibility, not her job. Whereas for a man, his job is his primary responsibility, not household work. She also pointed out that Asha's husband did not feel the need to accompany his wife to the meeting and encourage her on her organisational skills and speech. If he had been asked to give the same speech, he would have expected Asha to prepare his food, wash and iron his clothes, look after the child, and so on. Because women are expected to sacrifice their careers for the family, they are not taken seriously at the workplace. This affects their chances of upward mobility.

CASE STUDY 2

Pushpa works in a hotel. She has a sister who works in a bank. Her brother is jobless. He is very upset that his sisters work and that he is unable to bring home any money. He doesn't like Pushpa working in the hotel, but he cannot stop her from working because of the financial condition. Once, while Pushpa was coming back from work at night she was followed by three men. When she confronted them, they abused her and called her a prostitute. She narrated the incident at home, but her brother asked her not to reveal it to anyone. He said that he would take up any job that came his way to earn something for the family, and that Pushpa would then have to leave her hotel job, as it was not a good place for women to work in.

Points brought out by Group 2

- She should have physically retaliated and questioned the boys who followed her.
- She should try to reschedule her work timings.
- Transport facilities should be offered to women who work on night shifts.
- She could be helped by some organization if she wanted.

Through this case study, the trainer discussed how spaces get defined for men and women. She also explained how society views women who come out into public spaces, especially at night. She spoke about the brother's insecurity and his double standards regarding the jobs of his two sisters. Her brother had no right to stop her from working. Why did he disapprove of her job, and not of the other sister who worked in a bank? The trainer also talked about men's control over women's sexuality. Pushpa may be the first one to be harassed by the boys, but does that mean that they would not harass her sister, who has a daytime job? We should not let a divide and rule policy to break our connections with other women by labelling them as deviants. Women have the right to be out whenever they please. It is the men who need to learn to respect women. Violation of anybody's rights can never be justified.

Is gender good for men?

After the discussion on men's and women's roles in society, the trainer explained that gender is a problematic issue for both boys and girls. Both are coerced into living up to society's expectations of the roles assigned to them. Women faced abuse, violence, desertion, and even death when they do not conform to their gender roles. People have little sympathy for women who are inefficient in house work or when they are childless. Does this mean that men can transgress their gender roles easily? That is not the case at all. In fact, women are grudgingly allowed to take on men's roles if they become very insistent – such as becoming pilots, wearing pants and shirts, cutting their hair short, or earning salaries. However, men are never allowed to dress like women, to wear make-up, to grow their hair, or to prefer housework instead of a job. Society gives more value to being a man; therefore, women are sometimes forgiven if they want to be like men. As long as women do the jobs that are expected of them (such as being good mothers and wives), they are allowed to take on additional responsibilities that men are expected to shoulder. However, if a man wants to behave like a woman, society punishes him severely. Other men would beat him up on the street, he may lose his job, he may be called a homosexual (there is absolutely nothing wrong with being homosexual, but there's a problem when this term is used in a derogatory manner to humiliate men), or he may even be killed in order to teach other men, who may be garnering such wishes, a lesson.

Thus, when we work on gender issues, we do not work against men. All men and women come out from the same space – our wombs. We are not against a male child being born, but we are concerned about the way in which he is raised. This concern applies to the girl child as well. We are worried about the way our little boys are made to grow up into tough, violent men and how girls are raised to accept violence and suffer silently. Thus, we are not against biological sex, but against the social construction of gender. We want a society where no one commits violence and no one accepts such acts.

To use an analogy, men are like racehorses and women are like carthorses. Because so much money and power is associated with racing, men are treated with great value. They get better food, more privileges, quicker health care, and more opportunities so that they can perform the roles expected of them –become bread earners, earn more than the neighbours earn, and become socially and politically powerful. Men do not have the freedom to say that they will not earn a living, but write poetry instead. On the other hand, women are trained to do housework and child rearing from an early age. They are not given the same opportunities as men are, resulting in women getting jobs that are pay less or not getting a decent job at all. Women are expected to do unpaid work at home or on the family's field. Moreover, for work on others' fields they are paid less than men are even if they do the same work that men do. They are like the under-fed, beaten, ill-treated carthorses that draw weights until they drop dead. They never retire and have no 'leave' from housework all their lives.

Because so much social value is given to men, they are expected to perform and compete with other men all their lives. If they lose out like racehorses, they are dumped (racehorses are often shot dead when they stop winning). No one wants to invest in a losing horse. The point is that neither men nor women are free in a gender-based society. Both run for someone else and not because they want to.

If the above logic is true, then why is it that when we talk of gender we talk mainly about women? This is because men get privileges in a society that puts a premium on masculinity. It is therefore difficult to convince men about the disadvantages of gender. Women, however, perceive the disparity and discrimination of gendered roles faster, as they are subjected to violence and face severe consequences within and outside the house because of these roles. We therefore have to begin to work with women and create safe spaces for all women to speak out, without forgetting to work with men as well. Firstly, unless men (such as fathers and husbands) cooperate, it will be difficult for most women to realise their dreams. Secondly, men will not be doing women a favour by helping them to change society – they will be liberating themselves too.

In the **fourth session**, the trainer identified the root causes of women's subordination. She pointed out that people often believe that discrimination against women or violence against them exists only in 'bad' homes. They say that most homes are happy and that no inequality exists in good homes. The trainer said that one would need to address these beliefs if one has to convince society about gender and discrimination.

She started the session by asking the participants the following questions:

- On whose name is the house, usually?
- On whose name is the field?
- Whose name do the children get despite coming out of a woman's womb?
- Whose name does a woman take on?

She then explained that in spite of homes being 'good' to women, the assets and resources usually belonged to men. Women's production, reproduction and sexuality are also owned by men. Thus, it isn't just a small matter of changing bad homes into good ones, but there is a need to identify the root cause of women's subordination. As long as the ownership of homes, fields, children, and women belonged to men, one would need to question this power imbalance. The trainer then asked the participants to name the systems that oppress women. Terms such as **male-dominated society** and **patriarchy** came from the group. The trainer then elaborated upon these terms. The fact that our society is male-dominated became evident in the morning sessions. However, what is patriarchy? In simple terms, it means 'rule of the father'. The term is used to stress the fact that not only are resources owned by men, but that they are also passed on from the father to the son – not just from any one man to any other man. Decisions in the home, the community, the society, or in the spheres of politics, religion, or the economy are all taken by men. This power gets transferred from one generation to another through the passage of wealth and privileges to the sons of the family. In fact, over the centuries, this power system has taken deep roots in society.

<u>What's in a name?</u>

The trainer asked the participants to recall the names of their ancestors - names of their grandparents, great grandparents, and so on. They were asked the name of their mother, her natal name, their grandmothers' names, and so on. Most of them could recall the names on the father's side of the family but were not aware of the names beyond two generations on the mother's side. Men's names were remembered more easily because they were mentioned as the middle (father's) name. Women's names, especially their natal first names, or family names were not known. Thus, women were obliterated from the family history, and what was recorded was a long string of men's names. The family property passed down to the names that were mentioned, so one could rightly say that women did not even qualify for this gain. The participants were quite disturbed by this revelation. The trainer then said that 'naming' or deleting of a name involved 'gender politics'. As an example, she asked some participants their full names. She then asked them if they would respond if someone called out to them on the road by a different name. If not, then how did they expect women to take on a different name after marriage? Often, the first name of the woman is also changed at marriage.

Isn't this an act of completely wiping out her identity? The only other places where individual's names are taken away are in prisons or asylums. Isn't taking away or changing a person's name a violation of that person's right?

The problem becomes even more severe when one insists on the father's name for a child. Even though motherhood is a certainty, one insists on giving the father's name to the child for reasons of property and 'legitimacy'. Every person who is born is legitimate – how can the absence of a father decide the right of a person to exist? One cannot stigmatise anyone because s/he does not carry her/his father's name. Children are never born without fathers; it is just that some fathers are irresponsible enough to deny paternity. By denying paternity, they also deny economic rights to their children and sexual partners. In the clinic setting, one has to be sensitive to these issues. Women who do not have a man's (especially husband's) name tagged on to their own name suffer humiliation and violence more than others do. Single, deserted, or widowed women and single mothers must be made to feel comfortable in our hospital. At the same time, we must also change our work environment to make it safe and enjoyable to our women colleagues.

Having spoken about gender and patriarchy throughout the day, the trainer warned the participants not to lose sight of issues of class and caste. Gender is not the only oppressing system in society – rich women have more privileges than do poor men. The caste system oppresses *dalits*. Minority religions and ethnic groups are marginalised in most societies. However, within each community, women are treated worse than men are. That is why the focus was on gender issues in these sessions.

The trainer then gave a recap of the major learnings of the day and answered questions related to the various sessions. At the end of the day, the participants were requested to answer the post-test, which consisted of the same pre-test questions as in the pre test, in order to gauge any changes in knowledge, attitudes and beliefs.

MODULE - III

VIOLENCE AND ROLE OF HEALTH CARE PROVIDER

DATE	DECEMBER 15TH AND 16TH, 2000 (One-day session for two groups)
TIME	11.00 A.M. TO 4.00 P.M.
TRAINER	DR. SEEMA MALIK MS. REKHA KALE MS. CHITRA JOSHI

OBJECTIVES

- To create awareness regarding the role of a health care professional in dealing with domestic violence.
- To train them to care for women patients facing domestic violence.

PROCESS

The session began with an inspiring song "Tu Jinda Hai". It was followed by a brief recap of the previous session. The participants were divided randomly into three groups and were each given a topic.

1. Patriarchy
2. Gender and Sex
3. Gender Sensitisation

These topics were discussed in the last training session, however, it was seen from the post-test sheets that the participants still had confusion about the concepts of patriarchy and gender sensitivity. The group shared what they had learnt in the last session and then there was a discussion on each of these topics.

After the recap, the participants were given case studies to discuss, and then each group made a presentation about the emerging issues and possible solutions to it.

Life Story : Situation 1

Jamuna got married ten years ago at the age of 15. Her husband, a truck-driver, is planning to take a second wife because Jamuna has no son. Jamuna has been suffering from white discharge problem for the past six months, but she has not received any treatment because the health centre is too far away and her mother-in-law will not take her there, saying that the family, which is already poor, cannot afford to treat a useless woman. Perhaps for the same reason, Jamuna's two daughters also get lesser amount of food than the boys do in the joint household.

Jamuna has missed her periods and feels happy that she may be pregnant again, but every one at home says that she is only pretending. Since Jamuna's periods are irregular, she cannot defend herself. Yesterday, Jamuna's friend Phulan, told her that one could detect the sex of the unborn foetus. The test, which is very expensive, is available in the city, 50 miles away from their village. Jamuna's husband will return from his long trip in a couple of week's time. He will then be finalizing his marriage to the new bride that his uncle has seen for him. Jamuna knows that her husband doesn't want to leave her or her daughters, but she doesn't know if she can find the courage to talk to him about her problems. She is losing her appetite, has become irritable, and is also unable to sleep at night. What do you think will happen to Jamuna now?

Possible solutions in Case 1

- State that it is a criminal offence to be married a second time when the first marriage still exists.
- Another choice would be abortion of the unborn foetus as she already has two daughters.
- An observation was made as to the extent to which technology has reached the villages and amniocentesis can be misused by quacks and become a moneymaking racket.

Life Story: Situation 2

Aarti, the second daughter of a family, was married off at 16 to a man whose wife had died a few years ago. Her parents agreed to the marriage since the man, who was

12 years older than her, did not ask for too much dowry. Aarti presently lives with her husband and his parents, and looks after the six-year-old daughter from her husband's previous marriage.

Aarti's stepdaughter, Guddi, is very fond of her. One night when Aarti was putting Guddi to sleep, Guddi told her that her mother had been poisoned and killed by her father and grandfather. Aarti was very disturbed to hear this, but she did not know whom to talk to. When she tried to speak to her husband about it, he got very angry and beat her up as well as Guddi. He threatened to send Guddi to her maternal grandparents and ordered Aarti to refrain from speaking such nonsense. He has also told Aarti that she had better produce a son quickly or she will be in trouble.

Aarti's parents understand her problems, but they do not want to get involved. They say that all marriages have some rough patches; therefore, Aarti should put up with her troubles for a while and be patient with her husband. Aarti thinks she is pregnant, but does not know what to do. What do you think will happen now?

Possible solutions in Case 2

- Make the parents aware of their mistake of marrying off their daughter at an early age
- Make her in-laws more responsible and aware of their mistakes
- File a complaint against the husband and the father-in-law
- Give the daughter proper education and make her economically independent
- Aarti can convince her husband in relation to her pregnancy and they can find a solution together.

In the next session, the group was divided into 4 sub-groups and each sub-group was given two case studies. Each sub-group had to assume one of the following roles: victim, abuser, observer, or health professional.

The case studies were:

1. A woman who faced a homicidal attack, e.g., Rinku Patil who was burnt in public
2. A woman who attempted suicide through poisoning

After the discussion, each group presented/performed the role they had assumed. The trainer noted their response and summed up the activity.

VICTIM

The victim in any of these situations may experience sudden shock, fear, turmoil, loss of trust, feelings of insecurity along with humiliation, low self-esteem, revenge and/or feeling hurt and angry with self for not being able to retaliate. The victim may distance herself or put up a barrier, and avoid communication with the abuser. The victim is also likely to keep the traumatic experience to herself. She may fear recurrence of the incident along with feelings of helplessness due to lack of support from anyone. The victim may also fear the consequences of the act on other members of the family.

ABUSER

The abuser justifies himself of his acts by saying that the victim provoked him and thus blames the victim for the incident; he may be suspicious or jealous of the victim. He may indulge in violence to prove his power, assuming that it is the privilege of a man to do so. It is another way of controlling the behaviour of the victim.

OBSERVER

An observer may feel pity for the victim and anger for the abuser. S/he may also feel threatened when such things happen around her. Conversely, s/he may be sceptical about the victim and may adopt a neutral, or 'non'-involvemental attitude towards the matter. S/he may ponder over the issues that could have caused the incident and comfort herself that every coin has two sides. S/he may even blame it on modern culture and the media. However, in most cases the observer does not wish to get involved as s/he feels that she might be harassed and repeatedly summoned to the police station, though finally justice may never be meted out to the abuser.

HEALTH PROFESSIONAL

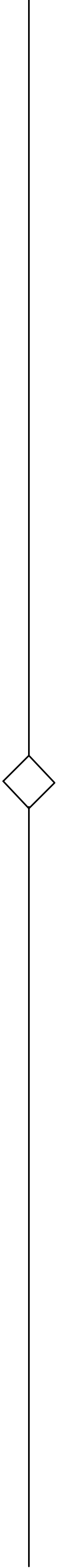
A health care provider observes the issue, and her prime priority is to put the patient at ease. The victim has to feel comfortable. Medico-legal cases should be made after the medical treatment. A health professional may then make referral to take care of the emotional aspects of the abuser.

Other activities the health worker can undertake

1. Write articles in newspapers and magazines, based on medical records, to sensitise people to this problem
2. Make the patient aware of the fact that the MLC can be used to make a police case against the abuser
3. A family physician may try to analyze and find out the reasons behind chronic somatization cases
4. Screening the cases can help women in distress approach the crisis centre.

The trainer pointed out that many of these cases could be prevented if victims are allowed to ventilate the tension, which may be gradually building up. She emphasized that the health professional could play a major role in doing so through the screening of such cases in the OPD; family physicians and paramedical staff too can play a vital role in spotting and directing such victims for appropriate action.

The session ended with participants filling up a feedback sheet and answering post-test questions.



MODULE - IV

COUNSELLING

DATE	MARCH 7TH AND APRIL 4TH, 2001 (One-day session for two groups)
TIME	10.00 A.M. TO 3.30 P.M.
TRAINER	RADHIKA CHANDIRAMANI

OBJECTIVES

- To impart skills required by key trainers to communicate with women patients who report abuse and maltreatment.
- To help them gain an understanding of the concept of counselling, and the principles involved in it.

PROCESS

The trainer began the session by explaining the role of the key trainers in providing emotional support to the woman facing domestic violence. Acquiring these basic skills would help the health care providers to communicate with women facing domestic violence. She also clarified that they were not expected to play the role of a counsellor.

The trainer started the training with an exercise.

The exercise entailed asking the participants to recollect an incident that had upset them in the past. They had to recall the person with whom they had shared this experience and what this person had felt about it. After that, they had to share it with the group. The participants said it had helped them to think of the problem objectively, picture the problem clearly, and reduced the shock of the incident. They felt that there was someone who was willing to listen to them, to help them find a solution to their problem, and to give them the feeling of being understood. However, one of the participants said that she faced criticism when she narrated her problem to someone close.

The trainer added that sharing is a human need, which occurs among people who are close to each other. However, when one tries to solve the problem there is a lurking fear that the other person might be taking it lightly. This could lead to loss of confidence and faith in the person one confides in. There is a need to understand that people share their experiences with their close ones in the hope of support, to unburden oneself, or to understand silence. This is called a helping relationship, which may be of different kinds. It may be in the form of an advice, guidance, befriending or counselling. The difference between counselling and other helping professions was explained.

The trainer explained that Dilaasa is a centre where women are provided with the space to decide for themselves. She briefly introduced the concept of counselling and the role of the Dilaasa team. Listening is a prerequisite in the case of health care providers, which they do every day. However, there is a need to do it sensitively so that women can express their trauma. If not sensitively done, there is a possibility that women may feel they should not have spoken at all. Listening to the patient does not mean offering solutions to their problems, as that would encourage dependency. Women may not even be seeking answers, but merely wanting to unburden themselves.

There is a need to establish a relationship based on trust, which will enable the patients to confide in the health care provider. The counsellor's approach, attitude, body language, and interest shown send unspoken messages to the patient. Hence, it is essential to have professional competence. Every person may differ in these qualities. The counsellor needs to have the capacity to listen, be patient, sincere, non-judgmental, attentive, interested, alert, understanding and trustworthy.

The trainer then asked the participants to role play the part of a speaker and a listener and reverse it. They were divided into pairs and asked to share with their partners a situation that had troubled them. Twenty minutes were allotted for the interaction, after which they shared the outcome with the group.

The participants looked at the exercise as a new learning experience. Some said that they felt good to have shared another person's problem. They could also relate it to their own situations. It was satisfying to feel trusted. It would have been better if they had had more time for the exercise. It was easier to talk to an unknown person than be a listener to someone known. It also revealed that non-verbal behaviour, such as eye contact, non-judgmental attitudes, and other body languages, help the victim to confide in the counsellor.

Women facing violence may come to the hospital with different expectations. Hence, to draw forth feelings of reassurance in them, an attitudinal and societal change is necessary.

It was pointed out that while one could always advise the client to take a particular step, it is always expedient to understand the pattern of abuse suffered by the woman, to allow her to think realistically, and to explore viable solutions with the counsellors. Only when the woman's life is threatened, is there a need to urge her to take specific and immediate action.

After lunch, the participants sang an inspiring song Tu Zinda Hai.

The discussion continued after lunch, which emphasised the importance of "listening" for health care providers was emphasised. It was pointed out that women may be hesitant to talk about family relations, sex and violence. Women often feel ashamed to reveal the abuse suffered or they may be reluctant and fearful about betraying the family name. In such cases, it is important to be non-judgmental.

One of the nurses narrated that a sex worker was reported to have been raped by five or six people and was brought to the hospital for treatment. The woman, being a sex worker, suffered derision to her complaints even from the police. If this be the kind of treatment meted out to them, they will refrain from seeking help for fear of being insulted and discriminated against. Hence, it is essential to restrain personal views that may hinder counselling.

Certain important principles of counselling were shared with the group. It was stressed that lending a patient ear was an important aspect of counselling and the woman's need to be silent should be understood and respected by the counsellor. One must not interrupt this silence as this would disrupt the patient's flow of thoughts and she may be led to feel that, you, as a counsellor, were not competent enough to deal with her feelings. The participants were also told that asking a question was an art, and examples of both open- and close-ended questions were given. It was reiterated that the counsellor should ask open-ended questions, which will encourage the woman to talk.

No pre- and post-tests were administered for this training.

MODULE - V

ROLE OF TRAINER

DATE	FEBRUARY 26TH AND 27TH, 2001 (One-day session for two groups)
TIME	10.30 A.M. TO 4.00 P.M.
TRAINER	RENU KHANNA

OBJECTIVES

- To understand the principles of adult learning.
- To help participants gain an understanding of the different methods involved in conducting a training session.

PROCESS

The training began with an inspiring song that made the group feel more involved. Immediately after the song, the participants were asked to play a game by forming pairs.

This was a demonstration of an introductory game that participants could use as trainers.

Participants were asked to share with their partners adjectives that described each of them. The adjectives describing each partner should start with the first letter of his or her name. They were also asked to describe one activity, which was typical of their gender that they liked to do, one which was typical of their gender but they hated to do, and one which was atypical of their gender but they liked to do. The time allotted for this sharing between the partners was 10 minutes.

For example, one participant stated that his partner Pradnya wanted to be called 'Pretty Pradnya'. She liked to cook which was typical of her gender, hated to clean utensils, an activity considered typical of her gender, and liked to travel alone which was atypical of her gender.

The trainer summarised all the qualities that had emerged from the sharing, and which are listed below.

Typical of gender (Like to do)	**Typical of gender (Do not like to do)**	**Atypical of gender (like to do)**
Partying (M)	Looking after children (M)	Cooking (M)
Loves to cook (F)	Washing dishes (F)	Household work (M)
Looking after children (F)	Washing clothes (F)	Repairing electric gadgets (F)
Hosting parties (F)	Cooking food (F)	Making decisions for the family (F)
Looking after the family (F)	Wearing conventional clothes (F)	Camping and Army activities (F)
Decorating the house (F)	Others taking decision for one self (F)	Outdoor games (F)
Reading news paper (M)	Stitching (F)	Travelling (F)
Playing outdoor games (M)	Knitting (F)	Travelling alone (F)
Arranging flowers (F)	Partying (M)	Partying in the night (F)
To help people in their difficulties (F)	Discussing politics (F)	Professionally aspirant (F)
To talk less (F)	Household work (F)	Providing financial support to the family (F)
	Gossiping (F)	short hair cut (F)
	Cleaning the house (F)	Looking after the family (M)
		Cooking (M)
		Reading (F)
		Leadership qualities (F)
		Spend time relaxing (F)
		Higher education (F)
		Boxing (F)

At the end of the sharing, the trainer stated that this exercise had brought out new facets of each participant's personality. The participants became more aware of how each had been socialized to fulfil gender roles as men and women. They also discovered those aspects of their personalities that they were not allowed to develop or even talk of. They realized that social norms did not permit certain things because of the way society had defined the roles of men and women.

In the introductory session, the facilitator also pointed out that the learning that occurred during the training needed to be extended to the rest of the hospital staff. Hence, the participants would need to take on the role of trainers. This would involve drawing up a 'sensitization programme', which would include understanding the objectives of Dilaasa, as well as gender issues. The trainer elaborated upon the skills needed by a facilitator, including the use of verbal and non-verbal communication skills combined with a thorough knowledge of the subject.

After the session, the trainer divided the participants into three groups, and each group was subsequently asked to review the three previous training workshops. Each group was given handouts (See the section "Reference Materials") They were allotted different tasks. The time assigned for the preparation of the presentation was 15 minutes.

GROUP - 1

Review the three trainings sessions along the following lines

- Topics covered in the training sessions
- The training methods used
- The learning that occurred during the training.

In their presentation, the participants explained that in the first training workshop on gender and domestic violence, the training methods used had been picture drawing and small-group discussion. The topics covered were types of violence and definition of domestic violence. The specific learning targets of the participants were: (a) sensitivity to basic rights, and (b) knowledge on the issue of domestic violence.

The second training workshop covered the concepts of sex, gender and patriarchy. Songs, games, small-group discussions, case studies and lectures were some of the methods used. Participants learnt about the differences between the concepts of sex and gender, and about women's rights.

The third workshop covered the topic of violence against women and the role of health care providers in addressing it. The methods used were case studies and group discussions. The participants acquired knowledge of the ways in which the health care providers could help the survivors of domestic violence when they entered the hospital setting.

GROUP - 2

List the methods used in the three training workshops

- Read the handouts on Methods Used in Training (Handout No 5 from section "Reference Materials")
- Review the three training workshops in the context of the methods used

The participants reported that the methods they found most useful in all the three training workshops were 1) small-group discussions, 2) role-plays, 3) songs and games. The first helped the participants to share their ideas, views and experiences on the given subject. It also helped them participate more effectively. The participants were of the opinion that the small-group discussions employed in the first and second workshops contributed in creating a friendly atmosphere, as it enabled the participants to express their ideas freely.

Role-plays helped demonstrate the dynamics of the problem and familiarised the participants with the positive or negative aspect of each role. The disadvantage was that there was a possibility that the participant may over-identify him/herself with a role and thus become emotional. This had occurred in one group where a participant had connected her role to her personal experience.

In the case-study method, the participants were made to reflect on the experiences of the people in it. The use of case studies in the three workshops helped them to reflect and come up with a solution through discussions. However, the participants stated the necessity of directing the discussion. A team-building effort was made in all the three workshops through songs. Games involving physical activity helped participants to lose their shyness and inhibitions, encouraged participation, and facilitated familiarity. Games also helped the trainer to assess the participants' clarity of concepts.

The trainer pointed out that in participatory training, different methods that are interactive and stimulating can be used. She also stated that the responsibility of learning lay as much with the trainees as with the trainers. It was emphasized that through the use of interactive, action-oriented training methods, the learning is deeper and the recall, easier.

GROUP - 3

Make a presentation on adult learning in the context of the three training workshops

- Read and reflect on the handout on Adult Learning. (Handout No. 4 from Reference Materials Section)

The participants stated that they had gained information on the concepts of gender, violence, patriarchy and other concepts at the training session through case studies and role-plays. It was emphasised that such learning took place because these were based on life experiences. It is important to understand that people learn what they choose to learn. The presentation brought out that adults learn in many different ways, hence different training methods need to be used. Good training addresses not only the intellectual but also the emotional levels of the participants. Sharing of life experiences on violence committed by them or on them in a non-threatening atmosphere allowed them to feel comfortable with each other. Another important point in this presentation was that the participants were allowed to make mistakes and this created a non-hostile environment. Adult learning also underlines the importance of respecting the participants and the necessity of this being a two-way process. Values such as respect and trust encouraged the participants to open up to the rest of the group.

GROUP - 4

Make a presentation on participatory learning in the context of the three workshops

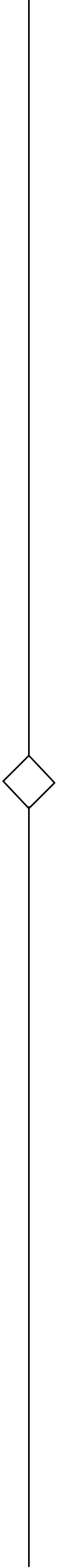
- Read and reflect on the hand out on Participatory Learning. (Handout No 6 from Reference Materials Section).

The presentation highlighted that participatory learning induced mutual interaction, conceptualisation of their thoughts and created a platform where individual experiences could be shared. The informal atmosphere of the workshops aided the participants in opening up and sharing without inhibitions. The training that they had undergone also achieved a balance between the content and the methodology used. It discouraged value judgments and encouraged respect for one another. Experiences of the participants proved useful for feedback and evaluation. It was also shared that the training workshops had definite objectives and schedules but the trainers were flexible and open to new ideas from the participants. These were incorporated into the discussions and training agenda.

CONCLUSION

At the end of the training, the trainer summarized that enjoyable ways of learning should be included in any training programme. It was also emphasized that in order to maximize learning there is a need to diffuse hierarchies when participants belong to different strata. When hierarchies are dissolved, prejudices or biases do not have much influence on the sharing of life experiences. . The trainer also needs to challenge preconceived notions (or stereotypes that participants carry) about people and dispel them in the course of the training.

In the end, each participant gave his/her feedback of the session to the trainer in three words, and a clap followed. The adjectives stated in the feedback included: interesting, fun, joyous, intellectual, monotonous, informative and comprehensive.



MODULE - VI

COMMUNICATION SKILLS FOR TRAINERS

DATE	AUGUST 7TH, 2001
TIME	11.00 A.M. TO 4.00 P.M.
TRAINER	RENU KHANNA

OBJECTIVES

- To help the participants understand the methods, principles, roles and tasks involved in conducting training sessions.
- To gauge the preparedness of the participants in conducting training sessions.

PROCESS

The trainer asked the participants to state all that they had learnt in the last session. The gist of what they recalled is as follows:

- Principles of participatory training methods, such as capability and capacity of each individual; participants developed more confidence and capacity to conduct training.
- Principles of adult learning involve learning from life experiences; solutions to problems should be based on life experiences; a relaxed atmosphere helps mutual learning based on sharing; respect for what is shared helps to bring about an atmosphere of trust.

Session 1 (Skills and qualities of a 'good' trainer)

In the first session, the facilitator explained to the participants that each of them would have to indicate their strengths and weaknesses as a trainer through drawings. The participants were provided with crayons and coloured papers. Gradually, all the participants got involved in drawing, but many felt inhibited in expressing their thoughts. This exercise evoked much laughter.

Some drawings indicated flowers in half bloom, waiting to take on the role of a trainer; some drew a train that carries all the compartments of knowledge and skills and depicted themselves in the driver's seat; while some drew a small image of themselves because they felt that they were still learning to be a trainer, and then a bigger image to represent them when they would become more competent at this job.

STRENGTHS AS A TRAINER	POINTS TO IMPROVE UPON
* Respect for peoples' opinion	* Lack of patience
* Good at facilitation	* Very soft voice and poor personality
* Charming personality	* Not a good listener
* Industrious nature	* Quick reactions
* Sincere	* Strong reactions
* Courageous	* Advising without listening
* Confident	* Need to have adequate information on the issue of domestic violence
* Cheerful nature	* Inability to talk slowly
* Drive to learn more	* Fear of talking in public
* Non-neglecting nature	
* Good at documentation	
* Good listener	
* Lively nature	
* Good at using different media	
* Ability to speak fluently in Marathi and Hindi	
* Organized and hard working	
* Good body language skills	

The trainer summarized the exercise by stating that the positive qualities had outweighed the shortcomings of the group. In the light of the negative qualities listed, the trainer emphasized that perfect knowledge is a myth as every day something new could be learnt. She also reiterated that the fear of talking in front of a group was natural. However, one could overcome it through practice and interaction. She gave the example of the participants themselves saying that initially they were shy of talking to the group, but as the training progressed they began to talk and express themselves freely.

The trainer explained that a good facilitator has to have the ability to handle irritable, bored, or inattentive participants. She further stated that every group was going to have such participants; hence, there is a need to be prepared for that. She emphasized that a good facilitator needs to learn of congruence in verbal and nonverbal behaviour.

She drew the attention of the participants to the fact that she could have used the lecture method to achieve the objectives of the first session but she used a different method so as to demonstrate how alternative participatory and 'fun' methods could be used.

SESSION - 2

The trainer divided the participants into three groups. Each group was given a particular theme. They had to read the material given to them and present it to the rest of the participants. (List of reading material is in the section "Reference Materials"). To read the material each group was allotted half an hour, and to make the presentation another half an hour.

Group - 1

Self evaluation of a trainer

1. Handout on Observation Checklist for Key Trainers (Handout No 9, from Reference Materials Section)

2. Handout on Self-evaluation Checklist for a Trainer (Handout No 10, from Reference Materials Section)

3. Handout on Principles for Giving and Receiving Feedback (Handout No 11, from Reference Materials Section)

Instructions

a) Read the Self-evaluation and Observation checklists

b) What is the utility of these checklists?

c) Would you like to make any modification to these checklists?

d) What are the rules of giving and receiving feedback?

e) Prepare a 30-minute presentation on what you have read. Others in the group can act as trainees.

   To communicate the contents of the handouts the group used the lecture method. They started by explaining that the observation checklist could be used to assess how well the trainer had followed the principles of training, as well as acquaint her to the fact that training entails the use of participatory methods and aids. The checklist also gave the participants an idea of the number of skills a trainer is required to have for effective communication with the trainees. It was also emphasised that the checklist would sensitise the trainers to the minute details of nonverbal behaviour of the participants as well as to group dynamics, which could affect the training process.

Through the self-evaluation checklist, the trainer could know whether the learning objectives had been fulfilled. The checklist would also help them evaluate their skills in terms of methods used, their ability to handle bored or distracted participants, as well as other group dynamics.

It was stated that honest feedback and constructive information shared after a training session can help a person make informed changes and improvements in the future. The act of receiving and giving feedback between trainers and between trainers and participants is aimed at refining the training skills and competencies of the trainers. Through feedbacks, a trainer learns from the participants about those training aspects that interest the latter, as well as gauge the effectiveness of the methods used. This helps them plan the next training session.

Group - 2

Use of games and exercises in participatory training

1. Handout on games and exercises. (Handout No 12, from Reference Materials Section)

Instructions

a) Read the handouts and exercises allotted to your group.

b) Select one exercise for testing it out on the group.

c) Identify two facilitators from the group who would conduct a 15-20 minute game or exercise session with the group.

d) Conduct the exercise with 6-8 participants.

e) Group 1 observes the facilitators conducting the session and uses the observation checklist to provide feedback, keeping in mind the rules of giving feedback.

f) The facilitators should do their self-evaluation first and then follow the rules for receiving feedback.

The facilitators started their presentation with a game in which each member would clap thrice and then utter the name of either a fruit or an animal alternately.. For example, if A clapped thrice and said Apple, then the next participant would have to clap thrice and name an animal and not a fruit, and so on.

After the game, the facilitators stated the importance of games in participatory training. However, the game should be related to the topic that is being discussed. The facilitator also elucidated that the length of the game should be appropriate. Too long ones result in too much training time being wasted and could lead to boredom. The trainee facilitators also pointed out that a game could evoke different reactions from the participants. The trainer should be specific about the learning outcomes expected from the game and use the game accordingly.

After the presentation, members of Group 1 gave their feedback to the trainee facilitators of Group 2.

Group - 3

Role of health care providers for violence against women

Handout on Gender-based Violence and its Health Effects (Handout No 13, from Reference Materials Section)

Instructions

a) Read the handout (page 6, 11-13).

b) What do you think the various persons of the hospital could do to address violence against women?

c) What are the barriers that need to be overcome in order to enable them to play the suggested roles?

d) Design a half hour session using participatory methods and test it on the group.

In their presentation, the trainee facilitator of Group 3 stated that each member of the hospital staff had an active role to play in dealing with women who reported domestic violence. The group chalked out different ways in which health care providers could help a woman develop trust in them. Points listed were positive body language, proper observation, being gentle in probing for history and spending five minutes with the woman alone to provide her an opportunity to confide about anything else that she might want to. The facilitator also conducted a role-play to explain the role of a health care provider in addressing domestic violence.

However, some members of this group were not able to focus on their role as trainers. They remained in their role as health care providers and enumerated only the problems that prevented them from addressing violence as a health issue. They stated that they were under great work pressure and it was impossible for them to refer such women to Dilaasa. Following this, other participants also began listing their difficulties in making referrals, thus digressing from the task given to them.

CONCLUSION

The trainer summarized all the three presentations by stating that games and exercises are an important element in participatory training. Hence, facilitators need to be skilled in their use. The trainer also reiterated the importance of giving and receiving feedback and the need to do it sensitively. The obstacles that the participants ran into while dealing with women facing domestic violence were also discussed. However, as trainers, the participants need to develop skills that can enable their trainees to see beyond these obstacles and to come up with alternatives through which they, as health care providers, could address violence as a health issue.

The training ended with the participants filling in the post-test sheets and giving oral feedbacks about the training session. Most of the participants found it interesting and lively. The participants also stated that the recap of the previous session was very helpful as they could connect well with what they had learnt. Some suggested that the workshop should be for two-days as it was difficult to absorb all the information at one time. Another suggestion was to make the handouts available in Hindi and Marathi.

Interested participants were then asked to come forward and express their interest in conducting training for rest of the hospital staff. A few of them did so. It was decided to hold a meeting with these individuals later for more concrete planning.

MODULE - VII

GENDER BASED VIOLENCE AND ROLE OF HEALTH CARE PROFESSIONALS

DATE	FEBRUARY 9TH, 2002 (One-day session with the full group)
TIME	9.00 A.M. TO 4.00 P.M.
TRAINER	MANISHA GUPTE

OBJECTIVES

- To understand gender-based violence and its manifestations.
- To understand the health consequences of violence against women.
- To bring about the realization that violence is a public health issue.
- To explore the role of health care providers in dealing with gender-based violence.
- To think of an integrated and ward-wise plan to address the issue of violence against women.

HIGHLIGHTS OF THE SESSION

- Recap of the previous sessions
- Small-group discussions and presentations based on certain questions related to gender-based violence
- Effects of sexual violence, and the ways in which it takes place
- Case study, discussions and presentations

PROCESS

One of the sisters asked us whether she could include one more participant who was interested in participating in Manisha's training session. This indicated an attitudinal change; last year participants had to be literally coaxed into coming while today people were coming of their own volition. The trainer said because of certain personal crises a long gap between training sessions had occurred.

The trainer started by asking the participants the meaning of gender. One of the staff nurses stated that gender has been forced upon women by the patriarchal society. Men and women differ biologically, where women have childbearing capacity and can breast-feed their offspring if they wish to. The trainer elaborated that biological differences related to the reproductive and sexual organs were exaggerated in such a way that 'gender' roles were considered to be 'biological or nature-given'. She told the group that these days the notion of 'two-sex' theory was also being questioned. Many people are born intersexual (that is having biological characteristics of both the sexes). These people surgically change their sex to either be a male or a female. If only we could let people be what they are in terms of sex or gender, they would not have to change their bodies to fit gender expectations. The trainer reminded the group of the earlier sessions on sex and gender and said that even if women give birth to children, it is wrong to assume that they should solely take full responsibility of the children. Expecting only women to have all the maternal instincts and love is a gender construct; men can also feel the same. However, gender specific roles do not allow men to enjoy the experience of childrearing.

The trainer elaborated that gender biases are further encouraged through statements like 'Why are you crying like a girl'? These are some of the ways in which children are conditioned into gender stereotypes. She also discussed the Marathi translation of "gender", which is called *ling bhav* or *samajik ling*, whereas biological sex could be translated as *sharirik ling.* It was stressed that gender changes over time, with regard to culture, region, religion, race, caste and class, but that biological sex more or less remains constant across these categories. Customs and traditions also affect gender. However, there are some people who are trying to change it while some others are still sticking to it. The example of Bajrang Dal was given which had threatened that if girls wore skirts to school their feet would be slashed with blades. Women are expected to 'wear' their caste, ethnicity and marital status through their clothes and appearance more than men are. That is why it is easy to identify women of a particular caste or religion easily.

The trainer noted that there is no discrimination in nature's mind when male or female are created; however the social value that is added to (or subtracted from) biological sex creates gender and through that, discrimination is socially generated.

Another example given was that of the concept of dowry which was generated out of greed and not because women are inherently inferior to men. In some societies a bride-price has to be paid instead of dowry, and in some, no exchange of money takes place during marriage. Dowry is a socially-constructed norm in some societies based on the notion of gender, whereas women in nature are born equal to men. Hence, it is wrong to say "We do not want to have a girl child because we cannot provide for her dowry". It would be more practical, as well as ethical, to do away with the custom of dowry (which is created by us and is discriminatory) rather than to do away with girls. You cannot solve a problem by eliminating those who are victimised by it.

The trainer then divided the participants into two groups; each group discussed four questions and made a presentation on the same.

The questions given were as follows:

* List out the kinds of violence based on gender.

* Why does gender-based violence occur?

* What are the physical, psychological, financial, and social effects of gender-based violence?

* In what form do we see gender-based violence among women who come to our hospital?

The time allotted for the discussion was 30 minutes. The trainer explained each question with the help of examples. Each group was directed to have a timekeeper, one to make the presentation, and one to take down notes and write the transparency for presentation in the larger group. The trainer reiterated that a verbal dual or an argument was not an act of violence. Violence occurs where the intent is to harm, hurt, or humiliate. It also depicts an inherent power relation, which is unequal. This is evident when a husband quarrels with his wife. Similarly, in a hospital setting when a doctor speaks rudely to a class IV employee, it shows an unequal power relation.

GROUP - 1

One of the doctors made the presentation.

She stated that violence against women begins even before their birth. Most people grieve the birth of a girl child. There is often discrimination in the naming ceremony of a boy or girl. In the development stages too, discrimination is obvious in the way a girl is given a certain kind of toy to play with, the clothes she is made to wear, the education she is given, and the restrictions on her outdoor play activities. When a girl starts menstruating, her participation in religious ceremonies is restricted and so is her travel during night. As soon as the girl starts menstruating, she is married without any choice for a husband. Before marriage, the family is trying to get her married off because she is seen as a burden. Post-marriage, she faces violence in different forms. At times, it is in the form of demands for dowry, or mental, physical and sexual harassment from her husband, or financial control over her or control over her personality and social life.

The doctor stated that gender-based violence takes place because of unequal power relations between men and women. This situation gets aggravated through social upbringing, customs, religion, caste and patriarchy. She stated that extreme forms of violence are also inflicted by sadistic individuals. Other aspects that make people violent include poverty, joblessness, bad habits such as alcoholism.

She said that violence is borne out of economic inequality, as the women are dependent on the breadwinner of the house; and thus the vicious circle of violence continues. Physically she undergoes injuries of a different nature and intensity each time she is beaten and which could lead to abortions, or stunted growth of the foetus. Psychologically she may often feel depressed, and may suffer from lack of sleep and other personality disorders.

In society, the inequality in the rights of men and women is evident. In the political sphere too society does not accept women at all, barring a few exceptions.

The trainer stated that women facing violence might come to the hospital reporting physical injuries and psychological trauma. In the case of the former these could be bruises, CLW's (contused lacerated wound), head injuries, burns, consumption of poison, and abortions. In the case of the latter, she may report vague and repetitive complaints, loss of sleep and sexual feelings, anorexia, or have suicidal tendencies. Thus, merely giving medicines for her overt complaints is not the solution; what is required is a probe into her psychological sufferings, as well as occurrences of violence in her life.

The presentation was well received by the participants.

GROUP - 2

One of the nurses made the presentation for this group.

Group 2 had made an exhaustive list of violence. They had started by listing out the violence in the following forms: sex detection tests, forced abortion, female infanticide, lack of proper education for girls, types of games taught to her and discrimination on the basis of what games she should play, less nutritious food for girls as compared to boys, social restrictions on mobility after menstruation, restrictions on the type of clothes she wears, training in mannerism (such as do not laugh loudly, no right to participate in a discussion), restrictions in general such as not allowing her for outdoor picnics or overnight stays, becoming victims of eve-teasing, being taunted if she happens to give birth to a girl child, taunted too for not having a child, her behaviour becomes suspect, subjected to severe violence- such as rape, sexual harassment, burns, homicide and suicide.

The trainer then led the discussion towards the consequences of gender-based violence. Gender discrimination and customs, such as purdah (or burqua), denial of basic human rights to women, expecting them to be dependent on the family and the community, social restrictions, discriminatory or gender-insensitive laws and policy, child rearing practices for girls, as well as secondary status of women within the family have severe implications for women both inside and outside the home.

Economic implications of violence include dependency, deprivation of basic needs, control over her earning, a feeling of being unproductive in doing household work, a feeling that the kind of work she is doing is not for her growth as a person but merely to supplement the household income. Often, a woman does not even have access to her own earnings or a bank account in her name. Socially, she does not have much say in the decision-making pertaining to her own life, as she is expected to follow the decisions made by others for her. She suffers from lack of self-confidence, lack of self-respect, and often an early marriage thwarts her growth. In case of early widowhood or divorce, she may be forced by her parents to remarry, or if she is widowed at a later stage, she may become a dependant on her son. Throughout her life, she remains dependent on someone or the other in the family. Physically, this results in never-ending weakness, premature ageing or premature death. Neglect also leads to various disabling conditions such as untreated eye (or cataract) problems, infertility, and so on. Psychologically, it adversely affects self-esteem, creates feelings of worth-lessness and self-harm, induces feelings of frustration, or a sense of being trapped, and often gives rise to a desire to commit suicide. We see gender-based violence manifested in our hospital wards in the form of burn and poisoning cases, assaults, headache, insomnia, fractures, depression, anaemia, and lower backache. One also sees violence affecting the reproductive and sexual well being of women. Women and girls often come to us after being raped - often by their own family members.

The trainer summarized the issues that emerged from the two presentations. Women are not expected to work for their self-enhancement but only to fulfil the needs of the family — be it the in-laws, children, husband, or her own parental family. It was also brought out that the kind of household work a woman does is monotonous, repetitive, unchanging in it's quality, and over and above, it is unpaid labour. She can never finish this work in advance or all together. For example, the dishes cannot be washed once in fifteen days, or beds cannot be made altogether for a week. Chores like cooking food, sending the children to school, filling water, and other tasks have to be done on a daily basis and at a specified time. For this reason, she is expected to be at home at all hours. Hence, even if there is absence of overt violence in the life of a woman, the husband may complain, "We have such a lovely house and kids, but she just does not take interest." There are

other times when a tired husband comes home and sees that the food is not cooked 'on time' and feels justified in slapping his wife. The never-ending nature of women's work is neither understood nor appreciated.

One of the participants, a doctor, said, "When a woman is tired of her job she can leave it, but what can she do if she is tired of doing the same work at home?" The trainer emphasised that it is acceptable for a woman to leave her work outside home but if she finds that she is tired of her household chores she has no real option. Women's household work is considered more important than her wage labour - this results in the myth that a woman's earning is only secondary or supplementary to the man's income. A man on the other hand is never expected to quit his job. However, a man has the theoretical option of leaving his job and staying at home - a woman cannot give up her home for a paid job so easily. While a man's status largely depends on his ability to bring home the family income, a woman's status entirely depends on whether she lives with her family or not.

When a married woman goes to her natal family as a guest, she is welcomed, asked to dress up brightly, encouraged to go and meet her friends. The fact that she is 'happily' married is made public to all. However, if she returns to her natal family after being thrown out of her husband's home, she is made to feel unwelcome and is seen as a burden and a source of social embarrassment to the family. If she is allowed to stay, her brother then exerts strict control on her, and monitors her behaviour minutely. Restrictions are placed on what she can or cannot wear, whom she should talk to, and where she should or should not go. Hence, it is necessary to realise that because a woman does not really have a choice, she ends up staying with her husband since society accepts her living there. The family, as well as the community, also glorifies women when they stay in their marital home inspite of severe violence.

The trainer stated that societal changes are like a pendulum; hence any effort to change society often results in severe backlash. Since discrimination-whether it is based on class, caste or gender, is created by society, it will not accept a change in the established status quo very easily. The trainer stated that the two groups had made an exhaustive list of the health consequences of violence faced by women and elaborated on the effects of sexual violence on their health. Sexuality is considered to be such an intimate issue that it is often not discussed publicly, and therefore the existence of sexual violence is not recognised. She further elaborated that sexuality, which can become a wonderful means of communication between intimate partners, is unfortunately seen as a tool of control. We get upset (and rightly so) when a young girl is raped, but do we feel upset when a young girl is married off? Do we recognise the right of a woman to say no to sex within marriage ? If she denies sex to her husband, either she is forced into it, or she faces physical violence, or faces threat of being deserted. Women are also not able to confide in their partners if they have been sexually abused, because their husbands may be disgusted, and even accuse them and their family of hiding facts. Hence, women have to keep that trauma bottled up. Sexual violence is not to be understood only as vaginal penetration by the penis. As health workers, we have to be sensitive to various kinds of sexual violence. This violence could be perpetrated through sexist comments, men exposing their genitals to women, touching someone sexually against their will, forced prostitution, asking for sex from women in junior positions at work, and so on. In extreme forms of violence, women have also reported of chilli powder and sharp objects being forced into their genitals. If we are not aware of the varied forms of violence, how will we understand women's silences? If we appear shocked at what a woman tells us, or if we start 'prescribing' advice to her, how will she tell us what is bothering her? The important lessons, therefore, are not to pass judgement, not to provide ready-made answers, and not to treat the woman just as a victim. We should not take decisions on her behalf, but should create an environment in which she can make her own decisions. Health care providers need to be especially sensitive to women reporting sexual violence, so that they are able to access our services. This change can begin at Bhabha Hospital with the help of Dilaasa.

A question raised by one of the participants was, "What could a man do if a woman refused sex?" To which the trainer replied that first and foremost we need to find out the reasons for not wanting sex. If there was no serious problem of incompatibility or of violence, then there was a need for individual counselling for both the partners, starting with the sharing of good experiences. There are counsellors who help the sexual relation to build up gradually, without putting pressure on either of the partners. We often confuse sexuality with intercourse. We forget that sexuality is much more than that. Communicating with a smile or with our eyes is important, after which body contact may

feel good. There is a need for the woman to emotionally want the sexual act and to be aroused, because the sexual act is not just physical. The trainer also highlighted the fact that the therapist should provide the couple with skills so that they may feel comfortable and find the sexual act mutually pleasurable. She stated that forcing someone to have sex without his/her consent is a gross violation of his/her dignity. The trainer used two transparencies to communicate the manifestations of sexual violence (Annexure 3 and 4). She said that the transparencies were not fully applicable to our needs, as they had been made in the context of American society. However, they provided some food for thought.

While concluding the morning session, the trainer said that women have also been brought up on a particular model of what a "male" should be like, and hence they are often not accepting of any men who are thought to be soft. One often criticizes them as being 'unmanly' or 'hen-pecked'.

The lunch was delayed and the participants kept raising questions. One of the participants observed that it has always been argued that men drink alcohol, however, *Adivasi* women also consume liquor. The trainer explained that social drinking is acceptable among women in the *Adivasi* communities because those communities are more liberal and open than ours. Drinking is permissible for men and women, but is socially monitored. Over drinking was not encouraged. The problem of alcoholism among tribals did not exist until non-tribals began exploiting them for their labour and forest resources. An unequal barter system existed between the *Adiv*asi communities and the non-tribals. Often, they would get paid black jaggery in return for their labour. Alcohol, which was earlier made from forest produce (such as the flowers of the mahua tree) in small quantities, is now made in large quantities from jaggery. The alcohol consumption was very regulated in the *Advasi* community, until the time that their land was encroached upon by the dominant communities. We should not judge any community for a certain behaviour that we might find objectionable. Speaking of tribal culture in India, the trainer said that there is no concept (or word) for rape in the *Adivasi* communities because their lifestyle is liberal, and the boy and girl have a choice to decide upon their life partner. Divorce, as well as pre-marital sexual relationships, is not frowned upon.

One of the participants asked the trainer the meaning of sexual harassment at the workplace and the ways in which it happens. To which another participant stated that it was all a question of unequal power play where the victims were naturally the less powerful. The example of a fellow nurse, Aruna Shanbaugh, was cited. After being raped, she has been in a coma for more than 25 years. The rapist is moving around freely after having served a short jail sentence. He has again got employment. One of the staff nurses said that sexual harassment also took place in the Bhabha Hospital. A hospital employee had threatened a nurse that if she tried to act "over-smart" then he would do to her what had been done to Aruna Shanbaugh. The trainer endorsed the feelings of the participant and explained that one needed to pass on to as many people as possible what one learnt here, so that everyone knows what their rights are.

Drastic changes cannot be brought about quickly, but the fact that there are women nurses and doctors today provides a role model for one's children and grandchildren. Such role models were not available before. The change is slow, but today one sees young fathers carrying their children on the road, or laugh and talk to their wives in public. This was not 'openly' witnessed a few years ago.

One of the staff nurses pointed out that these days women also conduct cremations and insist on performing the last rites of their parents. This suggests a shift in the way the family sees their daughters. This is a positive change. Another nurse said that nowadays women are dressing up in shorts and tight clothes, which is vulgar, so why do they do it? To this, the trainer responded that how one dresses up is a personal issue. All of us try to dress according to the occasion. For example, we dress differently when we go to work and differently when we go for a social gathering or on a special occasion. However, it is important to note that all the restrictions on dress are for women. Do Indian men wear Indian clothes? No, they wear shirts and trousers, which is a European way of dressing. No one pounces on a man if he bares his body while having a bath in public, so why should we accept the argument that a man may feel like pouncing on a woman if she wears short clothes? Hence, the problem lies in the perceptions in which society views women. Examples were given of women doing modelling. What a woman wears while she models is not to be seen as shameful for that woman, because one should always keep in mind that multi-national corporations would cash in on these displays of clothing and cosmetics and rake in billions of dollars of profits worldwide. To show how the concept of decency may be different in different societies, the trainer cited the example of the sari, which was perceived as a conventional and decent attire in Maharashtra. However, women from Punjab found it vulgar because it does not cover the legs and showed off the

midriff. The traditional costume of the Punjabis - the salwar-kameez— covers the legs as well as the midriff. In Maharashtra wearing a salwar-kameez is considered fashionable! The trainer added that one has to question both women's bodies being covered out of shame and women's bodies being exposed for business interests by other people. What really matters is what the woman herself wants. The session ended on the note that people must be recognized on the basis of what they are and not what they wear.

The post-lunch session started with giving a case study to each group. The trainer told the group that it would be good for each group to have participants well-versed in English as well as in Marathi. The time allotted for group discussion was 30 minutes, while that for presentation was 15 minutes.

GROUP - 1

Health Professionals and VAW – Case Study 1 – A

Dr. Kumar has been working as a gynaecologist in a city government hospital for the past 20 years. He wanted to do private practice after his post-graduation but did not have enough money to start a hospital. His older brother, who is an orthopaedic, got a lot of dowry and so could start a hospital of his own. Dr. Kumar feels that his family gives his brother more importance than they do to him.

Day after day, Dr. Kumar sees women come in for deliveries as well as with gynaecological problems. He works hard, and often feels that he cannot give enough time to his children. During the past two months, he has been shouldering more work, because his colleague Dr. Jacob has been attending some training sessions in the hospital. In the beginning, Dr. Jacob attended the training only because the Dean had insisted that he do so, but now he enjoys the sessions. Ever since the training began, Dr. Jacob is seen by his colleagues as acting funnily at his job. He insists that they should look at women's complaints more carefully. He says that one should ask questions about domestic violence. Dr. Kumar is horrified. He feels that whatever happens inside the home is none of their business, and the job of finding out such things is that of the social workers.

Today, a 30-year-old woman named Rehana has come to the hospital OPD with severe white discharge, backache, and third degree uterine prolapse. She is accompanied by her husband and her face is covered with a *burqua.* Dr. Jacob, however, sees some bruises on her wrist and asks her about it. She says that she has fallen down. Dr. Kumar is irritated because Dr. Jacob insists that a nurse should give her a check up to find out if there are any other marks on her body. He also wants to talk to the woman in private. Dr. Kumar feels if people are so backward and wanted to cover their faces, why should one go out of the way to ask such personal questions? He scolds Dr. Jacob and tells him to stop wasting time. After this, Dr. Jacob keeps quiet the whole day.

Rehana was asked to get admitted to the hospital for surgery, but she was worried about her young children. Dr. Kumar told her that he could not help her if she behaved so irresponsibly. After being prescribed some medicines, the woman left.

Dr. Kumar went home feeling very upset. He felt that patients unnecessarily wasted the precious time of the doctors. People were afflicted with such problems because they were unhygienic and dirty. Maybe the woman's husband had four wives and was spreading the infection around. What could doctors do about such people?

At home, when his wife complained that he wasn't helping their son with his XII standard studies, he got angry, shouted at her, and told her to shut up. He said that if her parents had given her enough dowry, he would not be working in such bad conditions for such a pittance. She has been crying ever since.

Points for discussion

1. In what ways are Dr Kumar's personal frustrations affecting his job?
2. How do you think that he and Dr Jacob can resolve their conflicts?
3. What problems, at the level of the hospital, make it difficult for women to feel comfortable and safe?

4. What needs to be done at the level of the hospital ward to make it more meaningful for the women who come there?
5. In what ways can a gender-sensitisation training help to make this happen?

Presentation of Group-1

1. In what ways are Dr. Kumar's personal frustrations affecting his job?

   The presentation brought out that the patient-doctor relationship was lost and so was the mutual relation between doctors. There was irritability, dependence, anger as well as disinterest in the job. There was low self-esteem; overload led to frustration which was then vented on a junior doctor. Concentration and focus were absent. He also had certain prejudices and was judgmental.

2. How do you think that he and Dr. Jacob can resolve their conflicts?

   Dr Kumar can ask Dr Jacob about the changes in his attitude and try to understand the reasons for the same. Dr. Kumar also needs to understand his role as a doctor, a colleague, and most importantly, as a human being. The group felt that his behaviour needed to be changed at the earliest.

3. What problems, at the level of the hospital, make it difficult for women to feel comfortable and safe?

   The patient has no privacy. The relative, who accompanies her to the hospital, is often disinterested in the patient. The heath- care providers have made watertight compartments of their job profiles, and do not connect the various physical problems that the victim faces. It is also difficult for a woman to talk to a male doctor. He often has a judgmental attitude, and the patient feels guilty for having wasted the doctor's time.

4. What do you think needs to be done at the level of the hospital ward to make it more meaningful for the women who come there?

   There is a need to provide a comforting, reassuring and respectful environment for the patient. There should be genuine interest and empathy so that her confidence is built up. There is a need to take a holistic approach inclusive of physical, psychological, and social realities.

5. In what ways can a gender-sensitisation training help to make this happen?

   The health care providers need to probe into unexplainable aches, pains and injuries. Introspection though the process of training is required.

GROUP-2

Health professionals and VAW: Case Study 1-B

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 *burqua,* 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, are 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.

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 daily wages 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 *burqua* 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 in 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 pre-scribed medicines and so she does not know where to go now.

Points for discussion

1. What are the various problems that Rehana has faced in her life?
2. What choices did she have or not have?
3. Why did she return from the hospital without receiving any real help?
4. What do you think will happen now?
5. What can be done, at the level of the hospital, to make the services more meaningful to women?

Presentation by Group-2

1. What are the various problems that Rehana has faced in her life?

Rehana had problems in adjusting to her life in the urban slums. She had to constantly move from one urban slum to the other. She was also scared of the police and the other people around her. The problem was further aggravated with burkha. Her husband was jobless and moreover, had become an alcoholic. She was also facing gynaecological problems, such as white discharge, prolapsed uterus, and pain during and after intercourse. She is also scared of her husband being suspicious because she avoids sex. However, most of the times it is forced upon her. She has faced physical violence when she refuses to have sex. Her husband dominates her all the time and does not even allow her to confide her problems to the doctor.

2. What choices did she have or not have?

Rehana had no choice in the selection of her husband, housing, financial problems, and husband's dominating behavior. She has no freedom from household chores. The choices available to her include confiding in a neighbour about her problems.She can reveal proper history to the doctor.

3. Why did she return from the hospital without receiving any real help?

She returned from the hospital because the health care providers were not sensitive to her prob-lems. She refused the surgery because her children would be left alone at home. She also had financial problems and hence, to get the operation done would mean more expense. She did not

even have the money to get medicines for herself.

4. What do you think will happen now?

Rehana will continue to suffer from the illness and may come to the hospital when her condition deteriorates further. She may either go back to her native place, seek some quack's services that may be less expensive, or attempt suicide if the situation becomes unbearable.

5. What can be done at the level of the hospital to make the services more meaningful to women?

The hospital staff could be made more sensitive to women. Help could be sought from the social workers in terms of financial aid, counselling, and motivation for surgery. The health care provider should also make an attempt to know the proper medical history of the woman, as well as that of her relatives.

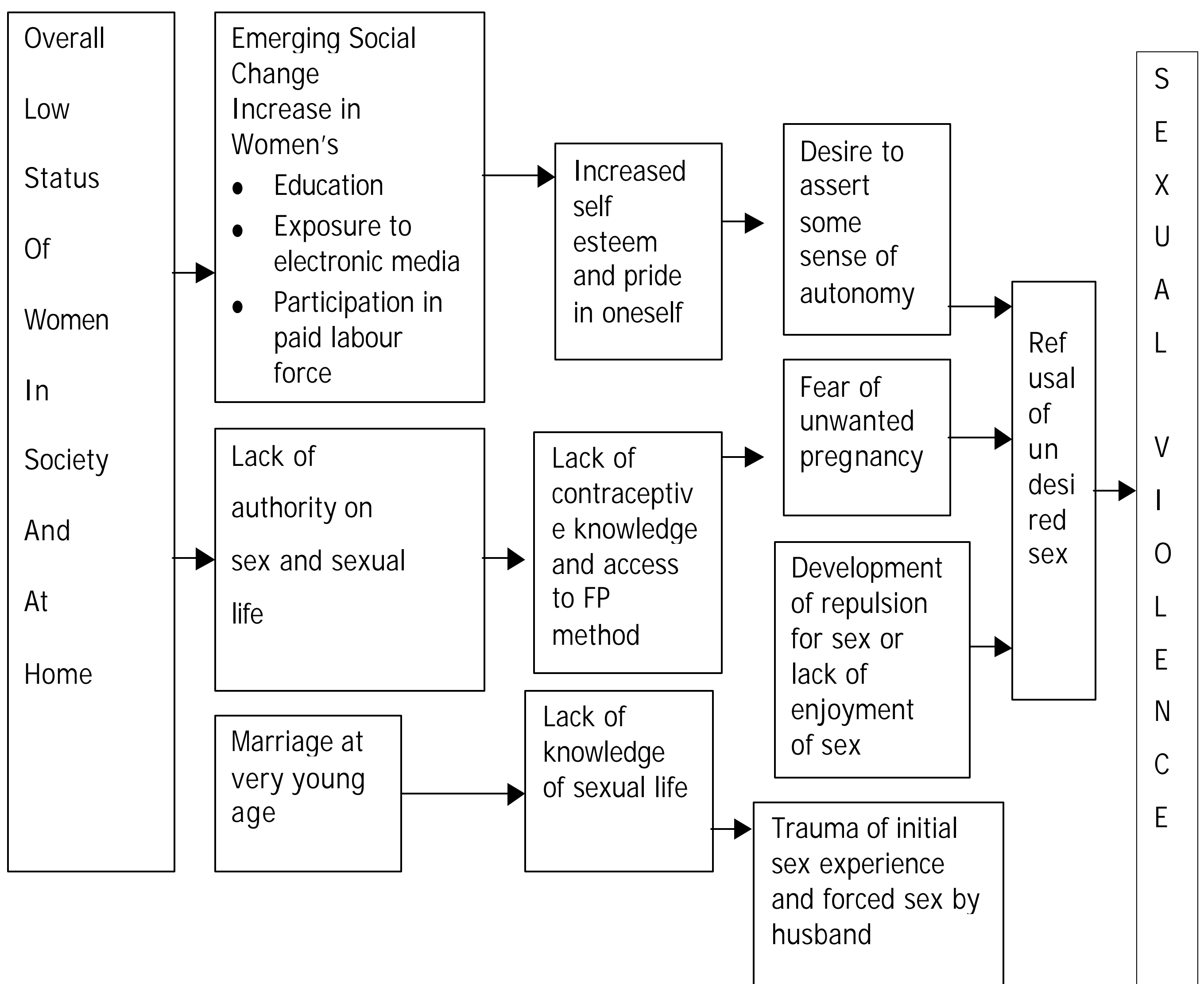
At the end of both the presentations, the trainer stated that both were done very well and that they reflected their understanding of and sensitivity to the issues concerned. We have to realise that when someone faces violence, they cannot exercise choices in the way that we understand choices. So we have to create a space (often inter-linked with the various wards in the hospital) wherein the woman can freely speak out. The trainer further added that the doctor had certain prejudices that could be dangerous.

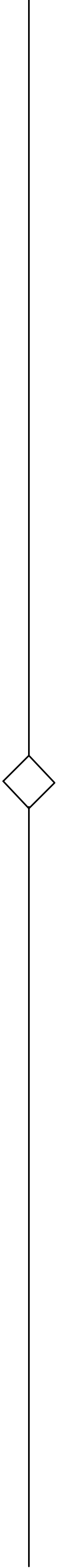
To explain the general prejudice that exists against a certain community or religion, the example of the bombing of the World Trade Centre was given. Osama Bin Laden was alleged to have a hand in it and incidentally, he was a Muslim. However, the general belief prevailing after the attack was that every Muslim was a Bin Laden. The trainer gave the example of how, when a woman employee of the hospital was being harassed by a man, she made a police complaint. However, the police gave it a communal colour as the man was a Muslim and stated, "These Muslim men deserve to be beaten up". The trainer said that although Rehana might want some action to be taken against her husband's violent behaviour, she does not want him to be hit inhumanely because of the biases of the police. He is the only support that she has as of now. She would rather not make any complaint if it endangers his life. Added to this was her insecurity of belonging to a minority community, upon which the majority of the people looked down. Who could she trust – the police and the court who may not understand her problem or her own husband who needed to be protected from the majority community? Thus, while dealing with violence against women, one has to work on our own prejudices and biases against minorities of all kinds.

Dr. Kumar is not sensitive about why Rehana is wearing a *burqua*. He is not able to see that the social insecurity is what brought the concept of *burqua*. He also forgets that many women of the majority community also have to cover their heads or their faces at all times. Dr. Kumar also does not consider the various factors that could lead to a uterine prolapse, such as carrying too much weight, complications during delivery, and inadequate rest. Without considering these factors, Dr. Kumar calls Rehana's behaviour irresponsible and then blames her husband also. The trainer pointed out that health care was inadequately available in villages and inspite of this facility being easily available in urban areas, most women were not able to approach them freely because of the lack of sensitivity shown by the health care providers. Dr. Kumar is hard working, but this is not of much use because of his insensitivity and biases towards women patients of Rehana's community. The trainer further reiterated that people have to take time off from their work to come to the hospital. Hence, the questions that the health care providers need to think about include distance a woman may have to travel to reach the hospital, whether there are relatives with her, and why they are not allowing her to talk. Asking these questions is not very time-consuming – it is more a question of changing one's attitudes and mindsets. If one is sensitised to these issues, it will definitely bring about a change that will reassure a woman who comes to us after having faced violence. The example of Dr. Jacob was discussed in this context.

The trainer summed up the session by stating that CEHAT members of the Dilaasa staff may move out after a few years, but people within the hospital would continue to run the Centre. Hence, there is a need to start putting certain structures in place. There is a need to understand that the relationship between the provider and the client is a very intimate one. Issues discussed in these sessions should not be treated lightly or as matters for gossip. It is important to maintain confidentiality, trust, and ethics in the relationship with women who come to us. Perhaps women employees of the hospital may need to visit Dilaasa sometime. One should not talk loosely about these cases because it is important to maintain the sanctity of these confidences. Otherwise, the trust invested in the Centre will be lost and even the employees of the hospital will not be able to approach Dilaasa if the need arises.

Dynamics of Sexual Violence Within Marriage





Participants' Feedback

Participatory training methodology lays substantial importance on feedback from the participants. As the methodology seeks to convey the training objectives through games, case studies and role-plays, the learning process takes place through them. Since the group of trainers at the hospital- doctors, nurses and other para medical staff, were adults, the resource persons used the participatory training methodology for their sessions.

The resource persons either gave both pre- and post-test surveys for their sessions or only gave one of them. A separate file was made for each of the key trainers so that one could gauge their progress. There were certain problems that we faced. Many key trainers could not attend all the training sessions because of other hospital duties, some joined the day's session late so did not fill in the pre-test sheet, or some left early and did not fill in the post-test sheet. As we had not envisaged these problems at the beginning, we had not taken any steps to avoid this. Given this situation, we have therefore not attempted to scientifically score the responses of the key trainers. That being the case, no attempt has been made to comment on the effectiveness of any training session. We have, however, collated the overall responses of the group to a particular training session and cited some common responses of the participants.

Before the first training module of the key trainers began, the trainer administered a baseline questionnaire to get a feel of the general attitudes of the key trainers towards gender and violence. It consisted of statements about gender, domestic violence and the role of health care providers in responding to women patients facing domestic violence. Participants were asked to indicate whether they agreed or disagreed with these statements. The view that prevailed in the group at that time was that there was a need for a centre like Dilaasa in the hospital. However, they felt that it was the social workers' job to look into the problem of domestic violence. They also thought of domestic violence as a social problem, and hence, they had no role to play as they belonged to the medical fraternity.

<u>Some of the myths held by the key trainers prior to the training programme were</u>

1. "Women can bear pain and illness better than men"
2. "Whatever happens between a husband and wife is a personal issue, and therefore we should not interfere"
3. "Poor families report of a higher incidence of violence; compulsory family planning will solve the national problem of poverty"
4. "We need not get involved in issues of violence because women will finally return to their husbands anyway"
5. "Interfering in domestic violence is not our job, because we are only the medical staff"
6. "As far as possible, we should avoid getting involved with police and court procedures in the hospital"

The focus of the first training session was on creating awareness about domestic violence as a public health issue and motivating them to become key trainers for the Dilaasa project. The resource person did not give any post-test here.

The second training module dealt with building a perspective on gender-based violence therefore concepts such as the difference between gender and biological sex, patriarchy, and the need for gender sensitivity were dealt with. The pre- and post-tests for this session consisted of three questions: What is the difference between gender and sex? What is patriarchy? What is the need to have gender sensitivity?

In the pre-test most of the participants were able to state that there was a difference between sex and gender. While in the post-test, most of them were able to explain what gender means.

We give here the responses of one key trainer-

Pre-test response: "Sex is an individual trait while gender is a group trait."

Post-test response: "Sex is determined by birth and gender is determined by the way in which one is conditioned by society. Biological sex cannot be changed; it is universal, while the concept of gender changes with society and culture. It brings forth inequality and discrimination."

To the question on patriarchy, most were able to state that it means "male dominance in society" in the pre-test; the post-test responses state what patriarchy meant and how it affected women. To cite an example: "Women are not a part of the decision-making process and are not even allowed to make decisions about the family. The do's and don'ts which they are supposed to follow are decided by the male members of the family, and which are also obeyed by others in the family."

Most of the participants could not understand the concept of gender sensitivity in the pre-test, but were able to state the need for gender sensitivity in bringing about awareness and raising the status of women, amongst others, in the post-test. One respondent said: "Gender sensitivity is needed to make society aware of women's rights."

The third training module focused on gender and violence, as well as the role of health care providers in responding to domestic violence. Only a post-test was administered for this training workshop, which had the following questions: What is the relation between gender and violence? What is the role of a health care provider in handling the issue of domestic violence?

To the first question, the participants understood that gender and violence were linked but they were not able to describe the relationship. They said what gender meant and also the fact that violence was inflicted on women by men. For example, one participant said: "Gender is a social construct and hence violence is a phenomenon that has been taught. Hence, women are taught to tolerate violence."

To the second question, very few participants were able to state clearly that the role of health care providers was to treat, document, and refer women for counselling. Most of them said that they could treat such cases but it was after all a social issue. Thus, it appeared that the link between violence and the role of the health care provider was not comprehended well at the training session.

The fourth training module gave an insight to the key trainers on basic skills of counselling, with a special focus on listening as a skill. The key trainers were introduced to the principles of counselling, such as confidentiality and privacy, which are not considered as important in public health settings. At the end of the session, most key trainers informally said that they found the training quite interesting and that these were new concepts for them. It helped them to learn about ways in which they could sensitively deal with women reporting violence, or ask questions in such a manner that they feel they can trust the health care provider and share information on the violence faced. No pre- or post-tests were administered.

The fifth training module concentrated on imparting theoretical inputs on adult learning, participatory learning, and the role of an effective trainer. It helped the key trainers locate the training that they were undergoing in a context where they would be assuming the role of trainers in the future. They recapitulated the earlier training sessions, listing the different methods used during those sessions.

The participants were asked to answer three questions before and after the training: What are the principles of adult learning? What are the principles of participatory training? What is the role of a trainer?

To the first question "What are the principles of adult learning?" the pre-test responses were general in nature, such as: information should be given systematically; it should be simple. However, after the training, most of them were able to state what was of particular importance when training adults. As one participant noted, "Adults have fixed ideas about particular topics that need time to change. They also learn better with the sharing of their experiences. However, different methods need to be used as every adult learns in a unique way."

Another person stated, "The atmosphere should be conducive to learning, feedback should be given, and different techniques of learning should be used."

In response to "What are the principles of participatory training?" again, very few were able to state the principles of participatory training. Most of them gave general responses relating to proper coordination and understanding. However, after the training, some were able to respond adequately to the questions. "The atmosphere in the training session should be informal. The trainer should have the ability to be one with the group, and should be flexible to ideas of others in the group."

Similarly, for the third question "What is the role of a trainer?" the pre test responses included: a good trainer should be specific, understanding, but after the training they said that a trainer should use participatory methods, equip him/herself with knowledge about the topics, be a good listener, and involve the group.

The sixth training module focused on communication skills as a trainer. The key trainers were introduced to ways of conducting training sessions such as the use of games and exercises in different situations, the need to evaluate a training session, and the importance of feedback. The key trainers could link this training session to the games and exercises they had participated in the previous trainings.

They were asked to answer the same five questions before and after the training. The first question was: In your opinion, what are the three ways in which a trainer can make self-introduction of the participants effective? Most of the participants were able to give examples of exercises used by the resource persons in the earlier sessions both before and after the training. After the training they were able to give more examples.

The second question was: Give at least three effective ways of using games and exercises in participatory training?

While in the pre-test the participants stated the usefulness of using games and exercises, most were able to cite examples after the session on how games and exercise could be effectively used. In fact, they even stated particular games for particular topics.

In the third question, the participants were asked to state whether the following statements are true or false.

* There is not much that doctors and nurses can do for victims of domestic violence. (F)
* Generally, perpetrators of violence have themselves been abused therefore their inflicting violence on others is acceptable. (F)
* The major obstacle that health care providers face in dealing with domestic violence victims is lack of time (F)
* Health care providers need to listen carefully and patiently when dealing with victims of violence. (T)
* Health care providers need to be extra observant when dealing with victims of violence. (T)

While most of them understood that they need to be sensitive in responding to women facing domestic violence, they continued to feel that there is not much that they as doctors can do to help these victims in their lives. Moreover, time constraints put a check on their efforts.

The fourth question was: What are the different aspects that need to be evaluated in any training programme? List at least five aspects. Most of them were unable to state five aspects. Before the training session began they stated some aspects that they must keep in mind while conducting training session. For example: "Ask direct questions, wait for indirect question from the participants. Also look out for positive and negative body language and have the ability to assess the participants' understanding." In their responses after the training session, some were able to state certain aspects, like involvement of participants, meeting the set objectives and keeping to time. Overall, the responses indicated that they were not really able to articulate the answers to this question.

The fifth question was: What are at least three rules for giving feedback?

The sixth question was: What are at least three rules for receiving feedback? To both these questions, the participants mentioned some methods of giving and receiving feedback, like it could be written or oral, it should be non-judgmental and should be received without putting up any defence. Before the training session began most of them could not come up with the correct answer, but after the training session they were able to, at least, give one rule correctly. Even to this question, we found that the participants, for some reason, were not really able to respond.

After the sixth training module, a core group of trainers emerged who were interested in conducting awareness sessions for the rest of the hospital employees. This group also designed the module that they would use in conducting these sessions. The core group also had a meeting with one of the master trainers, Ms. Manisha Gupte, to review the module and address their questions to her. After this meeting, it was felt that there was a need to reiterate the following facts to the key trainers: domestic violence is a public health issue, the health consequences of violence, and the role of health care providers in responding to women facing domestic violence.

The seventh training module therefore addressed these issues. The trainer gave a brief recap of the training sessions that they had attended earlier and asked them to explain the meaning of concepts like gender, patriarchy and violence. It was seen that key trainers were able to list almost all the different types of violence that women faced. In fact, they were able to identify sexual coercion as a form of violence. The key trainers were able to draw up the various forms of violence that are perpetrated against women from right before her birth to until her death. They understood the finer interlinks of patriarchy and how it affected women's lives. They were also able to give their own examples as the environment was conducive to sharing of views and they no longer felt hesitant to discuss their own "personal lives". They were also able to list out the role of health care providers in addressing the issues of violence: taking the women into confidence and asking her questions in a sensitive manner. The trainer did not give any pre- or post-test for this session, but the documentation of this session clearly brought out the articulateness of the key trainers on these issues.

Reference Materials

Foundation and Characteristics of Domestic Voilence

FACTS ABOUT DOMESTIC VIOLENCE

There are many myths about domestic violence, but the following are the facts:

* One out of three women have been assaulted by a domestic partner in her lifetime.
* One woman is beaten every twelve (12) second nationwide (FBI).
* 95 percent of the family violence is committed by men against women (March of Dimes).
* Children in homes where domestic violence occurs are physically abused or seriously neglected at a rate, which is 1,500 percent higher than the national average.
* More women are seen in emergency rooms in this country (the US) for battering, than for rapes, muggings, and automobile accidents combined.
* More than 40 percent of murdered women are killed by a spouse, or someone with whom they have been intimate. Ten percent of the murdered men are killed by their partners.
* Twenty five percent of female suicides are preceded by a history of battering.
* Approximately 90 percent of the children in violent homes are aware of the assault against their mother.
* Male children exposed to domestic violence have a 700 percent greater chance of beating their female partners later in life. Children from violent homes have a 300 percent higher risk of alcohol/ drug abuse and juvenile delinquency.
* A California prison study found that 93 percent of the women who had killed their mates had been battered by them.
* Battered mothers are eight times more likely to hurt their children when they are being abused than when they are safe from violence.
* Of all juvenile and adult criminals, 80 percent lived in domestically violent environments.
* Domestic violence involves six out of every ten couples.
* Domestic violence occurs in all classes, races, income levels, and educational levels.
* No one deserves to be abused. No one can provoke violence. The abuser chooses to abuse.
* Abusers are controllers who seek to isolate and overpower their victims.
* There is no reason for battered women to be ashamed.
* In Sri Lanka, Syria, and the Philippines, women are detained, tortured, or killed for being related to someone the government considers undesirable.
* In Saudi Arabia, six female university professors were fired from their jobs in 1993 for driving their cars. It is illegal for a woman to drive.
* In China, the murder of female children often occurs in rural areas. Moreover, women who try to organize unions are raped and tortured.
* In India, the burning of women on their husbands' funeral pyres—despite regular government denunciation is still in practice. Marriages are still arranged and the bride is obligated to bring dowry.
* Throughout the world, we see military units specializing in the rape of women and children.

WHAT IS ABUSIVE BEHAVIOUR?

Physical Abuse

Any one or more of the following behaviours is abusive and against the law. Physical abuse takes place when your intimate partner has:

* Pushed or shoved you
* Held you to keep you from leaving (false imprisonment—a felony)
* Spit at you
* Pulled your hair
* Slapped, pinched, or bit you
* Kicked or choked you
* Hit or punched you
* Thrown object at you
* Torn, broken, or otherwise damaged your belongings
* Locked you out of the house
* Abandoned you in dangerous places
* Refused to help when you were sick, injured, or pregnant
* Subjected you to reckless driving
* Forced you off the road or kept you from driving
* Threatened to hurt you with a weapon

Sexual Abuse

Any of the following examples of behaviour is not a normal, healthy treatment towards the opposite sex. Your intimate partner has:

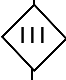
* Told anti-woman jokes or made demeaning remarks about women
* Treated women as sex objects
* Been jealously angry, assuming you would have sex with any available man
* Insisted you dress in a more sexual way than you wanted
* Minimized the importance of your feelings about sex
* Criticized you sexually
* Insisted on unwanted and uncomfortable touching
* Called you sexual names like "whore", "cunt" and "frigid"
* Forced you to strip when you did not want to
* Publicly showed sexual interest in other women
* Had affairs with other women after agreeing to a monogamous relationship
* Forced sex with him or others, or forced you to watch others
* Forced a certain unwanted sexual act
* Forced sex after beating
* Forced sex when you were sick or it was a danger to your health
* Forced sex for the purpose of hurting you with objects or weapons
* Committed sadistic sexual acts

Emotional And Mental Abuse

Emotional and mental abuse is less obvious but more damaging than physical abuse.

Emotional and mental abuse occurs when your partner has:

* Ignored you feelings
* Ridiculed or insulted women as a group
* Ridiculed or insulted your most valued beliefs, your religion, race, heritage, or class
* Withheld approval, appreciation, or affection as punishment
* Continuously criticized you, called you names, shouted at you, and used obscenities
* Insulted or drove away your friends or family
* Withheld money or coerced you to turn over control of your money
* Been irresponsible with marital debt, ruining your credit
* Isolated you from friends, family, and community
* Threatened your family members with physical injury
* Humiliated you in private or public
* Refused to socialize with you
* Took the car key, or money, away from you
* Regularly threatened to leave, or told you to leave
* Threatened to kidnap the children when he was angry with you
* Abused pets to hurt you
* Accused you of having affairs
* Manipulated you with lies and contradiction
* Tried to make you feel crazy, or to convince others that you are crazy

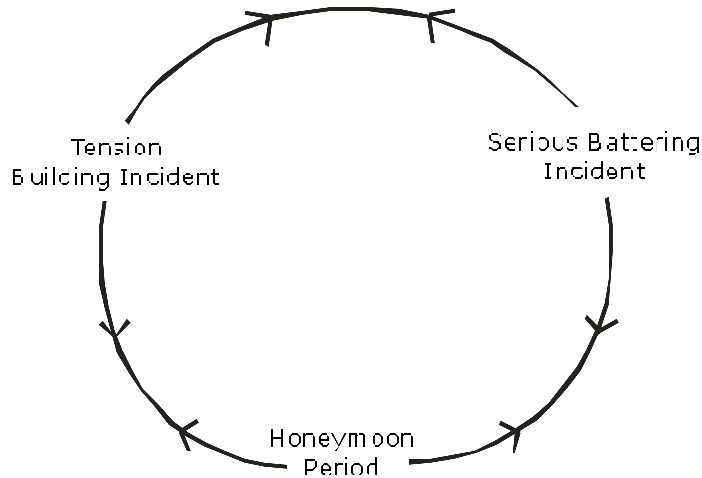


CYCLE OF VIOLENCE

This handout is designed to share with you what we know about the cycle of violence.

In General:

1. Abuse isn't constant or random.
2. Three phases vary in time and intensity.
3. Phases tend to occur with increasing frequency and increasing severity if the cycle is not broken.



TENSION BUILDING STAGE

Man

1. Minor battering incidents occur, includes much verbal and psychological abuse.
2. He doesn't control his behaviour and the abuse increases.
3. He may be aware of his inappropriate behaviour, but does not take responsibility for it.
4. He is afraid that she will be disgusted and leave; this increases his jealousy and possessiveness, and intensifies his hope that brutality will keep her captive.
5. He becomes frantic for more control, he misinterprets her behaviour, taking withdrawals as rejection.
6. Outside events can affect this stage.
7. He feels uncontrollable.

Woman

1. She becomes nurturing and compliant, staying out of his way.
2. She denies what is happening, i.e.,the escalating abuse and the serious incidents. This denial provides a sense of safety. The woman also denies her own feelings of fear and anger because they are not safe feelings to have.
3. She accepts the abuse as being directed against her; she doesn't believe she should be abused but does believe that what she does can prevent his anger from escalating. She attempts to alter his behaviour as a way of providing safety.

SERIOUS BATTERING INCIDENT

Man

1. Almost always occurs privately.
2. His feeling of rage is overwhelming.
3. Batterer justifies his behaviour.
4. Almost any event, either internal or external, can trigger violence when he needs the release. Violence may occur when he uses drugs or alcohol for easier release.
5. May deny the incident occurred.
6. Blames her saying that she caused the incident.
7. After the battering both minimize the severity and rationalize the event.
8. If the police are called in, he may appear cool and calm when they arrive.

Woman

1. She is anxious, depressed, and sleepless, over/under eating, fatigued, and/ or has tension headaches.
2. She has only one option: to hide.
3. Sense of futility in trying to "resist" further battering.
4. Woman does not seek help unless severely injured, usually not until a day after the incident.
5. When battering stretches over a long period, she may try to recall an incident to control at least the assault when it occurs. She senses the inescapability of a battering.
6. She may call the police. When the police arrive, it may appear that she is attacking them or protecting her husband. This is a survival skill.
7. She has a sense of shame, and a feeling that 'I've allowed this to happen to me.'
8. There is disbelief.

HONEYMOON PHASE

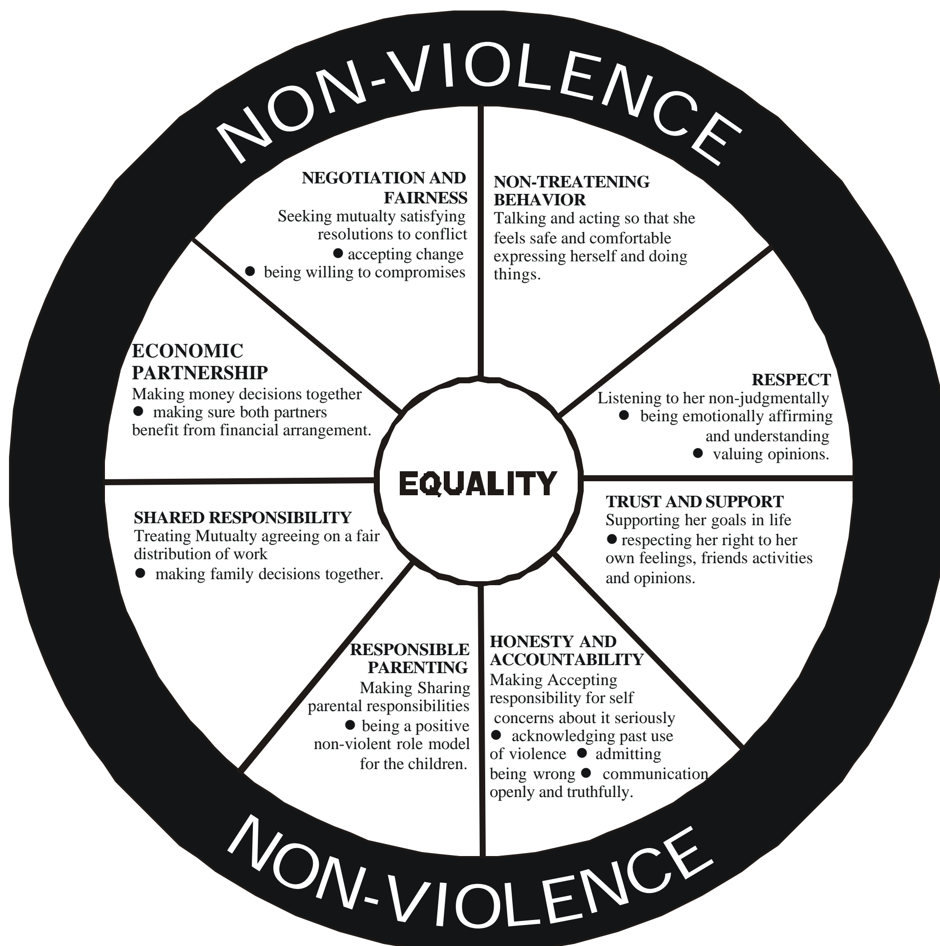
Man

1. He becomes loving, contrite, begs forgiveness, and promises it will not happen again.
2. He may truly believe he will never batter again, and truly be sorry.
3. He believes he has taught her a lesson. She will never act up again.
4. He will give up drinking (if he drinks) temporarily, in an attempt to convince her that he will change.
5. He pleads with the woman, attempts to blame the woman, and engages the family to do the same.
6. He knows he needs her, for if she is not there he will have to take responsibility for his actions.

Woman

1. Victimization is complete.
2. Woman translates his depression, and extreme need for her, as deep love.
3. She feels responsible for what happened.
4. She believes in the permanency of the relationship, and believes it is her responsibility to keep it together. She is an easy prey of guilt.
5. She believes that if she stays he will get help.
6. She wants to believe that she will no longer have to suffer abuse.
7. She returns to the original dream of her relationship and realizes how wonderful her man is.
8. Her self-esteem has been shattered. She needs to believe she is needed and wanted.

PHYSICAL VIOLENCE SEXUAL
USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her
● threatening to leave her, to commit suicide, to report her to welfare
● making her drop charges
● making her do illegal things.
USING INTIMATION
Making her afraid by using looks, actions, gestures
● smashing things
● destroying her property
● abusing pets
● displaying weapons.
USING ECONOMIC ABUSE
Preventing her from getting or keeping a job
● making her ask for money
● giving her an allowance
● taking her money
● not letting her know about or have access to family income.
USING EMOTIONAL ABUSE
Putting her down
● making her feel bad about herself ● calling her names
● making her think she's crazy
● playing mind games
● humiliating her
● making her feel guilty.
POWER AND CONTROL
USING MALE PRIVILEGE
Treating her like a servant
● making all the big decisions
● acting like the "master of the castle"
● being the one to define men's and women's roles.
USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes, ● limiting her outside involvement
● using jealous to justify actions.
USING CHILDREN
Making her feel guilty about the children ● using the children to relay messages ● using visitation to harass her
● threatening to take the children away.
MINIMIZING, DENYING AND BLAMING
Making light of the abuse and not taking her concerns about it seriously
● saying the abuse didn't happen ● shifting responsibility for abusive behaviour
● saying she caused it.
PHYSICAL VIOLENCE SEXUAL


NON-VIOLENCE
NEGOTIATION AND FAIRNESS
Seeking mutualty satisfying resolutions to conflict
● accepting change
● being willing to compromises
NON-TREATENING BEHAVIOR
Talking and acting so that she feels safe and comfortable expressing herself and doing things.
ECONOMIC PARTNERSHIP
Making money decisions together
● making sure both partners benefit from financial arrangement.
RESPECT
Listening to her non-judgmentally
● being emotionally affirming and understanding
● valuing opinions.
EQUALITY
SHARED RESPONSIBILITY
Treating Mutualty agreeing on a fair distribution of work
● making family decisions together.
TRUST AND SUPPORT
Supporting her goals in life
● respecting her right to her own feelings, friends activities and opinions.
RESPONSIBLE PARENTING
Making Sharing parental responsibilities
● being a positive non-violent role model for the children.
HONESTY AND ACCOUNTABILITY
Making Accepting responsibility for self
concerns about it seriously
● acknowledging past use of violence ● admitting being wrong ● communication openly and truthfully.
NON-VIOLENCE

ESCALATION OF DOMESTIC VIOLENCE

Listed below, in order of lethality, are the characteristics of abusers. The lower the number, the more lethal the relationship. If anyone scores on two or more ratings, move up to the next classification.

Relationship is Lethal

1. He has attempted to kill, or has used a weapon such as a knife or a gun.
2. There is instructional violence/torture that is planned, where the motivation is control
3. He has prostituted her.
4. He has raped her.
5. He has threatened her with a weapon.
6. He has attempted suicide.
7. He has killed a pet as an example to the family.
8. He has verbally threatened to kill.
9. He has threatened to commit suicide if she does not return.
10. He has threatened the safety of a loved one or a pet to get her to comply with his sexual demands.
11. She has required medical attention for violence, which usually is documented as accidental.

Exteremly High Probability of Abuse

12. He has hit her more than once.
13. He demonstrates extreme jealousy and she tries to manipulate him by being jealous.
14. He demonstrates extreme jealousy and she tries to avoid this.
15. He has a police record.
16. He has used something to hit her in a planned assault.
17. He has threatened to take the children away from her either by kidnapping or by reporting about her abnormal behaviour to Child Protective Services. Great care must be taken to determine if this is an authentic concern for the children or a blackmail manoeuvre. Men who have little involvement with their children are usually not concerned about them when a custody battle begins. If his major concern is her sexuality, he is not concerned about the children.
18. He has pushed her, squeezed her, or thrown something at her.
19. He has threatened to hurt the children or someone else she loves in order to get her to comply with his demands.
20. He has implied or directly stated he will hit or hurt her.
21. He has threatened to actively or passively hurt pets.
22. He consistently blames her for his violence or rage.
23. He has unrealistic demands.
24. He sabotages her job, school, or any activity that is independent of him.

High Probability of Abuse

25. Chemical dependence:
    * Methamphetamine
    * Cocaine
    * Alcohol
    * Marijuana

26. He owns or has a fascination with guns or other such symbols of masculine aggression.

27. He is cruel to animals or has invested in making dogs vicious, especially breeds that have a special reputation for viciousness.

28. If either of the partners were abused as a child.

29. He is EXTREMELY conscious of his image.

30. He publicly humiliates her because of her ethnic/religious background.

31. He sexually humiliates her in public.

32. He makes hostile sexist remarks or jokes.

33. He uses her childhood or past against her, especially if she was sexually abused as a child.

Medium Probability of Abuse

34. He is dissatisfied with their sexual relationship.

35. He criticizes her body.

36. He disapproves of her religious choices.

37. Recent increase in stress:

    * Pregnancy: Because of the demands played on the sexual relationship, it is one of the foremost stressors that lead to domestic violence.

    * Unemployment

    * Moving: Moving from another state, especially if there have been many recent geographical relocations.

    * Physical sickness: Illness puts a great deal of stress on the relationship.

Probability becomes EXTREMELY high with any one of these factors if he has abused her in the past.

Low Probability of Abuse

39. He supports her career not just her job.

40. He supports her continuing education.

41. He is comfortable with the majority of her friends.

42. He is not threatened by her having male friends independent of him.

43. He helps parent the children.

44. He plays by the same rules and expects her to play by them.

45. He takes care of himself.

46. His actions show that he accepts responsibility for childcare and household chores.

47. He is not chemically dependent.

WHY BATTERED WIVES DON'T LEAVE HOME

You stay because..........

Anywhere you go, he can go. When he finds you, his rage will make earlier abuses seem mild.

He has told you that if you try to leave he will find your child at school and take it out on her, or on your pet, or on your parents.

Your friends have become alienated and you have nowhere to go. If you do know people who may accept you, you inflict him on them, and few people are altruistic enough to put up with that. I learned this the hard way when a policeman told me that my violent husband was my problem, and that I had no right to inflict him on the police.

He lies convincingly. You ran away and the police bring you home after he "explains" that you are insane and must be returned to his custody.

Professionals find it hard to believe that a quiet, amiable, and educated man would do such things, especially since he never does it with witnesses around.

You finally get him to go to counselling, and the counsellor tells you that both of you must trust and communicate. Over your frantic, surreptitious protests, what you tell the counsellor in confidence is repeated to your husband, who reacts with quiet, intelligent concern. The satisfied counsellor then tells him you had assumed he would react with anger and violence. The counsellor sends you on your way extracting a promise from you to trust your husband and communicate with him as soon as your husband gets you alone he beats the tar out of you.

You got into the fix because you never expected a quiet, amiable man to be abusive. The first time he does it, his tears following the incident makes you feel sorry for him, than for yourself. Somehow, it seems to be your fault, because you did not love him, trust him, or support him enough.

Later, when the counsellor agrees it was your fault, all you know is that you have tried everything and cannot get away.

You were lucky. There are years and hundreds of miles between you and your ex-husband now, but you still remember with special bitterness the psychiatrist, the doctors and the policemen who told you that you must have enjoyed or needed such treatment, because you never would have put up with it otherwise.

Mereer County, New Jersey

December 12, 1983

BATEERED WOMAN AND ECONOMICS

Women often remain trapped in abusive relationships simply because of economics. Like all women, battered women may become the victims of the "feminization of poverty", should they attempt to support themselves and their children on their own. A woman with children who leaves an abusive partner is likely to face severe economic hardships; battered women know this when they are making choices about their lives.

Divorce can have a profoundly negative effect on a woman and her children's standard of living. Moreover, a battered woman is frequently coerced by the abuser to accept unfair divorce settlements that do not provide adequate support for the children. The following statistics illustrate the situation facing divorced women and their children:

* In the first year after divorce, a woman's standard of living drops by 73 percent, while a man's improves by an average of 42 percent.

* Only 58 percent of custodial mothers are originally awarded child support. 4.4 million custodial mothers are supposed to receive child support payments. Of these, barely half of them receive the full amount of support granted to them, one-quarter receive partial payment, and one-quarter receive no payment.

* U.S. Census figures show overdue child support payments totalled $2.7 billion in 1985.

Even if employed, a battered woman may face wage discrimination in the workplace:

* Full-time female workers earn 70 cents for every dollar that male workers earn.

* Female college graduates who work full time year round have earnings roughly on par with male high school drop-outs.

A battered woman also faces the hardship of finding decent, affordable housing for herself and her children:

* Women with children face discrimination in the rental market. Only 25 percent of leased units allow children. Of the remaining 75 percent, 25 percent prohibit children entirely, and 50 percent place restrictions on children.

* In many cities, public housing waiting lists have been closed because the wait often exceeds five years.

ALCHOL ABUSE AND DOMESTIC VIOLENCE

Many studies show a high rate of alcohol abuse among men who batter their female partners. Yet, is there really a link between alcohol abuse and domestic violence? No evidence supports a cause-and-effect relationship between the two problems. The relatively high incidence of alcohol abuse among men who batter must be viewed as the overlap of two widespread social problems.

Efforts to link alcohol abuse and domestic violence reflect society's tendency to view battering as an individual deviant behaviour. Moreover, there is a reluctance to believe that domestic violence is a pervasive social problem that happens among all kinds of American families. For these reasons, it is essential to emphasize what is known about the relationship between alcohol abuse and domestic violence.

* Battering is a socially learned behaviour, and is not the result of substance abuse or mental illness. Men who batter frequently use alcohol abuse as an excuse for their violence. They attempt to rid themselves of responsibility for the problem by blaming it on the effects of alcohol.

* Many men who batter do not drink heavily, and many alcoholics do not beat their wives. Some abusers with alcohol problems batter when drunk, and others when they are sober. For example, Walker's (1984) study of 400 battered women found that 67 per cent of the batterers frequently indulged in alcohol abuse; however, only one-fifth reported of alcohol abuse during all four battering incidents on which data was collected. The study also revealed a high rate of alcohol abuse among non-batterers.

* In one batterers' programme, 80 per cent of the men had divulged of alcohol abuse at the time of the latest battering incident. The vast majority of men, however, also reportedly battered their partners when not under the influence of alcohol.

* Data on the concurrence of domestic violence and alcohol abuse vary widely, from as low as 25 per cent to as high as 80 per cent of the cases.

* Alcoholism and battering do share some similar characteristics, including:

  - both may be passed from generation to generation

  - both involve denial or minimization of the problem

  - both involve isolation of the family

* A battering incident that is coupled with alcohol abuse may be more severe and result in greater injury.

* Treatment for alcoholism does not "cure" compulsive batterers; both problems must be addressed separately. However, provisions for the woman's safety must take precedence.

* A small per cent (7 per cent to 14 per cent) of battered women have alcohol abuse problems, which is no more than that found in the general female population. A woman's substance abuse problems do not relate to the abuse, although some women may turn to alcohol and other drugs in response to the abuse. To become independent and live free from violence, women should receive assistance for substance abuse problems in addition to other supportive services.

* Men living with women who have alcohol abuse problems often try to justify their violence as a way of controlling the latter when they are drunk. A woman's failure to remain substance free is used as an excuse by the abuser to justify his violence behaviour.

COMMONALITIES BETWEEN

ALCOHOLISM AND DOMESTIC VIOLENCE

1. High prevalence in general population.
2. Crosses all demographic distinctions.
3. Large number of deaths by homicide and suicide.
4. Topic for popular humour.
5. Both problems socially stigmatized.
6. Widely misunderstood - considerable mythology.
7. Pattern of repetition - from generation to generation.
8. Progressive - more severe over time.
9. Denial and minimization by everyone involved.
10. Blaming and jealousy on the part of the abuser.
11. Extreme social isolation.
12. Leads to other life problems (legal, medical, housing, financial, etc.).
13. Chronic crisis for the family.
14. Affects every family member - similar and fairly predictable.
15. Creates similar family "structures".
16. All family members must be considered in the recovery process - family members' needs may differ.
17. Separation can trigger dangerous crisis.
18. The problem itself poses a barrier to seek help.
19. Non-abusers in the family need to hear that the abuser's problem is not their fault.
20. Response has been by grass roots, peer, and para-professional approaches neglected in training and responses of traditional professionals.
21. Challenge helpers to confront the issues in their own life experience.
22. Influenced by preventive efforts.

From: The Women's Center. A Program of Bridgeway Counseling Services. Inc. 125 N. Fifth. St. Charles Mo. 314/ 946-6854 or 946-3257

DIFFERENCES BETWEEN CO-DEPENDENCY AND DOMESTIC VIOLENCE VICTIMS

CO-DEPENDENCY	DOMESTIC VIOLENCE VICTIMS
1. Not a victim of a crime	1. A victim of a crime
2. Ongoing choice of Co-D to be a part of the process	2. Losses sense of choice in process
3. Accepted as an illness	3. Not an illness
4. Help is accessible	4. Help not as accessible

DIFFERENCES BETWEEN ALCOHOLISM AND DOMESTIC VIOLENCE

ALCHOLISM	DOMESTIC VIOLENCE
1. Primarily harmful to drinker	1. Primarily harmful to victim
2. Equal numbers of men and women	2. Men overwhelmingly perpetrators, women overwhelmingly victims
3. Response to children is recent	3. History of responding to children
4. Disease model	4. Socio-political analysis
5. Not criminal behaviour (only specific behaviours)	5. Criminal act
6. Several decades "head start" in research, services and public awareness	6. Very recent research, services and public awareness
7. Partner co-dependant not necessarily co-dependant	7. Domestic violence victims are
8. Confrontive style in work with alcoholics	8. Support an empowering style in work with battered women

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FOUR FORMS OF WOMEN'S PSYCHOLOGICAL SUICIDE

By Adrienne Rich

Women internalize the message of the abuser. "You're not good."

Women fight a system that supports the abuser (family, friends, police, courts, and government).

Women live in a culture that subtly and blatantly dehumanizes them (images in advertising, lack of childcare, housing, employment, and other things women need to be able to survive on their own).

1. **Self-trivialization.** We put ourselves down and tell ourselves that we are less than we should be. Examples include:

   * Being afraid to add to a conversation because we think what we have to say is dumb or unimportant.
   * Starting a sentence with "This may be totally off, but…"
   * Apologizing all the time.
   * Feeling as though we're not dressed appropriately or our vocabulary is not sufficient.
   * Believing that we can't do it.
   * Disregarding compliments.
   * Not taking women's or our work seriously.
   * Finding the needs of others-our partners, children, parent, friends-more important than our own needs.
   * Thinking we don't deserve to pamper ourselves.
   * Feeling guilty when we spend money on ourselves.
   * Feeling as though people with more education have more intelligent things to say, and I should listen to them and not talk.
   * Thinking that we're "too old" or "too stupid" to do what we want to do.

2. **Horizontal Hostility.** We dislike other women and see them as enemies or competitors. We join in the culture's hatred for women by finding fault with other women, and measuring them by standards that none of us can really meet.

   * Hating a past partner of his, and finding and talking about her faults.
   * Saying a woman got what she deserves.
   * Looking at other women's bodies and joking about them being fat, sloppy, and promiscuous; comparing ourselves to other women as either better or worse.
   * Saying a woman in a prominent position made it there by sleeping her way to the top.
   * Preferring a male attorney, doctor, advocate, mechanic, etc., because men know more.
   * Asking directions, questions, instructions from a man instead of a woman.

3. **Approval Seeking.** We look for approval from those who have power over us because we need to survive. We do things to gain that approval even if it is at our expense in the long run.

   * Not challenging our boss or husband when he takes credit for our work or ideas because he can punish us somehow. (Or, we avoid looking superior or more knowledgeable than they).

* Wanting or needing male approval on how we look, how well we perform in our jobs, home, etc.

* Dressing to please our partners, rather than for our own comfort or preference.

* Not expressing opinions that he won't approve of, or not bringing up topics in public which he knows nothing about.

* Not contradicting him in public.

4. **Misplaced Compassion.** We know that when bad things happen to him worse things will happen to us. Therefore, we are always tuned to his needs, wants, and desires, so much so that when bad things happen to him and he beats us up for it, we feel more compassion for him than for ourselves.

    * Feeling no compassion for ourselves, ignoring our own physical pain and pride, worrying because he is in jail for battering.

    * Trying to figure out why he is so frustrated and angry. (How we are responsible and what we can do to change things).

    * Trying to figure out why things aren't going well for him, while we sit in a home that he has destroyed.

    * Feeling bad for him because he is discriminated against in the job market (for example), and letting him take the frustration out on you.

EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN

: Second Hand Abuse :

The Painful Legacy of Witnessing Domestic Violence

"Families under stress produce children under stress. If a spouse is being abused and there are children in the home, the children are affected by the abuse. Moreover, spouse abuse is a form of child abuse. Hurting someone the child loves also hurts the child" (Ackerman and Pickering. 1989: 155). Each year, an estimated minimum of 3.3 million children witness domestic violence. It is estimated that 30-70 per cent of children whose mothers are abused by their fathers are victims of child abuse and neglect. Victims of family violence are 1,000 times more likely to abuse as adults than children who grew up in non-violent homes. Boys are more likely to abuse than girls, who are likely to be abused.

EFFECTS OF DOMESTIC VIOLENCE ON CHILDREN

BATTERING CAUSES DAMAGE

Whatever affects the mother affects the baby. The foetus may receive direct or indirect injuries during the battering. Domestic violence is the leading cause of birth defects. The batterer often becomes more violent during his partners pregnancy because he is jealous of the unborn child. The battered woman is more susceptible to beatings during pregnancy because she is physically less available for the partner; she may have less energy, and she loses mobility as the pregnancy continues.

AND DISTRESS TO THE FOETUS

Baby's developing brain and tender nervous system may be zapped repeatedly by the mother's fear and adrenaline. A strong jolt of fear can send convulsion-like tremors throughout the foetus. Such energy often surges through the baby's brain at the very time when crucial nerve connections are forming.

A foetus's normal sleeping patterns can be disrupted when the mother is startled awake by the night-battering episodes—it may initiate a sleep dysfunction.

Just as a foetus can hear familiar voices and respond to music, a foetus can hear angry arguments, threats, and the noise from furniture being broken. These sounds of rage are much more intense than normal conversations; they also produce strong shock waves, which pass through the amniotic fluid and literally bombard the baby's head and ears.

Finally, the mother's other feelings also course through the foetus. For instance, the foetus feels pain when the mother's hair is being pulled.

BATTERING ADVERSELY AFFECTS INFANTS AND TODDLERS

The sounds of an adult's rage are overwhelming for a newborn's tender senses. Each time the batterer pounds on the table or shatters glass, the infant's nervous system is assaulted as well.

"Shell shock" literally occurs for the baby repeatedly traumatized by violence around it. Physicians report treating injuries to hands of infants who dig their nails into their palms during domestic dispute.

Because those are the earliest images and experiences, the infant's first and longest-lasting impression is that the world is a dangerous place. A young child living with violence may become irritable, experience development delays, or fail to thrive.

BATTERING MEANS EMOTIONAL ABANDONMENT

Fighting parents cannot attend to the child's emotional needs. The child feels anxiety as the tension builds up. Next, the child feels of fear and helplessness during the battering. Finally, the child feels guilty for not being able to stop the batterer. Without intervention, all of these feelings are never resolved.

A BATTERING HOME MEANS LIVING IN CONSTANT FEAR; VIOLENCE CREATES CONSTANT ANXIETY

Older children may get panicky during each battering episode. They may fear that the abuser (whose rage is out of control) might turn on them next, or what will happen to them if their mother is hurt or if their father is taken to jail.Violence in the home means being jumpy, watchful, and on guard at all times. It means learning to read your parent/abuser's every move. Battering means learning strategies to keep out of harm's way, and not daring to sleep until the fighting is over. Living with violence means that even in sleep, one does not have the luxury to be at peace.

A VIOLENT HOME MEANS FEELING POWERLESS

Children of abuse feel a complete sense of powerlessness. They cannot stop the abuse, they cannot fix the parents' abusive relationship, and they cannot save the parent or siblings who are abused. Untreated, this feeling of powerlessness will continue into adulthood. The result will either be a batterer who bullies in order not to feel powerless, or a victim who feels helpless and who learns to accept abuse from others.

BATTERING CREATES LOW SELF- ESTEEM

Children of abuse do not develop healthy self-esteem. They often blame themselves for the arguments and the violence. They may believe it is their own failing that they receive little love. Children of violence often learn to deny their own needs. They may also learn to get their needs met through manipulation or other indirect means.

FAMILY VIOLENCE RESULTS IN BEHAVIORAL PROBLEMS

Children of violence are at risks for alcohol and drug abuse. They may also develop eating or sleeping disorders. Children in abusive homes may experience stress-related headaches, bedwetting, ulcers, or rashes. Family violence may result in compulsive school performance (e.g., fear-driven perfectionism or over-achieving), or failure to perform well in school. Children of abuse are also at risk for workaholism, gambling, compulsive debting/spending, and sexual promiscuity in later life. The child's unresolved feelings of guilt or shame virtually assure some slow form of suicide. Untreated, survivor's guilt can last a lifetime.

BATTERING CREATES ISOLATION

Violence interferes with the child's ability to get close to his/her parents. Because trust in the parents has been violated, a child of abuse is frequently unable to trust others. Closeness equals emotional or physical devastation, and the child's deepest fear is that others will beat him, torture him, abandon him, or emotionally destroy him the way his parent(s) did. This feeling of isolation can create shyness, or result in the child withdrawing or turning within himself/herself.

BATTERED CHILDREN TAKE ON ADULT ROLES PREMATURELY

Children often become caretakers, comforting the abused parent or siblings. They may spend a lot of energy trying to make peace. The child may separate the fighting parents, call the police, or try to defend the abused parent. Frequently, children become clutches for the abused parent, i.e., the parent may turn to the child for companionship instead of resolving the troubled marital relationship. A three-year study of 146 children showed that 62 per cent of the sons over 14 were injured when they tried to defend their mother during an attack. It is also believed that 63 per cent of the boys, aged between 11 and20, who are arrested for murder, have killed their mother's attacker. Because a

teenager endangers him or herself in defending his or her mother, the teenager may have ambivalent feelings toward his or her mother. They love her and want to protect her, or they may hate her, think she deserves the abuse, or despise her for still being devoted to the abuser.

VIOLENCE RESULTS IN STRESS, DEPRESSION, AND FALSHBACKS

Children of violence may experience long-term depression. Abused children also experience flashbacks of the violent episodes they have witnessed. A child may also block out the violent scenes for years.

Moreover, although our conscious mind may forget, our bodies keep count of repeated shocks. Down the road, a body will "present its bill" in terms of nervous disorders, a low threshold for stress, or other serious illness.

CHILDREN OF ABUSE LEARN HOW TO BE VIOLENT TOWARDS OTHERS

Children in violent homes learn to treat others as objects. They learn specific techniques to hurt and humiliate others. They learn that men get to hit and that women tolerate it. They learn that violence is the way to settle problems, punish family members, or gain control of a situation. Violence becomes an easy way to get what you want, or to make things go the way you want.

BATTERED CHILDREN LEARN TO HARM THEMSELVES

Instead of self-love, children exposed to violence learn self-abuse. Children who experience or witness abuse may adopt self-mutilating behaviours, such as, pulling their eyebrows out, doing things to keep wounds from healing, self-induced vomiting, or self-starvation. Unable to externalize the feeling of rage or of vengefulness within, the child may turn them inward and harm himself/herself. Many "accidents" among young children are, in reality, suicide attempts.

ABUSED CHILDREN LEARN EXTREME BEHAVIOUR

A Violent home is a nursery school for abuse. Children who see a parent's rage get out of control do not learn positive ways to express their emotions. They do not have good role models for important skills, such as, resolving conflict, solving problems with other people, or for building close relationships. Moreover, children who witness substance abuse do not learn moderation and self-control.

CHILDREN OF VIOLENCE DO NOT LEARN BOUNDARIES

Children in violent homes grow up watching other people's boundaries being violated. Then, they have difficulty understanding and respecting physical and verbal boundaries. Some children do not learn that hitting someone, or verbally "taking swipes" at someone's heart is wrong. Other children do not learn that having their own physical or verbal boundaries violated by others is wrong.

Children and teenagers who come from violent households tend to share the following characteristics:

1. Lie about their actions in an attempt not to trigger an explosion. This is because they often believe it is their fault that their mothers are being beaten. Lie to cover up the family's problem in a conspiracy of silence.
2. Suspend fulfilment of their own needs so that their mothers may pay more attention to their fathers.
3. Suffer from severe feelings of guilt, resulting from accepting responsibility for the mother's beating, an inability to protect their mother, or still loving their abusive father.
4. A tendency to be overly passive, submissive, or quiet, in order not to draw attention to themselves.
5. Have problems expressing their anger.
6. May deny the violence that they see or experience. Sometimes they turn up the stereo or TV to block out the noise or fall asleep to pretend it is not happening.
7. Behavioural problems when with the other kids, resulting in their being labelled unruly, impulsive, or aggressive.
8. May have learning disabilities, especially if their mother has a history of moving from shelter to shelter or elsewhere, and consequently, the kids must move from school to school.

9. Have a need for direct physical contact.
10. Martha B. Straus believes that adolescents are prone to "acting-out", such as running away, stealing, substance abuse, sexual promiscuity, or suicide/homicide.

Mothers create mistrust and confusion in their children by such extreme shifts in their attitude: varying from ignoring them to being over-protective about them. Lacking stability, and a consistently loving environment, children learn from their elders to take out their own aggression through violence. The more people try to understand the effects violence has on different members of a household, the more they can try to intervene and break the transgenerational cycle of violence.

DATING ABUSE - HOW DO YOU KNOW?

One of four young people may be in a situation of verbal, emotional, physical, and/or sexual abuse. If you don't feel good about yourself as a partner in a relationship, something is wrong with that relationship.

YOU HAVE THE RIGHT TO:

EXPRESS YOUR OPINIONS AND HAVE THEM RESPECTED

HAVE YOUR NEEDS BE AS IMPORTANT AS YOUR PARTNERS

GROW AS AN INDIVIDUAL IN YOUR OWN WAY

TO CHANGE YOUR MIND

NOT TAKE RESPONSIBILITY FOR YOUR PARTNER'S BEHAVIOUR (ESPECIALLY IF THE PARTNER IS BEING UNKIND AND HURTFUL TO YOU)

NOT BE PHYSICALLY, EMOTIONALLY, OR SEXUALLY ABUSED (MADE TO FEEL DOMINATED, HELPLESS, AND BAD ABOUT YOURSELF)

BREAK UP AND FALL OUT OF LOVE WITHOUT BEING THREATENED.

ARE YOU BEING ABUSED?

ARE YOU:

FRIGHTENED OF YOUR PARTNER'S TEMPER?

AFRAID TO DISAGREE?

CONSTANTLY APLOGIZING FOR YOUR PARTNER'S BEHAVIOUR, ESPECIALLY IF HE/SHE HAS TREATED YOU BADLY?

HAVING TO JUSTIFY EVERYTHING YOU DO AND EVERYWHERE YOU GO?

FEELING THAT YOUR PARTNER PUTS YOU DOWN BUT TELLS YOU THAT HE/SHE LOVES YOU?

BEING HIT, KICKED, SHOVED, OR HAVING THINGS THROWN AT YOU?

NOT ALLOWED TO SEE FRIENDS, OR FAMILY, OR DO THINGS YOU WANT TO DO?

BEING FORCED TO HAVE SEX?

AFRAID TO BREAK UP BECAUSE YOUR PARTNER HAS THREATENED TO HURTYOU OR HIM/ HERSELF?

ARE YOU ABUSIVE?

DO YOU HAVE THE NEED TO:

CONSTANTLY CHECK UP ON YOUR PARTNER?

BE EXTREMELY JEALOUS OR POSSESSIVE?

HAVE AN EXPLOSIVE TEMPER?

HIT, KICK, SHOVE, THROW THINGS AT, FRIGHTEN, OR FALSELY IMPRISON YOUR PARTNER?

CONSTANTLY CRITICIZE OR INSULT YOUR PARTNER?

BE VIOLENT WHEN YOU DRINK OR TAKE DRUGS?

THREATEN YOUR PARTNER OR BREAK THINGS IN HER/HIS PRESENCE?

FORCE SEX ON YOUR PARTNER?

THREATEN TO HURT YOUR PARTNER OR YOURSELF?

THE ABC'S OF MEN WHO BATTER

Who are the men who batter?

Men who batter come from all socioeconomic backgrounds, race, religion, and walks of life. The abuser may be a blue-collar or a white-collar worker, unemployed or highly paid. He may be a drinker or non-drinker. Batterers represent different personalities, family backgrounds, and professions. In sum, there is nothing like a "typical batterer".

The majority of batterers are only violent with their wives or female partners. For example, one study found that 90 per cent of the abusers do not have criminal records, and that batterers are generally law abiding outside their homes. It is estimated that only about 5 per cent to 10 per cent of the batterers committed acts of physical and sexual violence on other people as well as their female partners.

THE ABCs

ABUSED AS CHILDREN

Most batterers were beaten, verbally abused, or sexually abused as children. Treated like objects, batterers were taught, by example, specific techniques to hurt and humiliate others. In addition, batterers learned that violence was "normal" in families; they were taught that bigger people got to hit and abuse smaller people (women/children). In turn, batterers disciplined their children with violence, thus maintaining the cycle of abuse.

BELIEVE IN TRADITIONAL SEX ROLES

Batterers believe in traditional sex roles. They believe that a woman is there to take care of them, feed them, bear their children, keep their house clean, etc. Batterers believe that women should be disciplined if they "disobey their husbands" or "forget their place". Batterers also hold attitudes consistent with ideas of male dominance such as, "A little slap will do her good", or "I'll show her who's the boss." They may be more violent when their partner is pregnant, or soon after she gives birth, because they feel threatened by the baby in grabbing attention.

CONTROLLING

Battering is purposefully a controlling behaviour by someone who wants total control. A man who batters may control his spouse's movements, like where she goes or whom she sees, or may monitor her phone calls, clothing, and make-up. A batterer fears abandonment and, therefore, tries to control his mate's actions in order to feel he has some control in his partner's life and some power in the world. A batterer's fear of not being in control is also related to the fear of death, injury, or the unknown he experienced as a child in a violent or neglectful home. At first, a batterer will say that this behaviour of his is out of concern for the victim's safety.

CRUELTY TO ANIMALS AND CHILDREN

An abuser often kills or punishes animals brutally, or is insensitive to their pain and suffering. The abuser may expect children to do things that are beyond their ability (spanks a two-year-old for wetting a diaper). The abuser may not want the children to eat at the table, or will expect them to stay in their room all evening while he is at home.

DENY, MINIMIZE AND BLAME

A batterer does not want to be responsible for his violent actions or for the harm he causes. Abusive men learn to deny wrongdoing, minimize injury, and blame others.

Men who batter will BLAME others for their actions and say things like, "If she didn't want a beating, why did she interrupt me while I was on the phone," or "She knew not to disrespect me in public.

"Batterers will also DENY hurting their partners with comments like, "She tripped and fell," or "I was swinging at the air, and she walked into it.

"Finally, batterers will MINIMIZE their violent actions with excuses like, "It was just a bump," or "I just twisted her arm a bit." A batterer may also say, "I didn't know what I was doing," or "I was out of control,"—as if someone else was responsible. In reality, battering is target specific: the batterer aims at his spouse-not the mailman or grocer—and he may even aim for specific parts of his partner's body, for example, her pregnant belly, or body parts not visible to the outside world. Moreover, he seems not to remember his actions.

EMOTIONAL ABUSE

Battering is not limited to physical abuse. Emotional abuse may include repeatedly criticizing his spouse—shouting at her, swearing at her, putting down her opinions, or treating her like a servant.

FEEL POWERLESS

Batterers are actually frightened men who are afraid to be alone in the world. Feeling as powerless as children do, batterers learn how to bully and dominate in order to overcome or minimise their sense fear, and avoid being victimized any further.

GREW UP WITH VIOLENCE

Batterers learn early that they can gain control of, and assert power over their partners, by throwing things or raising their voice. Violence becomes an acceptable way to express their emotions, or to get what they want. They also learn early on, by example, that "men get to hit" and "women tolerate it".

HAVE A NEGATIVE BELIEF SYSTEM ABOUT WOMEN VIOLENCE

Batterers lump together "all women" and do not see them as individuals. In addition, they have negative stereotypes about women, such as, "All women are manipulative" or "All women see men as pay cheques." Batterers also dismiss women's ideas and opinions.

INSECURE

Abusive men have a deep-rooted fear of being inadequate. They do not believe they have a lot to offer. Batterers are unhappy with what they are and see themselves as failing to live up to their image of manhood. All their bullying and intimidation serve as a smokescreen to keep others from seeing how insecure they really feel. Batterers are actually very lonely, alienated men.

ISOLATION

The abusive person tries to cut the woman off from all resources. The abuser accuses those who are the woman's supporters as "causing trouble". The abuser may want to live in the country without a phone, may not let the woman use the car or may try to keep the woman from working, going to school, or going to church.

JEALOUS

Batterers tend to be extremely jealous and have difficulty trusting others. They believe that "jealousy is natural in men." An abuser will say that jealousy is a "sign of love." Jealousy has nothing to do with love: it is a sign of possessiveness and lack of trust. The abuser will question the victim about those she talks to, accuse her of flirting, or be jealous of the time she spends with family, friends, or children.

KILL OR TORTURE WHAT THEY CANNOT POSSES

In the worst cases, battering involves extreme physical or mental cruelty, such as, tying up the woman's hands and feet, stabbing her repeatedly so that she requires hundreds of stitches, or cutting her throat. Some batterers stalk and kill what they can no longer posses. These tragedies are usually portrayed as crimes of passion caused by the man's intense love for and inability to live without the woman. However, murder is actually the ultimate expression of the batterer's need to control the woman.

TRY TO PUNISH AND CONTROL WITH SUBTLE FORMS OF ABUSE

Batterers often use subtle forms of abuse to punish, humiliate, and control their partners. A batterer may say things to create fear, such as: "If you EVER let the housework go, you'll be sorry." In addition, a batterer's verbal abuse and criticism often become chronic. A batterer feels so small inside, i.e., he has such low self-esteem, that he will repeatedly put his spouse and/or children down in order to feel more important, or feel better about himself.

UNABLE TO IDENTIFY OR EXPRESS THEIR FEELINGS DIRECLY

Men who batter are unable to differentiate their feelings and they do not have a vocabulary to express their emotions. All of a batterer's emotions are funnelled through anger. In addition, batterers have learned to use violence-instead of words-to communicate their feelings. For example, a slap literally says, "You humiliated me!" and a punch stands-in for "I loved you and you betrayed me!"

VARY BY TYPE

Men who batter vary in types: The Good, The Bad, and The Ugly.The Good: Men who only abuse women emotionally or verbally. They exhort women's equality but control and exert pressure on their spouse and their observations are often laced with snide remarks about women. Moreover, they expect a reward for being nice and are courteous as long as their partners comply with their wishes.

The Bad: Men who physically abuse their mates but not other people. They may be sporadic or frequent batterers. They may even be very charming to outsiders, making it hard for others to believe ill of them.

The Ugly: Men who are violent inside and outside the home, including anti-socials and sociopaths. Antisocials cause severe injuries and have severe drug and alcohol problems. Sociopaths have long criminal records, problems with both drugs and alcohol, and have a sadistic attitude in general.

WILL GET WHAT THEY WANT THROUGH PHYSICAL VIOLENCE

Batterers tell us that violence is a convenient tool to get what they want, to make things go the way they want. Beating the partner is a way to control a disagreement or put an end to a fight. Asserting one's physical superiority is a way to MAKE one's spouse stay.

XENOPHOBIA

A batterer is someone who fears, distrusts, and dislikes that which is foreign to him. This includes his mate, and women in general. In practice, this means that while a batterer may listen to other men, he does not regard women as equal, or take women seriously. Like racists, batterers fear and dislike those who are different from themselves (in this case, women). Also, like racists, abusive men act out of insecurity. Some batterers hurt others or sport others because it satisfies something in them.

YOU MUST FOLLOW HIS ORDERS-OR ELSE... AND NO MATTER WHAT YOU DO, HE IS IMPOSSIBLE TO PLEASE

As one battered woman put it, "You have to follow his commands (e.g. take his shoes off, stay away from his electronic equipment, heat his dinner NOW) as if he was the king and this was his domain and everybody else in the family were his little ants made to serve him." Batterers trigger-off whenever they are ready and for whatever reason they have at that moment. Often, battering occurs over the most trivial things, such as, forgetting to put the butter on the table, not ironing his shirt correctly, or not dressing fast enough. No matter what his mate does, a batterer is never satisfied.

ZERO IN ON PARTNERS' VULNERABILITY

Men who batter often betray the trust of their partner and break her confidence. Batterers also attack and expose their mate's vulnerabilities, and become adept at manoeuvring the confidences their partners have shared with them.

Source : Apna Ghar, Chicago, USA

Theme Section
Patriachy

The struggles of women the world over has led to the evolution of the concept of patriarchy. It encompasses in its entirety the structures of domination and exploitation of women in society.

The term patriarchy essentially means the rule of the father or the patriarch (a male member of the household or society). In feminist theory and practice, patriarchy has been looked at differently from the liberal to the socialist feminism viewpoints (see page 13-18). Defined simply, it implies a system in which the father or a 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. Very clearly, this system establishes male dominance and control over women in society in general, and particularly so within the family. The 'unequal power relationship' between men and women, accrues power to men in all-important institutions of the society. Thus, it is important to see patriarchy both as an ideology of women's subordination and control, and as a term conceptualising the struggle against the same.

The origins of patriarchy can be traced through different stages of civilization and there are several views regarding its origins and universality. The roots of patriarchy lie in history, religion and in the very nature of the concept. For some, it is a system that has a beginning in history, is man made, and can be ended by historical processes in the future. For others, it is a natural phenomenon and is based on the biological differentiation of man and woman. It is thus universal, god given, natural, and cannot be questioned. Changing patriarchy would therefore amount to changing nature. To many the above explanation is not acceptable. They believe that there existed a stage prior to patriarchy where women had a dominant status. This was the matriarchal or matrilineal stage of society. Evidence of such a society can be found in religious myths and symbols in different periods of history. The existence of matrilineal society in some parts of India, especially Kerala, is still evident (see pull-out for details).

While the differing perceptions about the origins of patriarchy can be endlessly debated, it is important to understand the modes of patriarchal control and its institutional manifestations that have led to women's subordination in society.

In this context, one would like to ask the oft-repeated question: "Do women have no power at all?" It has been seen that women are not totally powerless or totally deprived of rights, influence and resources, but that they are subservient to male control. Men have laid down the social norms and role models for women. This ensures that women are unwittingly made complicit in the perpetuation of the patriarchal system through: gender indoctrination (i.e. role stereotyping of men and women); denial of education and knowledge of their own history: dividing them from one another by defining norms of behaviour, i.e., respectability and deviance according to their sexual activities; by discriminating them in the access of and/or control over economic resources and political power.

Since patriarchy is perpetuated through the social, cultural, and religious institutions of society, and legitimized through the political, legal, and economic systems, it leads women to internalize, as well as further perpetuate patriarchal ways of thinking, both in terms of values and behaviour. Therefore, women are not a part of this system or out of it by choice. The system is a complex interplay of factors like sex, gender, class, caste, ethnicity, and race that entangles them in a web of exploitation, discrimination, and oppression. This complex system needs to be understood by women themselves, and by those who actively support or participate in women's struggles.

An elaboration of some of the issues of patriarchy and an examination of its institutional manifestations will enable us to redefine our analytical tools to fight against patriarchal forms of control over women—their identity, their bodies, their minds, their actions, and their very existence...

INSTITUTIONAL MANIFESTATIONS OF PATRIARCHY

1. THE FAMILY

* Man continues to be considered the head of the family, despite 40 percent of the households being headed by women. Man is considered to be biologically superior to, more capable of, and more experienced than a woman.
* Family is the basic unit where the exploitation of girls/women takes place.
* Boys are given higher value (son preference) and socialized 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 have no say in several matters, including sex within marriage, family planning measures, number of children, etc.
* Domestic violence against women is considered natural, and a private affair of the family, so that men can continue to maintain their control and authority over women.
* Sexual division of labour benefits boys and men, since girls/women are engaged in productive, reproductive, and domestic work of the family.
* The family perpetuates patriarchal ideology through gender-based socialization (which includes caste, class, and religious socialization) in which women play both the 'socializer' and 'socialized' roles.

2. EDUCATIONAL PROCESSES AND INSTITUTIONS

* It is well known that the opportunities of education for a girl-child are far less than that for a boy-child, not only within the family, but also in the world outside. The role expectations of the girl-child also influence the content, form, and methodology of education.
* The educational curriculum, the timings of school, the behaviour towards girl children, the training of teachers—all are reflective of the biased attitude towards girls. The patriarchal ideology is built into all the nuances of education.
* Since women are perceived more as 'doers' and 'implementers' than 'thinkers', they are seen as being very capable of using knowledge produced by men to serve men's interests. Therefore, the concept of women as 'creators' of knowledge is being denied in today's context. Thus, despite women having created knowledge that sustains society, it has been seen that her knowledge has been hijacked and appropriated by men.
* One of the significant ways of controlling women's consciousness has been to expose her to selective educational opportunities and information. Her care-takers (father, husband, brother...) perpetually deride her with issues like "Oh, you think you are going to be like men!" " We have heard enough about equality, freedom, but who will do all the household chores"—all in the name of denying her access to education.

3. ROLE OF MEDIA IN PERPETUATING SEX STEREOTYPES

* Today's media is in the control of elite men and it is most effectively used to portray the values of the upper class and upper caste, of dominant religions, and communal identities.
* 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. The co-modification of women and their bodies has reached an all-time high, with rape, nudity, and molestation being used for entertainment and marketing consumer products essentially for men's use, for example: shaving cream, men's underclothing, etc. The subliminal images of sexuality and violence on women are used to arouse and gratify men's desires and passion. Such depiction of women has a long-lasting impact on children who identify very strongly with these images.
* Women are primarily seen as 'consumers' for household products, 'consumers' of religious discourses and processes, 'consumers' of products to beautify themselves for male pleasure, etc.

4. MEDICAL HEALTH PRACTICES AND SYSTEMS

* Women's health has always received secondary importance. Research has clearly indicated the intra-household differences of distribution and consumption of food between boys and girls, men and women. Similarly, with respect to health care and medicines, women have been neglected, and it has affected both her physical and emotional growth. Women are anemic all the time, but despite that, continue to perform certain hard chores and long hours of work.

* Women's health has been given value only in relation to her child bearing role, (that too, in the hope that a male child will be born, but not as a person or a women. Post-natal care is also dependent on the sex of the child. Family planning advertisements on TV bear testimony to this concept. Examples from literature and religious texts have shown the psychological burden women have to bear in anticipation of a male child and the guilt they are made to suffer in the event of not giving birth to one.

* Women's bodies have been considerably used for experiments, particularly in the area of family planning techniques, which are geared to harassing and exploiting women's bodies to the exclusion of men's bodies. The intrusive technology of family planning has had severe side effects on women's health and bodies. For example, today, the harmful side effects of Norplant N (an inject able hormonal contraceptive) are being brought to light.

* Medical research has not sufficiently understood and analyzed women's health issues. Medical practices and health systems are designed and practiced to suit patriarchal biases (e.g., in gynaecology, psychology, psychiatry, etc). For example, the mental health of women is not given due recognition and even symptoms of menstrual cycle and physical stress are considered as psychosomatic and neurotic. The occupational health hazards of women go unrecognized both at home and in the unorganized sector. The technological revolution in computers and pressing machines have further increased the physical stress of women, thus affecting their already overworked bodies. This has also happened because much of modern machinery has been designed keeping in mind the physique of men, particularly those belonging to the West (for example, machines used in the pharmaceutical and other industries). In fact, medical services have still not taken cognizance of these components of women's health.

* Women's traditional knowledge of medicinal and health care practices is invalidated. However, today's booming pharmaceutical industry is successfully remarketing these traditional 'home based' remedies made by women.

5. RELIGIOUS INFLUENCE AND STRUCTURES

* Religion has primarily been in the control of men—the priests, the prophets, the *maulvis* and their likes. 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.

* Rights, duties, morality, ethics, behaviour of women, relationships with others in society, etc, as laid down by religious norms, emphatically state that women are inferior, impure, sinful, frivolous, emotional, deviant, etc.

* Religious texts continue to glorify certain images of women (e.g. Sita, Savitri, etc), thus perpetuating stereotype 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.

* Women are used to propagate religious and gender ideology that strengthen men's position. They are also seen as carriers of moral values and cultural practices.

* Religion defines and rationalizes women's life-long subjugation to men, recognizing her only in her roles vis-à-vis certain men in her life, thus negating a woman's individual identity.

* 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.

* Fundamentalism affects women, because there is a fundamental assault on their freedom and identity. She is driven into the home, the social norms are tightened, her communal identity is juxtaposed with her already existing identity, and she is restricted to spaces identified by men.

* We have also seen the close nexus between religion and politics. In this game, women become victims of communal and political violence unleashed by men to settle scores between themselves. In the event of communities warring against each other, women have to pick up the debris to take care of the family and children.

6. MICRO AND MACRO ECONOMIC SYSTEMS AND INSTITUTIONS

* Most properties and economic resources are in the hands of men.

* The domestic work of women is unrecognized and unpaid; productive work like agricultural work, tending to animals, preparing manure, collecting fuel also goes unrecognized and is undervalued.

* As a labourer and worker, the value of a woman's work is considered at a lower scale than that of men because it is assumed that it is less laborious than that of men. Therefore, her wages are less than that of men.

* The macro economic policies initiated at the behest of international agencies influence the economy of underdeveloped countries, and have a negative impact on women. Firstly, retrenchment of workers affects women, as she is rapidly sent back to the informal sector (to which she belongs anyway!), where she is poorly paid, and has no access to social service benefits. Moreover, she continues to have a declining access to shrinking resources like land, water, and forests.

7. LEGAL PROCEDURES AND VIOLATION OF WOMEN'S RIGHTS

* Legal systems today favour the economically powerful, that too men.

* Personal laws pertaining to family, marriage, divorce, custody, and inheritance are in congruence with different religious norms, which give priority to men and disempower women. While some personal laws are slightly progressive than others, the common denominator is an iniquitous gender balance. In recent years, certain demands for strengthening patriarchal features in personal laws have been made. A case in point is the demands made by some Sikhs (currently governed by Hindu personal law) for a separate Sikh personal law. This will deprive daughters of their right to ancestral inheritance and make the custom of levirate (i.e., a widow marrying the brother of the dead husband) mandatory. This will also ensure that the property she inherits from her husband remains within the family.

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

* The structure and process of the legal system makes justice inaccessible to women, e.g., in procedures related to getting bail where very often property and other legal documents are necessary, and in the absence of which women are denied basic legal rights.

8. POLITICAL PROCESSES

* Political processes are in the hands of powerful men. Most women who enter this system have class, kinship relations with powerful men, and are thus easy targets for manipulation. For women who make it on their merit (there are very few of them), the struggle is immense. Their political minds are negated; their femininity is used to neutralize political issues.

* Women panchayat leaders have little support from men, because women's leadership is usually grudgingly accepted. The world of leadership is defined in masculine terms and embodies the male ethos. Thus, the struggle to establish an alternative leadership is hardly thought of.

* As voters, women face threats of violence and victimization, and are hardly able to exercise their franchise in informed ways.

* Women have no 'informal political forum' since politics is supposed to be the preserve of men.

STEREOTYPES

FEMINITY	MASCULINITY
talkative	brave
tactful	ambitious
gentle	aggressive
submissive	active
religious	dominant
dependent	independent
emotional	objective
weak	strong
illogical	logical
lack confidence	self confident

9. GOVERNMENT AND ITS VARIOUS ARMS OF CONTROL

* The State is supposed to protect its citizens, especially the vulnerable sections. However, we have seen that the state is most representative of the patriarchal ideology: where the legislations go against women's interests, the judiciary seeks to protect men as opposed to women; the executive implements laws and procedures, which accrue to the interest of men.
* The State operates within the ideology of gender and recognizes women primarily as homemakers and secondarily as workers, and this is evident in their policies and programmes on education, health, childcare, etc.
* The Army/Police subject women to brutal violence either tacitly or actively.
* The government also controls women's reproduction by evolving family planning programmes that invade women's bodies and sees them as targets for experimentation.

Note: what needs to be recognised from the above analysis is that women are caught in a web of patriarchal institutions, each of which has certain specific characteristics of control and authority. These institutions do not exist in isolation, but have complex interconnections that define the systemic nature of patriarchy.

KEY HIGHLIGHTS

PATRIARCHY

* The term means the rule of the father or patriarch, in a sense the rule of men.
* An ideology of women's subordination
* Underlying basis is that men are superior to women and women are part of men's property.
* Manifestation of a social reality that is intermeshed with class, caste, race, ethnicity, and gender
* Establishes male dominance and control in the family and society at large
* Has a material basis, benefiting men
* Perpetuated through institutional beliefs and structures, which are kept in control through violence and cohesion
* Not static—keeps changing over time in different classes, castes, race, and ethnic groups

MODES OF PATRIARCHAL CONTROL

PATRIARCHAL CONTROL IS EXPRESSED THROUGH

CONTROL OVER WOMEN'S PRODUCTIVE POWER

Starting from the family to the outside world, women perform certain services, which constitute her labour power. This includes household work, child rearing, economic activities within and around the household, etc. However, her work in the confines of the home is not considered as 'work'. Why? The division of labour within the family serves the interests of men who can continue to be 'masters of the home' or 'head of the household', whilst women continue to maintain and run the household for them, so as to enable them to continue working outside.

Even for women, who are today working outside the family domain, we see that men control their work. From decisions relating to what kind of work she should do, to controlling her income, the pronouncements of men in the family prevail. Therein they control her 'mobility'. Mobility in terms of where she can and cannot go, and upward mobility in terms of her aspirations as a career woman (with its promotions and increased responsibilities), since her work is being validated because of the money she brings for the household.

Since men have defined the nature of women's work and decide on the 'value' it deserves, even the work she does outside her home is undervalued. This is evident in all the sectors —be it construction, agriculture, administration, teaching, etc—where women are paid less for the same amount of work than men, and are accorded lesser status than men. Men also sell the labour of their women and children, especially girls, (through prostitution, begging, etc.). In all these forms of control, men benefit materially and economically from women's labour.

CONTROL OVER WOMEN'S REPRODUCTIVE CAPACITIES AND SEXUALITY

Historically men have controlled women's reproductive capacities and roles. Men decide on how many children the woman should bear, and in what frequency. They decide on the number of 'sons' or 'heirs' that need to be born. In our society, the mother gains her status from the number of sons she has produced. Women who produce daughters alone are bemoaned at, and seen as having some 'biological problems'. Decisions of family planning are mainly taken by men on behalf of the women.

The father too influences child-rearing practices, since he is considered the natural guardian of children by our social and legal systems. Thus, "gender-based socialization in the family is sown through patriarchal seeds, and girls grow up to be 'women', and boys to be 'men' ".

Women lack knowledge about their bodies through 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. Thus, by maintaining control over women's bodies, men continue to subordinate women to a great extent. Rape, and the threat of rape, is a significant way by which men control women's sexuality. This also takes the form of prostitution, and rape within marriage. While men restrict the expression of women's sexuality outside marriage, they retain the 'liberty to have sex outside marriage. Any extra-marital act of sexuality by women is considered deviant behaviour.

CONTROL OVER ECONOMIC AND MATERIAL RESOURCES

Most property and other productive resources are in the hands of men and pass from one man to another man, generation by generation (from father to son to grandson etc). Women seldom have access to such resources; therefore, control is a rarity. In some social systems, large property resources are in women's names on paper; in reality, their control lies with the men. The men in the family decide on how and where to invest, they retain certain properties in the name of women to escape financial regulations of the state (as is the case especially among the upper and middle classes), and women are made mere signatories. These controls exercised by men are against fundamental human rights.

CONTROL OVER DECISION-MAKING IN ALL ASPECTS OF WOMEN'S LIVES

Needless to say that when men control all the above mentioned areas of women's lives, they are in fact exerting power over them through the economic, political, religious, social, and cultural institutions.

Use of violence becomes one of the legitimate ways of controlling women— be it violence on the home-front, i.e., domestic violence; be it rape within a m further carriage or outside it; be it sexual abuses of all kinds within the family (incest) or outside it; or be it harassment of women workers by subjugating them to sexual humiliation and threats. Men control women by imposing restrictions on their mobility, by controlling their sexuality, their productive and reproductive abilities. They also decide on the clothes women/girls should wear, the timings they should keep, the people, especially men, they should talk to.

Source: Kriti, No. 3, Jan-June 1993

Handout 3

m9ura te -&vrIdevI

s&0qaRcI kha8I

s&vad, S{aI A_yas ke&d/, smaj=aS{a iv-ag, pu8e iv±apI5.

ya AakDevarIt dDI&y ka

yat dDIay vgIRy, jatIy Aai8 pu£qsTtec ;ithas

gErsmj

bIaTkar Š fKt pu£qI Aakœm
d=Rn nahI tr ha sTta0arI vga
sTtahIn iS{aya&vr kelela AT

kulIn S{alvr k0I
blaTkar haetae?

dr ÎÌ imin4ala @k blaTkar
dr ÊÎ imin4ala @k ivny-&g

bIaTkar Š jmatI v jatIy
d&Gya&m)ye AapsI vEran
wgiv*yace hukmI =S{a

ivStva=I lae8I Aal&
kI ivtã8arc

dr ÌË imin4ala @ka S{aIce Aphr8
dr ÍÉ imin4ala @kIcI 2eD2aD

blaTkar kr8are
il&gipsa4 v mnae£G8

bIaTkar Š baher kay? 3rhI Asuri

raej ËË iS{aya&vr blaTkar
dr vqIR Ê d=Ix iS{aya&ca bãI

ba:cI Ab/U Mh8ij
3racI ;JJat !

blaTkar Š ‘fKt ba:cIc ;JJat jate?
blaTkar kr*yaéyaCya ;JJatIce kay?

Anaeã`I laeka&bãaebr
mulI&nI jav&c k=ala?

blaTkar nae&dvla jat nahI kar8
blaTkairt S{aI @k kI&k

bIaTkar Š fKt S{aICya ;JJatIca p/+n na
p/+n Aahe S{aIca SvtŠCya =rIravr fKt itCy
Ai0karaca.

kayda nustac vayc

blaTkar kayda

-artIy d&Div0an kIm ËÏÍ
jeVha @`ada pu£q `alII piriS9tIt @`a±a S{aI=I bãjbrIne s&-aeg krtae teVha blaTkaraca guNha kela Ase manle jate.

É. S{aICya ;C2eiv£²

Ê. itCya s&mtIi=vay

Ë. ku5LyahI p/karcI dh=t 3alUn

Ì. ip/ykr ik&va ptI AsLyace -asvUn

Í. tI S{aI n=eCya A&mla`alI Astana

Î. Tya S{aIce vy ÉÎ pexa kmI AsLyas.

ya kay±anusar ‘yaenIt il&g p/ve= hae8e’ @v7I ikœeya blaTkar hae*yas pure-a Aahe.

blaTkaraca guNha ha d`Ipa{a AjamInpa{a.

i=xa kmIt kmI ÉÈ vqeR v jaStIt jaSt jNm5ep.

‘blaTkar zala’ he is² kr*yacI jbabdarI ifyaRdI S{aIcI.

pãva4a

ptIne pTnICya ;C2eiv£² kelela s&-
blaTkar 5rt nahI. ‘vEvaihk blaTkar’ hI s&kLpna AmaNy.

kayda S{aICya s&mtI v =r8agtIt frk krt nahI.

kevã ‘yaenIt il&gp/ve=’ hae8e MI
blaTkar. pr&tu TyapUvIR S{aICya
hae8are ATyacar v lE&igk -agavr
ja8aéya j`ma blaTkar 5rt& nahIt.

lGnasa5I mulIce vy ÉÐ vqeR pU8R
p8 pTnI ÉÍ te ÉÐ vyaeg4atII AseI
tae itCya=I ptIne kelela s&-aeg ha
blaTkar 5rt nahI.

ALpvyIn mulIvr blaTkar zaLyas itce
‘vy ÉÐ pexa kmI Aahe’ he is² krave
lagte. te Anekda Av3D jate.

ya guN-aCya i=xeCya s&d-aRt Ny
AapLya Ai0karat AaraepIcI i=xa km
k£ =ktae.

---

bãI tae kanipãI ha inym maeD*yasa5I kayda
Aala. p/Tyxat ma{a p/S9aipta&nI SvtŠCya fay±
vapr kela Aai8 ifyaRd 3eWn ja8arI S{aIc bãI

tpas8Ice duQ4ck/

paeIls

iniQk/yta Aai8 nkaraTmk d<iQ4kaen.

blaTkaraca guNha nae&dv8e é S{aIsa5I @k idVy.

paeIlsc guNha nae&dv*yapasUn prav<Tt krtat.

AshkayR é blaTkara=I s&b&i0t vStU&ca Aai8

jageca p&cnama kr*yat idr&ga:.

rxkc -xk bntat.

vE±kIy tpas8I

mhTTvaca purava p8 Aa8`I @k AiGnidVy.

‘kaEmayaR’cI cac8I! Aav+ykta kay?

tI kay is² krte? S{aI kumairka Asae va nsae,

itCyavr blaTkar haeW =ktae.

Anav+yk tp=Il k=ala?

yaenIp4I fa4le Aahe va nahI?

=uk/j&tU Aahet ka nahIt ?

S{aIne Aa&3aeã keLyamuãe purava nQ4 haetae. yaca

blaTkar zala nahI Asa haetae ka ?

vE±kIy tpas8I kr8are Da$K4sR S{aICya AshaYYateca fayda

NyayalyIn tpas8I

s&mtI v =r8agtI yatIl frk dulRixt.

S{aIce nIit0EyR `CcI kr*yasa5I Anav+y

A[III p/+na&ca -iDmar.

vadaca ke&d/ib&dU é ‘S{aIce cair{y’.

j8U S{aIcI vag8Ukc blaTkaras kar8I-Ut.

saxIdar @k purava é Aa8`I @k ADc8.

paeIls, vE±kIy tpas8I Aai8 NyayalyIn p/ik/

tIn AiGnidVy. j8U dusra blaTkarc.

lhan mulI&vr hae8are blaTk

ÉÑÐË é ALpvyIn mulI&vrIl blaTkaraCya guN-at A
ÉÈ vqaR&Cya i=xecI trtUd.

Nyayalyaca d<iQ4kaen é braebr iv£²

Ï vqaRCya hirjn mulIvr ÉÐ vqaRCya mulane blaTkar kela p8
Ixat 3eWn Nyayalyane Tyala Í vqaR&cI i=xa idlI.

Anekda lhan mulI&vr hae8are blaTkar kr8are 3ratlec pu£q A
kaka, mama, cultémame -aW, kahI veãa vDIlsu²a. yamuãe
dbII jatat. yatUnhI @`ada `4la w-a raihlac tr nKkI kay zaale
mulI&na sa>a yet nahI. 3DlelI 34na hI Tya&Cyasa5I duŠS
mulI yamuãe w)vSt haetat.

lE&igk ATyacarala fKt mullc
bãI pDtat Ase nVhe. tr bãI
pD8aéyat mul&hI Astat. ma{a
mulI&vr hae8aéya lE&igk ATya
p/4ma8 `Upc jaSt Aahe.

idLLaItIl @k w±aejk SvtŠCya
bara vqaR&Cya mulIvr raej blaTkar
krt haeta. TyaCya mae5ya mulIne
ya {aasala k&4aãUn AaTmhTya
kelI. teVha Tyane SvtŠCya 0ak4ya
mulIla AapLya ATyacaraca bãI
bpivle.

ËÑÑË m)ye ÉÈ vqaR&`alI AsleLya ËÑÌ mulI&vr blaTkar
blaTkaratIl ÏÈ 4Kke blaTkar he 3rI ik&va =ejarIpajarI hae

s)yaca blaTkarivqyk kayda, S{aIvrIl blaTkar v lhan mulI&
blaTkar yat frk krt nahI. Mh8Unc Anek S{aIés&34na&n
mula&vr hae8aéya lE&igk ATyacaraCya s&d-aRt Svt&{a
kelI Aahe.

mI m9ura ...... •ÉÑÏÊ—

@k ÉÎ vqIRy AaidvasI mulgI. ip/ykrabraebr pãUn geLyaCya Aaraepa`all paells caEklt nele. it9e maZyavr hvaldarane blaTka kela. jmavaCya dbabamuãe guNha nae&dvUn 3e*yat Aala.

vE±kIy tpas8Is ÊÈ tas ivl&b.

p/itkaraCya `u8a nsLyane guNha is² hae*yas ADc8.

kaEmayR cac8It inQkqR é s&-aegacI svy.

c&d/pUr s{a Nyayaly é

AaraepI&cI indaeRqI muKtta.

vy ÉÎ AsLyaca sbã purava nahI.

Aivvaiht mulgI s&-aeg k£ =kt AseI tr tI ku8abraebrhI zaepU =kte.

s&-aeg zaLyace maNy. p8 blaTkar zala yas nkar.

wCc Nyayaly é

AaraepI&na Í vqaR&cI sja.

's&mtI' v '=r8agtI' yatIl frk Ixat 3e*yat Aala.

ra{al paells caEklt S{alvr blaTkar hae =ktap he maNy kr*yat Aale.

AaraepI sevetUn bDtfR.

svaeRCc Nyayaly é

ÉÍ sP4e&br ÉÑÏÐ

AaraepIce svaeRCc Nyayalyat ApIl v indaeRq muKtta.

p/itkaraCya `u8a nsLyane, itcI s&mtI haetI he g<hIt 0£n blaTkar zala nahI Ase jahIr kr*yat Aale.

ÉÑÐÈ te ÐËCya kaãat tIv/tene zaleLya S{alés&34na&Cya Aa&daelnamuãe kay±at 3DUn Aalele bdl.

É. S{al, pu£qaCya kS4DIt Astana itCyavr blaTkar zala tr Tya guN-at 'blaTkar zala nahI' he is² kraycI jbabdarI Aata AaraepIvr ....
i=xa kmIt kmI ÉÈ vqeR.

Ê. `4Lyace kamkaj guPt rItIne calv*yace 5rle. ifyaRdIce nav 5ev*yace Aade=.

Ë. sUyaRSt te sUyaeRdy drMyanCya kaãat S{alla paells caEkIvr n mihla Da$K4rkDUn vE±kIy tpas8I.

p8 yan&tr pu7e kay ?

mI rmIza bI ...... •ÉÑÏÐ–

kQ4krI vgaRtIl @k S{aI.

ra{aI nvéyabraebr isnemahUn prt yetana paeIIsa&nI ve+ya AsLy
paeIIs caEkIt nele. it9e Ai0karI Aai8 hvaldara&kDUn blaTkar kr*y

purava nQ4 kr*yasa5I jbrdStIne Aa&0aeã 3atlI.

ya iv£² wTSfUtR Aa&daelne w-I raihlI.

ya p/kr8aCya caEk=Isa5I Svt&{a Aayaegacl nem8Uk.

paeIIsŠ

paeIIsa&nI bcavaTmk piv{aa 3etla. blaTkaraca mudd\a 4aãUn it
kr*yas survat kelI.

paeIIsa&cI prSprivrae0I iv0ane é tI bur~yat haetI Ase Mh8tana it
d=Rnaca Aaraep 5evla gela.

paeilsa&Cya ;-/t ra`*yaCya p/yTnat rmIza bI NyayapasUn v

AaMhI prarIya gavatIl pac kQ4krI iS{aya

AamCya zaepDya&vr paeilsa&nI hLla kela. ÊÍ paeIIsa&nI AamCyav
s&d-atR srkarne ÉÈÈÈ £. nuksan-rpa: idlI.

NyayalyŠ AaraepI&cI indaeRq muKtta !

kar8Š

É. kQ4krI iS{aya&Cya cair{yacI hmI de8e k5I8 Aahe.

Ê. ÉÈÈÈ £pya&sa5I Tya `ae4& baeIU =ktat.

Ë. Aitp/s&g zala AseI p8 blaTkar fKt ApvadaTmk iS9tItc haetae.

Ì. ÊÐ te ÎÐ vyaeg4atlI pu£q @kaveãI blaTkar ksa krtII ?

Í. virQ5 paeIIs Ai0karI kinQ5a&smaer Ase vtRn kr8ar nahIt.

mI maya TyagI > > > > >

Í mihNya&cI g-RvtI S{aI.

ptIsaebt -avaCya lGnala jat Astana paeIIsa&nI 2eD ka7lI.

ptIla marha8 k£n gaeãI zaDII. Tyat Tya&ca m<TyU zala. Na&tr m
k£n bajaratUn i0&D ka7lI.

“n&tr paeIIs caEkIt maZyavr samUihk blaTkar kr*yat Aala.”

paeIIs é paeIIsa&nI SvtŠca guNha lpiv*yasa5I gaeQ4 rcII kI mayaca
haeta Mh8Unc TyaCyavr gaeãIbar kr*yat Aala3a lt*yasa5I
Aale haete. Tyamuãe jmavane icDUn itcI i0&D ka7lI.

rajkar8I é lGnala calII AsLyane itne daigne 3atle haete. ya babt tTka
p&tp/0an ;&idra ga&0I&nI iv0an kele, “iS{aya&nI daigne 3a
Anek rajkIy pxa&nI mayala pai5&ba idla, p8 blaTkaraca mU
lEig&k ATyacar ha bajUlac rahUn Tya&nI ‘S{aIcI ;Jjt hIc k
v smajacI ;Jjt’ A=I iv0ane kelI.

Nyaya0I= é tBBal Aa5 vqaRn&tr inkal lagUn AaraepI&na i=xa zalI. p8
kalav0It Aa8`I @ka S{aIca bãI gela. mayacI sasU Mh8alI, “Aa
veãIc i=xa zalI AstI tr duséya S{aIca bãI gela nsta.”

mI sumn ra8I >> > > > >

hrya8atIl samUihk blaTkar

wCc Nyayaly @kacI indaeRq muKtta tr caE3a&na k5aer i

svaeRCCa Nyayaly é AaraepI&cI i=xa Í vqaR&ne kmI !

i=xa kmI kr*yacI kar8e

é guNha nae&div*yas zalela pac idvsa&ca i

é itce s&=yaSpd cair{y !

“bhutek veãa blaTkaraCya `4Lyat Nyay detan
S{aIce cair{y ivcarat 3etle jat AsLyace Aa7ãte.”

mI -&vrIdevI > > > >

@k dilt S{aI é vy ËĐ

rajS9an mihla ivkas kayRk/matII sa9In

smajatII va:4 £7I&iv£² maza I7a

-4erI gavatLya 'gujr' jmIndar balivvah rae`Lyaca pir8am éé

ÊÊ sQ4e&bIÑÊ ÉÑÑ aejI maZyavr zalela

samUihk blaTkar

guNha nae&div*yas nkar

Nyayasa5I I7a su£c > > >

Da$K4rla&Tkar aCya d<iQ4ne tpas8Ist nka

pir8am blaTkar aca guNha is² hae*yas ADcN

smajatIl bihQkar

trIhI sa9In v S{aI s&34na&ca -&vrIdevIla pa5I&ba sI.bI. Aayr

Nyaya0I Š= keIl- ih&dU 0maRm)ye, pTnIvr blaTka
Astana ptI b3t bs8e =Ky nahI.

s{a NyayalywCc Nyayaly
pa&chIj8 ;9ehI
indaeRqI inra=ac

wCc jatIy pu£q kinQ5 jatIy S{aIvr blaTkar kr8ar nahI

kes pa&7re zaleLya S{aIvr blaTkar =Ky Aahe ka?

kaka, put*ya @k{a @S{aIvr

blaTkar krtII kay ?

@ka dilt S{aIne wCc jatIy pu£qp/0antela idleLya AaVhanacI sja é
Aaj de=-r -&vrIdevICya I7yane sm9Rn haet Aahe Aap8hI Aapla pai5&b

puNha @kda blaTkar ivr
Aa&daelnacl grj

ÉÑÏÑ é m9urela Nyay imãvUn de*yasa5I -art-r Aa
S{aI s&34na, vataRhar, isiVhl ilb4IR g/uP
kayda t}a ya&ca sh-ag.
-art-r inqe0aTmk maeceR.

blaTkaraca p/+n ha vEyiKtk n ra
rajkIy bnla.

maya TyagI > > > rmIzabI > > > sumnra8I > > >
Aai*a Anek n nae&dvleLya keses > > >

ÉÑÑÊ éé -&vrIdevIvrII ANyay éé prt @kda taec p/-

blaTkaraCya p/+navr puNha @kda s&3i4t Aavaj v
grj > > >

blaTkaracI Vyapk Vya~ya é vgR, jat v vyaCya gu&tagu&
Aav+yk. kay±atIl blaTkaraCya Vya~yeca punivRcar Vh

ivvaha&tgRt blaTkaracI nae&d 3etII javI.
samaijk jai8vetUn samaijk dbavacI grj.

Handout No. 4

How Adults Learn

* Adults learn only what they like.
* Adults learn by their own ways.
* Adults use their own personal experiences for learning.

PRINCIPLES OF LEARNING

* Adults are exposed to many internal and external pressures. They learn throughout their lives.
* Adults have certain predisposed ideas, which are based on their own experiences. So learning is influenced by their previous experiences.
* It is necessary to respect one's experiences; otherwise, adults think that they are useless. This kind of thinking hampers their learning process.
* Adults only learn if the atmosphere is conducive to learning, gives them encouragement, gives them a secure feeling, and treats them with respect.
* Adults come for learning with their own needs, emotions, expectations, and problems. If these are respected, then only can one generate enthusiasm in them for learning.
* Solutions to the problems of adults should come from their own experiences and analysis. These should be related to their life experiences.
* It is necessary to evaluate these adults through regular feedback.
* If the adults' need for learning is satisfied successfully, then only will they be interested in learning further.
* Adults go through a lot of emotional upheaval while learning; this can range from enthusiasm to tension, fear, anger, etc. These can affect their learning process. Therefore, it is essential to handle such situations with care.
* Different adults learn differently. Therefore, it is essential to use different teaching techniques for each of them.

<u>Adults learn better if the following facts are kept in mind while teaching them</u>

* Give them encouragement
* Make them understand their own life experiences
* It is okay if any mistake is committed.
* Everyone is unique.

* It is very natural to be not clear.
* Respect yourself and others for the things they need to learn. This is possible in a free atmosphere.
* Make learning a two-way process
* Create a good atmosphere among learners

Trainer should also remember

* Training is to be based on trainees' needs.
* In training, it is essential to increase one's capacity and awareness along with the information. Therefore, it is necessary to use new ideas, techniques and views for training.
* Learning through experience should be emphasized during training, for example: past experiences, experiences gained through games and role-playing should be used.
* Training should create a very relaxed atmosphere. Participants should be assured that they will not be ridiculed or laughed at if any mistake occurs. They should be encouraged and constantly appreciated, to increase their participation and enthusiasm.
* Training should be related to life experiences of the participants, so that they can utilize it in their day-to-day work.
* Participatory training can be used to form a group or to start some cooperative effort.
* Finally, trainers should not only have knowledge and skills of training, but they should also realise that their values and behaviour play a vital role in the teaching process. Trainers should be finely tuned to the participants' emotions. They should be good listeners. It is only then that they can ensure good group participation.

Source: Translated by WCHP Priya, New Delhi, 1994. Prashikakon ka prashikshan sahabhagi prashikshan padhatiti

Different Methods of Learning

Different methods are used for participatory training. They are as follows:

I) LECTURE

This method is used to give new ideas and information to trainees. The lecture method can be used to either give information or to summarise a session after it is completed. One can use charts, slogans, pictures, posters, and transparencies to supplement lectures. These aids make learning more effective and interesting. If certain important questions are asked, then lectures become a one-way communication rather than a dialogue with the lecturer. Therefore, it is necessary to decide how one can use lectures for optimum results.

Points to remember for good lecture

* One should be well prepared with the subject and contents of the lecture.
* The lecture should be based on the objectives of the session.
* Introduction should be interesting.
* Observe the given time limit.
* Points in the lecture should be informative.
* The level of the lecture should match with the participant's level of understanding.
* If the lecture is long, try to involve the participants.
* Try to maintain eye contact with the participants by having proper seating arrangements.
* The body language of the trainer should be such that it doesn't detract the participant.
* The seriousness of the topic should be maintained.
* Don't preach the participants.
* The language of the lecture should be simple and lucid.
* The main objective of any lecture is to disseminate information and ideas. Keep that in mind, always.

Advantages

* One can properly give information and ideas through a lecture.
* A good lecture can enthuse and involve the participants in the subject.
* It is easier to give information and views to the uneducated through a lecture.

Limitations

* Only a trainer's views and understanding can reach the others through a lecture.
* Participants are not active recipients during the session.
* It is difficult to evaluate the effect of a lecture on the participants.
* Irresponsible trainers can confuse participants with wrong information.
* Many times the lecture method is more beneficial to trainers than participants, because their work is done once the lecture is delivered, but one is not sure whether the participants have gathered the information or not.

II) SMALL GROUP DISCUSSION

Small group discussions help participants to share their ideas, views, and experiences on the given subject. This helps them to think and participate effectively.

Advantages

It is necessary to understand the subject that they discuss.

* Participants find it easier to discuss in groups. They express themselves in a better way.
* This method increases group participation.
* To assimilate certain things, small group discussion is effective.
* This method also creates a friendly atmosphere.

Points to remember

* Make appropriate groups, e.g., keep participants of same age, or designation, or place, or experience together; though sometimes mixed groups are also beneficial. Division of groups will mainly depend on the topic and objectives of the group discussion.
* A trainer should participate in all the groups for some time. This will enable him/her to see whether the participants have clearly understood the topic, and whether they have actively taken part in the discussion or not.
* Keep track of the time and remind the group of this so that they can summarise their discussion.
* The trainer should give the group a plan to present the topic so that they can introduce their ideas effectively.
* One person from each group should be selected for the presentation. The selection of this person should be done by the group.
* Equal opportunity should be given to all the groups for making their presentations.
* If the trainer wants to save time by way of avoiding repetition of certain points, it should be told to the groups.
* The trainer should appreciate in the end the efforts of the participants and conclude by summarising the points.

Limitations

* It is necessary to have a good facilitator.
* Sometimes more time is required to complete the given subject.
* If the participants do not take the discussions seriously, then this method fails.
* More space is needed for all these groups to sit.

CASE STUDIES

Case studies method uses the experiences of people, other than the participants, for learning.

Case studies are either written down or narrated. The topic for case studies should be suitable for the session.

Objectives of using case studies as method

* To give participants an exposure to varied experiences.
* To make participants think, to reflect on the experiences provided in the case study, and to compare them with their own experiences.
* To take an objective look at the situation given in the case study, and think of ways in which the participants would have behaved if they were involved.
* This is to make them understand of the different attitudes of people to a given situation.
* Case studies are good technique to make people think, evaluate, reflect, and conclude on certain topics.
* Case studies enable participants to get acquainted with different experiences of people, institutions, etc.
* When a situation is analysed in a group, it helps to get new information, knowledge, and ideas.

Methodology of case study

* Listen to a presentation of or read a given case study.
* Analyse it individually.
* Have a small group discussion of these individual analyses.
* Make certain points from this discussion.
* Discuss these points in a group.
* Conclude

The trainer has to ask questions, make participants think seriously, explain, and correlate case study experiences with participants' experiences.

Advantages of case study

* We can think of various ways of solving a particular problem and decide on the best way to do it.
* It creates greater awareness about a given topic.
* Case studies help to analyse and plan accordingly.
* New ideas, and information get aired.
* If a participant has similar experiences like that of the case study, then it gives him/her more strength to solve the problems.

Limitations

* Participants tend to get too emotional about the experiences in the case study, and not much analysis gets done objectively.
* Sometimes discussion of topics not related to the objectives takes place, and the main topic remains unanalysed.

* It takes a lot of time to find the right case study, and the time to prepare for a proper presentation.

III) ROLE PLAY

Role play is a good method of learning in which participants can depict their real-life experiences. It helps to demonstrate different problems faced by people and the situation can be acted out. After the role play, the audience can discuss and evaluate the problem.

Characteristics of a role play

* Role play generates a lot of enthusiasm.
* It makes everyone think sensitively about each other's problems, experiences, and emotions.
* It helps to understand human nature and relationships, and think about them objectively.
* Role play can help to bring out suppressed feelings and ideas, and after evaluating them, new conclusions can be arrived at.
* Role play helps to understand a situation and the reasons behind that situation.
* Evaluation and feedbacks help to change the behaviour and ideas of a group.

How to use role play

* Make the objective of a role play very clear.
* Ask participants to come forward and participate in the role play. Explain to them about the roles they would be enacting, and to the observers what they need to observe.
* Give enough time to prepare and present the role play.
* After the role play, ask each one on what they felt about the play.
* Ask the actors and the observers to give feedbacks, and discuss these with reference to the objectives.
* Give enough time to the participants in the role play to come back to their normal roles.
* Summarise all the points that have evolved out of the discussion.
* Sometimes participants get carried away while portraying by the emotions in the role play, e.g., crying, shouting, etc. Help them to come back to normal.

Important instructions

* Discussion after a role play is very important, therefore, explain to the participants the objectives, and the subject of the role play carefully.
* Give certain directives for the discussion.
* One can ask the following questions to generate an interesting discussion:
  1. What did you see?
  2. What did you observe in this particular scene?
  3. What were the emotions or feelings of these people in the role play?
  4. Did you experience any emotion or feeling while watching the play? If yes, why? And what was it?
  5. Will you be able to do the same role in a different way? How?
* Either the trainer himself can enact the role play, or give time to the participants to prepare for it.
* It is essential to see that no negative feedback is given as it may create tension in the group.

Subject of a role play

Sometimes facilitator (trainer) will have to explain the roles in detail with respect to certain situations, feelings, actions, and attitudes. The things that should at least be explained to participants

are:

* Where is this particular event taking place?
* Which are the roles?
* What is going to happen?
* Reasons behind a particular role, etc.

Advantages of role play

* This is a very easy and cost-effective method.
* It helps us to concentrate on a particular situation, and provides ways to face it. It makes participants to think.
* In a limited time, one can arrive at various solutions to a problem.
* In this group training method, everyone comes together to think and arrive at a conclusion.
* It does not need any particular resource or preparation.

Limitations of a role play

* If participants don't take role play seriously, then it loses its educational value and becomes just fun.
* Participants can get carried away by the emotions or feelings being portrayed in the role play.
* Sometimes, role play fails in its objective as a training technique when it turns into a play in which acting and actions gain more importance.
* Discussion after a role play is important. However, if due to time constraints it doesn't take place, then the full benefit of this training method does not accrue to the participants, and it remains a job half done.

IV) BRAINSTORM

Brainstorming is a technique of training in which lots of ideas are generated. This group method can be used for small or big groups. Participants should know about this technique. In addition, they should know that they are free to express their views and ideas. An objective of this method is to get the maximum number of ideas and points from the group.

The trainer should start as if he knows nothing about the subject and ask participants to express their views and ideas. Ensure good participation from the group to get the best out of them.

How to use this method

* Ask a question or give a statement to which participants will answer, e.g., women's health. What do they know about it?
* Ask every participant to give his views or ideas in writing, or ask them to read out their jottings.
* Write down all the ideas and views that come up during the play/discussion. Don't reject anything in the beginning.
* Again ask the group to give more points.
* After this, keep aside those points that are not so relevant to the subject or are not clear.
* Solicits the help of participants for clarification and consolidation.
* Make a final summary.

V) GAMES

Introduction Games

In participatory teaching methods, it is necessary that participants feel comfortable to express themselves in a group. Introduction games help to break the initial inhibitions of the participants. These games help them to get to know each other in the group, and establish a playful and relaxed atmosphere. Games such as the potato game, or who stole the cookies from the cookies jar, or games on hobbies and interests, or games on memorising names are of great help in this regard.

Energisers

These games also help in infusing energy into the group. Learning often involves sitting, thinking, talking, and very little physical activity. Physical exercise helps to drive away lethargy that sets in after long hours of talking and listening. It also stimulates the participants and energises the atmosphere. It also helps to drive away tensions that may have built up during intensive emotional exchanges. For guidance, some of the games that involve physical exercise are:

Tiger and goat; fire on the mountain run, run, run; mother's handkerchief; one two, one two; high land and low land; dog and the bone; musical chairs; lock and key; Mumbai, Mumbai, etc.

Attention expanders

When participants find it difficult to concentrate on a particular activity, or all that is said in a session, and need a break, attention expanders can be used. Sometimes energisers can be used as attention expanders and vice versa. Attention expanders involve little physical activity and a minimal disruption of group meetings. Games like Captain, Captain be Quick, or even Shavasana can be used as attention expanders.

Songs

Songs are one way of bringing back enthusiasm into the group and release pent up energy. Different kinds of songs are used for training. Songs should be used effectively to make the training interesting and effective.

i) Group songs

* Songs should be written and circulated to every one or written on the blackboard.
* Participants who know the tune of the song can take the lead, and others can follow them.
* Once the group learns the tune, everyone can sing together.
* Select songs with simple words, catchy tunes, and manageable pitch.
* Team-building songs, songs on woman's struggles with messages of hope and happiness increase motivation among participants.

ii) Prayers

* Prayer songs should be sung at the beginning and the end of the day.
* Let the group decide what prayer song they would like to sing.
* Prayer song should have universal appeal, and include people of all religions.
* Prayer songs with message of love, acceptance, and forgiveness can be comforting as well as harmony promoting.

iii) Popular film songs

These are the best energisers for sleepy, bored participants and do not require any preparation. Group members usually initiate such songs, and all join in instantly. Antakshari can also be played for greater participation.

VI) USE OF VIDEO FILMS

Video films can be used for giving useful information or for demonstrating facts and figures. For example, if health workers are to be told about oral rehydration then the film will be a good method.

* Films can be used to create greater awareness and sensitivity on a particular subject.
* Films can be used to get reactions on certain problems or situations.

Things to remember

* Films should be in accordance with the subject.
* The trainer should himself see the film before it is shown, and should be clear about the objectives and time limit.
* The trainer should be well versed with the operations of the video player.
* After the film, the trainer should discuss it with the participants, and should see whether the message of the film has reached them.
* Sometimes a film should be stopped in-between, and a discussion should take place.
* Before the start of the film, the trainer should explain to the participants the points of discussion and seek feedbacks after the film is over; this will immensely help the participants.

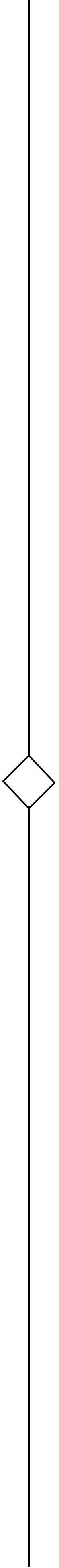
Merits of video film

* An effective, entertaining media.
* Subject can be lucidly explained with its help.
* Participants learn to observe and evaluate a film based on points given by the trainer.
* Film generates enthusiasm in participants and is a good alternative method of training.

Limitations of a video film

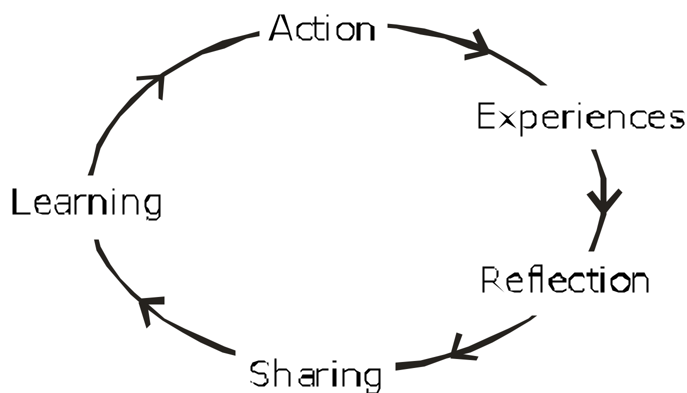
* If the quality of a film is not good or the reception poor, then it is difficult to view the film properly.
* Technical problems can also lead to poor reception, and thus objective of showing a film is not achieved.

Source: Handout prepared by WCHP for training of trainers; 1997.
Training Manual for ANM in communication and research in women and health PID



Participatory Training

Participatory training is a structured learning process in an enabling/open environment whereby learning takes place through interaction and facilitation based on people's knowledge and understanding of his/her reality.



Participatory training methods are different from traditional training methods in that they are non-didactic, and allow the trainee to actively participate in the process of learning. Both trainers and trainees learn from each other in a non-formal, ongoing process.

Principles of Training

During the entire training process, some principles need to be adhered to, which are as follows.

1. Experiential and participant centred: It takes into account experiences of the learners, and inputs from the trainer are based on the existing knowledge of the participant. This approach is intended to build learners' confidence in their ability to criticize, analyze, and figure out things for themselves. It stimulates independent thought and creativity.

2. Participatory: Training should be participatory in all respects: right from the planning of need-based contents to the assessment stage. Training methodologies can range from group discussions to quizzes, role plays, exercises, games, self-study, book reviews, and so on. Such methods help the participants to take initiative, and the responsibility of learning along with the trainers.

3. Informal and flexible: Since the training is participant-centred and not trainer- oriented, it is flexible. The pace and rhythm of the participants is the guiding force. In this way, the participants build up not only their critical consciousness and analytical thinking, but also their ability to articulate and express themselves.

4. Focused on action: The training is directed towards a goal, which the participants are supposed to fulfill after the training is over. In each module, there is an element of skill enhancement. The participants can experiment with new ways of doing things by way of practical exercises, role plays and feedback sessions. After the first phase of training, a field exercise is given to the

participants. Sharing of experiences after the field exercise helps in making the necessary modifications in the training module.

5. Balanced: A balance is kept in both: the content and the methodology. Thinking exercises or theoretical sessions are interspersed with exercises for physical and mental relaxation, which facilitates the learning process.

6. Non-judgmental and respectful of self and others: Training is done with all categories of staff together, in one group, in order to eliminate hierarchical differences, for example, all participants sit together with the trainer in a circle where all are treated equally and with respect. It is emphasised that each one in the room is important and valuable.

7. Joyous and fun: This method makes use of games and lively exercises, so that learning takes place through fun in a non-threatening atmosphere.

Participatory training is based on certain principles

* Every individual is capable.
* Uneducated people may not know how to write but they are smart.
* Educated people need not have knowledge of every thing.
* Uneducated people do have knowledge and have the capacity to solve their own problems.
* Participation helps to improve skills, capacity, and confidence.
* Work is completed faster through co-operation.

The process of participatory training is based on the following methodology

* Participants have certain knowledge and skills. Understand this and give it some importance.
* Start with what participants know and then lead them to new ideas and concepts.
* When participants realize that they also know something, and are not totally blank, it increases their eagerness to understand new concepts and skills.
* In participatory training participants learn to work in groups, and evaluate problems.
* This type of training helps participants to understand the value of unity. The very fact that they discuss certain problems together, and have the ability to solve them, boosts their morale.
* Change is brought through the process of education, evaluation, and finding different solutions to the problems.

Importance of facilitator in participatory training

* A facilitator should be well versed with the subject.
* Notes given should be easy to understand.
* Time, venue, and dates of the training schedule should be fixed by consulting the participants.
* Sitting arrangement should be circular.
* The facilitator should explain the objectives of the session and make the participants to talk.
* The facilitator should not have a know-all attitude, and assume that participants know nothing.
* He/she should be open to ideas and learn.
* First, the facilitator should allow the group to discuss and talk about the subject. He should then intervene and give his opinion.
* Keep the discussions interesting until the end.
* Ask participants about different ways of solving problems. From this discussion, one can get probable solutions.

Source: Training manual for auxiliary nurses, midwives in communication and research into women's sexual health issue; Khanna R., Pongurlekar S., PID project, BMC 1996

Handout No. 7

Participatory Methods of Learning

The training methods in which participants learn by active interaction with others are called Participatory Learning for Action Methods. You can use these methods for training adolescents in schools and colleges, as well as for group interactions with the (participants) and the community.

I. SMALL GROUP ACTIVITY

A small group is a basic unit for participatory learning. It means sub-divisions of a larger group. It is better to limit the group between three and five participants to ensure effective interaction.

Advantages of small group activity

1. It ensures a relatively easy and definite involvement of the participants.
2. It permits and encourages meaningful participation in a low-risk, non-threatening way.
3. It provides an opportunity to learn from other participants, and tests the validity of one's own ideas before they are presented to a big group.
4. It provides flexibility in the discussion and allows restructuring of the sessions.
5. Individual needs and differences can be recognized by assigning individuals to groups based on their interests, experience, background, etc.
6. It provides different views that are important for good problem solving.
7. It provides a sense of rapport, a source for support and recognition, and an opportunity to become acquainted with one another.

Disadvantages of small group activity

1. If the participants are not interested in the topic of discussion, or are uncomfortable with other group members, then small group activity becomes a passive exercise.
2. Sometimes people are not comfortable with each other, they may find it more difficult to develop trust, rapport, mutual support and intimacy.
3. Participants cannot interact with the rest of the group and the facilitator.
4. You may find it difficult to ensure focused discussion.
5. It may take more time than you had originally planned.

II. ROLE PLAYS

Role-playing is the acting out of real-life situations in a protected or risk-free situation. You can get feedback about your performance so that you can learn from what others see, hear, and feel. It is important to remember that everyone is learning during role-playing activities.

This is because they are either experiencing (acting out the role play), introspecting, engaging in self-critique, or critiquing others.

Uses of role plays

1. To present information to the participants. For example, you can use a role play to let people know of various approaches towards reproductive health.
2. To learn how to talk to the beneficiaries, other partners in the community, etc. During a training programme, you can practice counselling the eligible couples, motivating resistant groups, etc.
3. To change attitudes about some health-related issues. For example, you can use role plays to motivate people to use oral rehydration solution for a child suffering from diarrhea.
4. To develop practical skills important for service delivery. For example, you can use role plays to practice the correct method of examining a pregnant woman, or counting the breathing of a child.
5. To receive feedback about your attitudes, skills, etc. For example, you can enact a situation where you are explaining the early signs of complications during pregnancy or delivery. The rest of the group can give you a feedback on how you behave, and what your attitude is, and how you can improve your interaction with the Traditional Birth Attendant (TBA).
6. To identify with the other. By acting out the role of another person, you can understand better his/her perspective. For example, if a woman is not willing to accept birth control methods, you can have new insights into her behaviour by assuming her various roles as wife, mother, daughter-in-law, etc.

How to use a role play

1. Decide on the problem or issue.
2. Looking at a point of conflict or difference—an area where people view the problem or situation from different angles
3. Decide on the characters that would be involved in the role play.
4. Give the characters names.
5. Design the role play using the following guidelines:
   a) Have short role plays because the participants have only a limited time to think about their roles.
   b) Give clear and specific instructions while explaining the different roles.
   c) The characters should be realistic.
   d) Have flexibility so that the participants can enact their roles as naturally as possible. In other words, they should try not to be different from what they are in their real life.
   e) Keep the issues general, so that participants do not become defensive. Try to avoid situations and issues that are not relevant to the participants.

Advantage of role plays

1. It is a simple method and does not require any instruction material, such as, slides, videos, flip-charts, etc.
2. It focuses on the problems and issues, and helps the group to deal with them.
3. It enables the group to understand several important issues in a very short time.
4. It encourages the participants to test and use new ideas and suggestions with the support and understanding of others in the group.
5. It allows the participants to understand others' views.

Disadvantages of role plays

1. If the participants are not involved in the role play, they may have a lot of fun but not learn much.
2. If the participants are too involved in their own roles, they may not be able to accept feedbacks from others about their attitude and behaviour.
3. If role plays are not natural, they will not only reduce the learning process but also give wrong messages.
4. If the group does not review the problems and issues after the role play is over, the participants will not learn about the attitudes, behaviours, etc.

III GAMES AND SIMULATIONS

Games are learning activities where the participants have to follow a set of rules, and it results in winners and losers. They do not reflect reality, but facilitate learning through (a), the experiences that the participants have had by taking part in them, and (b), group interactions.

Simulations are training activities that reflect real-life situations and integrate them in all their activities. They facilitate learning through the participant's own learning through experience.

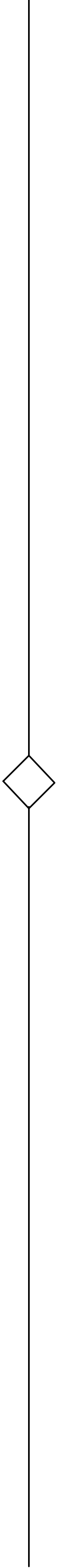
A simulation-game is a reality-based game where the participants experience other people's activities in real life. It is played competitively and facilitates learning through the real-life content of the game.

Basic requirements of games and simulations

1. Clearly defined purpose of the game and what should be learnt from it
2. Well-defined procedures or game rules which should be clearly explained to the participants
3. Active participant involvement
4. Should generate a lot of information
5. The facilitator and participants should jointly analyse the information generated.

Advantages of games and simulations

1. Participants learn by going through an experience.
2. They can bring them much closer to reality than other methods of learning.
3. They have high motivational value.
4. They provide an opportunity for everyone in the group to participate.
5. Participants learn from each other very quickly.
6. Since everyone learns from the experience, everyone is a winner.
7. Risks can be taken in a safe atmosphere.
8. They are good indicators of attitudes of the participants.
9. They help the participants to remember these experiences for a long time.



Handout No. 8

The Role and Tasks of Trainers

BEFORE THE TRAINING

PREPARE THE TRAINING PLAN

* Realize the training needs.
* Determine the objectives and outcomes.
* Plan the sessions and write down the objectives, resources required, duration, and methodology.
* That's the manual for you. And during the training, follow the manual.
* Plan for pre- and post- evaluation.

PREPARATION

* Enlist the participants and make subgroups.
* Decide the training calendar.
* Decide on the venue and book it in advance.
* See that the venue is conducive for group work. It should be big and airy.
* Write to the participants, informing them about the object, dates, and venue of the training.
* Collect the material and prepare the handouts.
* Divide the sessions among the facilitators, practice the sessions, and divide the tasks.
* Visit the venue and check for water supply, sitting arrangement, food arrangement, etc.
* Prepare the handouts (Xeroxing, etc.).
* Prepare the budget and seek the money.
* Arrange for the travelling allowance.
* Supervise all arrangements a day before the training commences.

DURING THE TRAINING

ARRANGEMENTS

* Arrange for registration and distribution of the handout file
* Make announcements about the drinking water, toilet, timings of lunch, tea, etc.
* Oversee the food and tea arrangements

FACILITATOR/TRAINER

* Create a conducive environment.
* Start the training programme properly and in the end, conclude it.
* Introduce each topic and its objectives. .
* Give space to all. Listen to each participant.
* Use different methods of training.
* Make use of audio-visuals.
* Pay attention to each participant and her/his growth.
* Remember the name of each participant and call her/ him by his/her name.
* Try to build a rapport with them during lunch and tea breaks.
* Help them to build confidence.
* If the discussion is diverted, intervene and bring it on the right track.
* Listen carefully to the presentations of the participants.
* In the end, conclude.

OBSERVATION

* Be alert and try to assess each session.
* Make your own notes when you are not facilitating.

EVALUATION

* Use different methods of evaluation.
* Give proper instructions for filling up the forms, and check them.
* Do a self-assessment, and try to enhance your skills as a trainer.

POST TRAINING

* Write a report and dispatch it to all the participants.
* Do a follow-up.
* Keep in touch with the participants.
* Determine the future training needs.
* See whether the training has helped them in community work or not.
* Give them tasks in which they can use all that they have learnt from the training.

Source: unknown

Observation Checklist for Key Trainers

Observation sheets to be filled by external observers during in-service and CHV(Community Health Volunteer) training of WCHP(Woman Centered Health Project) key trainers and the other key trainers.

Topic: ____________________ Trainer:______________ Observer: _________________
विषय प्रशिक्षक निरीक्षक

No. of trainees: Name of the training:_____________________
प्रशिक्षणार्थीची संख्या प्रशिक्षणाचे नाव

1a) Did the trainer make use of any participatory method? If yes, which methods?
प्रशिक्षकांनी सहभागी प्रशिक्षण पध्दत वापरली का ? हो असल्यास, कोणती ?

* Brainstorming
* Small group discussion and presentation
* Group discussion
* Role play
* Exercises
* Case studies
* Short lecture
* Long lecture
* Any other method ___________________________________

1b) What training aids were used?
कोणती शिक्षण साधने वापरला ?

Transparencies
Slides
Video/picture
Flip charts
Blackboard
Newsprint
Handout

2. Did the trainer do the following things to seek participation from the trainees?
प्रशिक्षणार्थींचा सहभाग मिळवण्यासाठी प्रशिक्षकांनी ‘ालील कोणकोणत्या गोष्टी केल्या ?

a) Looked at everyone in the room while talking?
बोलताना सर्व सहभागीकडे नजर वळवत होत्या.

b) Only looked at a particular subgroup or individuals (first benchers or females) in the class.
फक्त एका उपगटाकडे किंवा व्यक्तीकडे बघूनच बोलत होत्या (पुढील बाकावर बसणारे किंवा स्त्रिया)

c) Before giving out any information, tried to find out whether the trainees knew anything about the topic, and if so, what they thought about it.
माहिती देण्यापूर्वी सदर विषयासंबंधी प्रशिक्षणार्थींना काय माहिती आहे हे जाणून घेतले.

d) Asked the participants whether they had any questions or needed any clarifications.
प्रशिक्षणार्थींना काही शंका किंवा प्रश्न आहेत का हे विचारले.

e) Tried to find out the experiences / thoughts/ opinions of the participants.
ए‘ादा विषय पटला का किंवा त्यावर अन्य काही मते आहेत का हे विचारले किंवा प्रशिक्षणार्थींची त्या विषयावरील अनुभव/ विचार/ मते विचारली.

f) Asked them to share their experiences related to the topic.
विषयासंबंधित अनुभव कथन करण्यास सांगितले.

g) Asked questions to the trainees.
प्रशिक्षणार्थींना प्रश्न विचारले.

h) Listened patiently to the disagreements, or to the questions and doubts raised by the trainees.
प्रशिक्षणार्थींनी विचारलेले प्रश्न, शंका, विरोधी मत, पूर्णपणे ऐकून घेतले.

i) Tried to answer their queries, clarified their doubts.
प्रश्नांची व शंकांची उत्तरे देण्याचा प्रयत्न केला.

j) Appreciated and stimulated participation or contribution from individuals, or from the groups during group presentation.
गटाच्या सादरीकरणाच्या वेळेस किंवा गटचर्चेत गटाच्या किंवा काही व्यक्तींच्या कामगिरीची/ सहभागाची प्रशंसा केली.

k) Did any other thing to encourage participation? Specify.
सहभाग वाढविण्यासाठी इतर काही केले कां ?

3) How was the participation from the trainees? Mark the following items:
प्रशिक्षणार्थींचा सहभाग कसा होता ? यासाठी ‘ालील प्रश्नांची उत्तरे दया.

a) How many trainees asked for clarification?
किती प्रशिक्षणार्थींनी स्पष्टीकरणे विचारली ?

b) How many trainees asked questions?
किती प्रशिक्षणार्थींनी प्रश्न विचारले ?

c) How many trainees shared experiences?
किती प्रशिक्षणार्थींनी स्वत.चे अनुभव सांगितले ?

d) Did any trainee challenge the ideas presented?
मांडलेल्या मुद्यांना प्रशिक्षणार्थींनी विरोध दर्शवला का ?

e) Did any trainee talk about application of the learning, and/or of the problems in the field?
शिकलेल्या गोष्टींचा कामात उपयोग करण्याबद्दल किंवा त्यासंदर्भातील अडचणीबद्दल कोणी बोलले का ?

4) How did the trainer handle group dynamics? Did he/she attempt to do the following?
गटातील घडामोडी हातालण्यासाठी प्रशिक्षकांनी पुदील प्रयत्न केले का?

a) Encourage the quiet members to share their views or actively participate in the discussions.
न बोलणा-याना प्रोत्साहन दिले

b) Ask the more talkative or dominating members to give others a chance to speak.
जास्त बोलणा-या प्रशिक्षणार्थींना शांत करुन इतरांना बोलण्यास संधी दिली.

c) Were any subgroups formed? Yes/No
If yes, were the subgroups asked to participate in the group activity?
आपापसात छोटे गट पडलेले कां ? हो/ नाही
आपापसात छोटे गट पाडून कुजबुज चालू झाल्यास त्यानां सर्वांबरोबर किंवा सत्रामध्ये सहभागी होण्यास सांगितले

d) Was there any participant or group fooling around or making fun of others? Yes/No
If yes, was the participant/group asked to participate constructively.
टवाळी किंवा मस्करी करणा-या व्यक्तींना किंवा गटाला सक्रिय सहभाग घेण्यास सांगितले.

e) Were there participants exerting a negative influence on the group? Yes/No
If yes, did the trainer address these participants and refrained them from doing so?
सतत विरोधी भूमिका घेणा-या व्यक्तींशी बोलणे केले.

f) Were there participants or groups disturbing the session? Yes/No
If yes, did the trainer stop them from doing so?
सत्रामध्ये अडथळे आणणा-या व्यक्तींशी बोलणी केली.

g) Any other problem:
अन्य काही

5. Did the trainer conclude by summarising the main points of the session?
सत्राच्या शेवटी प्रशिक्षकांनी मुख्य मुद्यांचा सारांश केला का ?

Source: Checklist prepared by WCHP for assessing training skills of key trainers trained by the Project, June 1999

स्वतःचे मुल्यांकान व निरीक्षणाचा फॉर्म

सत्राचे नाव : प्रशिक्षकाचे नाव :

निरीक्षकाचे नाव : दिनांक : वेळ :

१. सत्राचे शैक्षणिक उद्देश कितपत सफल झाले ? ....
(उदा. पाचपैकी दोन सफल झाले २५)

२. प्रशिक्षणार्थींचा सहभाग
अ. कितीजणांचा सहभाग होता ?
(i) सर्वांचा (ii) बहुतेक सर्वांचा (iii) थोडया जणांचा (iv) अर्ध्या जणांचा

ब. जे मुद्दे शिकवायचे होते, ते प्रशिक्षणार्थींच्या चर्चेमधून निघाले का ? हो / नाही

क. सत्रामध्ये प्रशिक्षणार्थींच्या अनुभवाचा उपयोग केला गेला का ? हो / नाही

ड. प्रशिणार्थी व्यक्तीगतरीत्या समरस झाले होते का ? हो / नाही

३. सत्राची ओळ‘ व सुरवात कशी केली ?
(i) चांगली (ii) ठिक (iii) फारशी चांगली नाही का ?

४. सत्राचा सारांश व शेवट कसा केला ?
(i) चांगला (ii) ठिक (iii) फारसा चांगला नाही का ?

५. तुम्ही ट्रेनिंग साहित्य व साधनांचा चांगला उपयोग केला का ? हो / नाही

६. ग्रुपमधील सहभागींची वागणूक व भूमिका (Group Dynamics)कशा हाताळल्या?

७. प्रशिक्षकाचे कौशल्य सुधारण्याबाबत सुचनाः

Source: Checklist prepared by WCHP for assessing training skills of key trainers trained by the Project, June 1999.

Responding Effectively To Insensitive Speach and Behaviour

Realizing that some of our remarks and behaviours may hurt others is the first step in becoming adept at leading a multicultural organization, and a very important one at that. The next step is to create an environment in which it is safe for people to share their feelings about offensive remarks and behaviours when they hear, and/or see them.

In organizations where people do not openly and honestly share such feelings, the feelings fester, often resulting in an under-current of resentment and mild anger. The result is that often people leave the organization.

Sharing those feelings, while it may be difficult at first, needn't be painful and 'heavy'.

Doing so, in fact, is a simple way of giving information on how the remark or action affected the other person.

The attached handouts provide suggested guidelines for effectively giving and receiving feedback. We acknowledge that giving and receiving feedback in the manner suggested in the attached handouts may be difficult to do at first. Indeed, it may be difficult to do for a while because we have no role models for this kind of behaviour. Most of us didn't see our parents behaving this way. We don't see people on television behaving this way with each other. We don't see people in our everyday lives acting in this way towards each other. In following these suggested guidelines, therefore, we are shifting a very important behavioural paradigm. It may be difficult at first, but with continued practice, it becomes significantly less so.

In order to help individuals within organizations feel safe enough to respond to culturally insensitive speech/action according to the guidelines described in the attached handouts, the organization as a whole may have to adopt those guidelines, inform all employees that it has done so, and that individuals are both permitted and encouraged to use them when necessary.

FEEDBACK

Definition

A statement that gives a person information about the impact of his/her behaviour.

Purpose

To give reliable information that helps a person make informed decisions about altering or continuing certain behaviour in the future.

GUIDELINES FOR GIVING FEEDBACK

1. Be direct

Give feedback to the person who used the speech or action to which you are responding, not to others. The more people a message goes through, the more likely it is to be distorted.

2. Be specific

People learn from complete information. What speech, behaviour, or style do you want them to continue or discontinue? Saying, for example, "When you say those kinds of things, it offends me," probably doesn't give enough specific information to be helpful.

It might be more helpful to say, "When you tell jokes that put down women, I feel offended." It is much more specific and clearly tells the person what you would like them to change.

3. Be timely

Give feedback as early as possible after the speech or behaviour. Waiting a long time to give feedback allows memories of details to fade, and thus affects the accuracy of the feedback.

4. State how the speech/behaviour affects you

When describing how the speech/behaviour affects you:

A. Do not label the speech/behaviour: Describing your own reaction to the speech/behaviour, without labelling it, reduces the likelihood that the receiver will become defensive. Example: "When you tell jokes that put women down, I am offended," is less likely to make the receiver defensive than "Your jokes are sexist, and that offends me." The first statement simply describes the speech and tells how it affects you. The second labels the joke as sexist. In fact, that may be the case, but using the label will not help the receiver to change his or her behaviour.

B. Use 'I' statements. Example: "I am offended by that remark," is likely to be heard less defensively than "You offended me with that remark."

C. Share your feelings: Examples of feeling words include angry, sad, glad, frightened. Feelings are different from thoughts.

Words that convey thoughts include such terms as "unfair" or "discriminatory". Be careful not to express a thought in place of a feeling, for example: "I felt that was unfair," or "I felt that was discriminatory."

GUIDELINES FOR RECEIVING FEEDBACK

1. Listen carefully.
2. Try not to get defensive.
3. Restate what you think you heard to check your perception.
4. Ask questions if necessary. Ask for examples in areas that are unclear. Restate what you think you heard.
5. Gather additional information by observing your behaviour, both with the person who gave the feedback and with others.
6. Carefully evaluate the accuracy and potential value of what you observe and hear.
7. Do not overreact to the feedback, but, where desired, modify your behaviour in suggested directions and then evaluate the outcome.

1. Personal Feedback

Personal feedback means receiving information on how other people have reacted to one's own behaviour in a particular situation. It is very important for animators to know honestly how people have reacted to their behaviour, styles of leadership, and to the programmes that they have organised. Only then will they know whether any changes or improvements are necessary. Far too often, leaders continue organising certain programmes, acting in certain ways, and no one ever tells them that people are not interested, or are 'put off' by some of the things they do.

2. Indirect Feedback

If we are sensitive we can pick up a great deal of indirect feedback through observation.

* Do people begin to look out of the window or get a glassy stare in their eyes after we have been speaking for some time?

* Do people quietly drop out of our meetings, classes, clubs, or churches?

* Do groups actually carry out the plans we make with them?

However, if we rely on indirect feedback we may misinterpret what we observe.

(Maybe someone with a glassy stare actually has a stomachache!) We are much better off if we can directly ask people for their reactions and receive an honest reply, although sometimes people hesitate to say exactly what they think and feel if it is somewhat negative.

3. Direct Feedback

The purpose of personal feedback is to improve a person's performance and build up his/her self-confidence. It serves no purpose to cut a person down and destroy his/her self-confidence.

If it is well given and well received, feedback supports and encourages the positive aspects of a person's behaviour, and gives them an opportunity to change the negative elements.

Direct and indirect personal feedback is different in different cultures. If we agree that improvement of one's work with people is essential, then the following exercises and inputs need to be adapted to each local culture.

A camel does not make fun of the other camel's hump.

— Guinean proverb

4. Points to Remember on Giving Feedbacks

a. We can only provide helpful feedbacks to a person if s/he knows that we accept and appreciate him/her as a person.

b. It is important that an atmosphere of trust and mutual appreciation be established when feedback is given. This can only exist if we give genuine, positive, as well as negative feedbacks.

c. Feedback should only be given if the person wants to know how others see him/her, and has asked for the feedback. It should be offered, not forced upon him.

d. Feedback should deal with a person's behaviour, not his/her motivation.

e. It is often best if we can present a negative feedback as our own problem, a sharing of our personal feelings when something happened. For example, "I felt squashed and humiliated when you interrupted and brushed aside my suggestion just now," not "You always try to make people feel they have nothing to contribute."
(Only the person concerned really knows why he acted in the way he did.)

f. Each person should express only his own feelings and not assume that the whole group felt that way. Others can say so for themselves if they did so.

g. Feedback should deal with things that can be changed. "I would find it easier to listen if you made fewer points at one time." Not "Your accent drives me mad" or "I do not like the shape of your ears."

Using and Choosing Games and Exercises

The games and exercises described in this manual are not designed to be included in formal, non-participatory events where the physical and physiological conditions mitigate against their intended role. Such attempts will often fall flat or backfire on facilitators, or belittle the significance of games and exercises. They need to be carefully considered and planned by competent, experienced facilitators who believe in the power of games to advance group processes. They should not be used in a chaotic, ad hoc manner, with little thought being given to their outcome. The facilitator must prepare and plan, and therefore have on hand all the material needed for a particular exercise. Last minute substitutes and switches will appear unprofessional.

Games and exercises need to be sequenced properly in terms of their intensity, frequency, duration, and intended objective. For instance, a series of highly interactive games at the beginning of a workshop really warm up participants and "break the ice". However, they may appear to be childish and thoughtless to some participants who may lose faith in the facilitator. Activating senses and energizing people for no apparent reason may also put the facilitator into the role of an entertainer who is not serious about the content of the event. Instead, games and exercises have to be placed, and paced in an order and frequency which will allow a gradual build-up of experience and outcomes. They should be carefully built into other plenary and group sessions.

ROLE OF GAMES AND EXERCISES

Participatory processes can be enhanced by games and exercises, carefully placed in the learning process. Good games and exercises make people reflect, experience the emotion, bring about a sense of wonder or curiosity, "grab people in the gut", energize, create humour, relax, calm, and induce meditation. They provide an element of variety, a sense of discovery and surprise, and thereby keep participants engaged.

Games should be introduced into the learning process for a purpose, not just for the sake of playing, and enjoying a game, or as an attempt by the facilitator to gain "cheap popularity" from the group.

The best games and exercises activate both sides of the brain — the cognitive, logical side; and the emotional, creative side. They stimulate perception, kindle affection or improve expression, and create interest through the presentation of a challenging situation. They reinforce learning through experience. Experiential learning has proved to be a much more effective way than merely receiving, discussing, and attempting to digest information from authoritative sources. Games and exercises can simulate the actual experiences of our lives, and help us to reflect on the application of theoretical knowledge to these situations. They may also introduce a certain amount of complexity into the given situation or lead to a questioning of it, thereby stimulating a process of action-reflection—action throughout the proceedings.

Good games and exercises involve everyone in the group, advance the group proceedings, maximize participation, and allow as many participants as possible to express themselves in unique ways. They catalyze individual involvement and expression ingroup events, and bring about group synergy. They provide a common group experience, creating favourable conditions for the growth of participatory behaviour and democratic spirit.

A trainer should pay attention to the length of each game or exercise in order to use it within the workshop schedule. Another way of sequencing is to combine long and short games and exercises. Too many long exercises may consume too much time and may bore some participants. Too many short exercises can be distracting and inhibit real learning.

There may be questions, doubts, and uneasiness when instructions are given. During the game itself there may be a lot of action and tension. Attitudes or behaviours may be disclosed, and conflicts may arise. The game may produce some kind of an "Aha!" effect for some of the participants. Others may take a longer time to grasp the point. There are always a few who may be disappointed or frustrated. There is bound to be varying reactions from the participants but they all experience something, which helps to bond them together.

Some participants may already be familiar with certain games and exercises and may try to derail or monopolize the process. Therefore, it is best to find that out before the commencement of these activities. In case, some do know them, and immediate substitutes cannot be found, then give them roles, which do not spoil the proceedings of the session and influence the outcome. You may ask them to help you run the game or to act as observers.

Don't ask participants to assume the role of the facilitator unless you are certain they have the knowledge and skill to do so. Often, the participants will not be prepared. They will give unclear instructions and the result will be disappointing. Some participants may come up with a different variation of the game. Thank them for helping to open up a new dimension. However, if you don't know the variation and its possible outcome, stick to your original plan. See if there is time to play the variation in a less crucial session, such as an evening set aside especially for games and exercises.

Sometimes senior officials or experts refuse to participate in the session, which sets a negative tone for the whole group. You can overcome resistance (of the participants or the officials by explaining the use of the games at the outset, or by gradually increasing the frequency of interactive games, or by getting a few key people to support you and enthusiastically join the games. If participants see that their bosses or seniors are involved in the proceedings, their inhibitions usually disappear. In groups composed of people from different levels in an organization, games that accentuate conflicts and differences, including hierarchical ones, should not be introduced.

The facilitator must be aware of the age, gender, physique, and cultural difference of the participants and accordingly, avoid inappropriate games and exercises. For instance, older people and pregnant women should avoid rough, physical contact games. In addition, in such games all participants must be warned to remove breakable or potentially injurious jewelry or clothing, glasses and contact lenses. Physically disabled people should not be made to feel left out. Find games, which will include them.

References to sexual stereotypes, unless they are introduced for a specific purpose, and sexual language or other vulgarity, can create conflict and run counter to the spirit of participation. The balance and involvement of both sexes in games and exercises has to be thought out. Conflict may also be created when the participants read unintended meanings into games. Some games may threaten, introduce negative competition, or invade privacy. Games and exercises should be non-threatening and demonstrate the value of difference between people. They should never single out individuals for ridicule.

Not all games and exercises are appropriate for all cultural settings. Humour, for instance, varies a great deal in different cultures. In certain countries, men and women who are not married should not touch one another. Even if the participants accept such processes for the purpose of the workshop, non-participants may misinterpret pictures taken of such interactions. Setting up games or exercises on taboo subjects may induce conflict in the group and derail progress of the project. The facilitator must be sensitive to the cultural values of the participants, and should avoid pushing them in a direction, which opposes their worldview.

Games and exercises have many purposes and fulfill many needs. The criteria for the choice of one game over another are often complex. It will depend on the topic and overall objectives of the group event, and the conditions at the time you want to use a game or exercise. How far has the group progressed? How concentrated are the participants? What is the mood of the group? Is there a need to energize the group, or slow it down and allow the participants to relax and think about their inputs? Is there conflict in the group? These are some of the factors, which will determine the choice.

Games and exercise introduce an element of drama, which maintains interest and attention. Good drama has an introduction, a build up of action and complexity in plot, a climax, an unraveling of the storyline, and a conclusion. Group events can also be structured in this way.

However, there is no universal guide or prescription. Choosing games and exercises which work is an art. It depends on the ability of the facilitator to perceive the state of the group and to predict the outcome of different choices. The ability to sense and perceive where the group is at a particular moment grows with learning and experience.

Planning games and exercises in group activities usually entails allocating time for debriefing. Participants should have a chance to say what they thought of the outcome, or how they have felt during a game. Without such debriefing, participants may be 'left hanging'. They may not be able to come to a conclusion. They may feel frustrated because the learning was not shared. Rather than stimulating group activity, the exercise may introduce division, criticism, or even boredom.

What is done during debriefing? This is one of the most crucial tasks of the facilitator. S/he helps the group to reconstruct the experience by asking key questions prepared beforehand. These may be descriptive (what happened?), emotive (what did you feel?), analytical (what did you learn?), or related to the application of the findings (how do the results fit with the topic/theme of the event?). The conclusions should always come from the group. A trainer should be aware of the time that is needed for debriefing thoroughly, and stimulating discussion on the insights. Debriefing may take more time than the game itself, especially if the group is large. Having two facilitators doing the debriefing saves time; one addresses the group with questions while the other supports the proceedings by visualizing what participants say.

To conclude a debriefing session, the facilitator can read the comments made by the participants or have one of the participants do so. S/he should thank everyone for the achievements of the group.

<u>Using and Choosing Games: A Summary</u>

* Use games in the appropriate psychological and physical setting. They are not designed for formal events.
* Familiarize yourself well with all the instructions before applying them.
* Make sure all materials are quickly made available. Avoid ad hoc, last minute substitutions or improvisations. Avoid using games as 'lifesavers'.
* Sequence games and exercise carefully in terms of their intensity, frequency, and purpose. For instance, avoid putting a whole series of highly interactive games one after the other.
* Avoid turning yourself into an entertainer.
* Stick to your plan. Don't let participants who are familiar with a game put you off. Acknowledge them and use them to support or observe the proceedings.
* Involve potentially resistant participants by beginning with milder, less interactive games and exercises, and build up their trust gradually.
* Be aware of the age, physical condition, or other factors, which may cause harm to the participants. Have them remove items which may hurt them, or which may be damaged in physically active games.
* Do not force people into activities that are against their cultural values or worldviews. Avoid culture-specific humour and perspectives on gender and sexual stereotypes, unless you are prepared to do a session reflecting on such subjects.
* Always plan and carry out debriefing sessions after the exercise. Don't leave participants in limbo.
* Choose games carefully, according to the overall topic, time available, objective of the event, group progress, and mood at that time (for example, the presence of conflict), etc.
* Use games to introduce more drama, thereby increasing attention, involvement, and enthusiasm.
* Change the menu of the games and exercise frequently. Do not get trapped in a narrow repertoire.
* Use this "toolbox" to build your own plans. Modify and adapt according to your purpose and experience. There is no universal guide or prescription.

Notes

The time and the group size given for the exercises in the following descriptions are only approximations.

Debriefing

Note that debriefing is recommended after every game or exercise, but this has been indicated in this manual only when specific questions are recommended.

SKILLS I HAVE AND SKILLS I NEED

Group size: 10 to 25

Time: 45 to 60 minutes

Materials: Flip-chart paper, markers, and marking tape

Objective

To encourage participants to identify their strengths and weaknesses

When to use

At a time in the workshop when it would be helpful to encourage self-reflection

Steps

1. Ask participants to list on flip-chart paper all the skills they possess and the areas where they need strengthening. Ask them to keep the list to themselves.
2. Ask them to think of the one skill they do best.
3. Ask each participant to act out his/her skill without using any words.
4. Ask the rest of the group to guess what each participant's mime represents.
5. Put up the lists and let the participants read them.

Debriefing

Discuss the following:

- The number and variety of skills each individual has
- The fact that different individuals have different strengths and weaknesses
- The total composition of skills in the group.

ACTIVITIES I ENJOY

Group size: 10 to 30

Time: 10 to 45 minutes

Materials: Flip-chart paper and markers

Objective

To encourage participants to understand themselves better

When to use

At the beginning of a workshop

Steps

1. Ask participants to draw a picture of themselves doing something which they enjoy.
2. Ask them to find a partner, explain their drawings to him/her, and tell him/her why they enjoy doing that particular thing.
3. Ask each pair to join another pair and repeat the explanation to each other. This can be repeated many times.

Debriefing

In the large group, discuss the following:

- The variety of things that individuals in the group enjoy
- The gender differences in these enjoyments
- What the participants have learnt about themselves and others

HOW WELL DO I KNOW MYSELF

Group size: 10 to 30

Time: 45 to 90 minutes

Materials: Flip-chart paper, marking paper, markers

Objective

To help participants gain self-confidence, and to become more aware of themselves and of their strengths and weaknesses

When to use

At a particular point in the group activity where it would be helpful to encourage self-reflection

Steps

1. Ask the participants to draw a picture of themselves in the centre of a large sheet of paper.
2. In the top left hand corner of the picture, ask them to write the words "AS A PERSON", in the top right hand corner ask them to write the words "AS A WORKER".
3. On either side of the picture, under each heading, ask them to write five words that best describes them as a "person" or as a "worker" (in their occupation). Ask them to list things they like, enjoy, and can do well. Ask them to give the picture the title "THE BEST OF ME".
4. Display the pictures on a wall or board.
5. Ask participants to walk around and take a look at each other's pictures without talking.
6. Put names on pictures as they are guessed correctly.
7. Discuss the activity with the entire group. Categorize the skills identified as interpersonal, technical, or communication skills. Introduce the ideas of self-perception, positive self-concept, self-assessment, and self-acceptance.

Debriefing

Ask the following questions:

Is self-concept static or does it change? How?

Why?

How does self-concept relate to attitudes towards oneself? Others? One's work?

Discuss the pictures.

How easy was it for you to do this exercise?

What did you learn about yourself and about others?

Variations

1. Have participants describe bad points/weaknesses and draw something that they dislike doing.
2. Have them list five things they can't do so well. Title the picture "THE OTHER SIDE OF ME".
3. Gender training: Have participants list points that describe them as a person, and also as a man or woman.

THE RIVER OF LIFE

Group size: 10 to 30

Time: 45 to 60 minutes

Materials: Flip-chart paper and markers

Objective

To build friendship and encourage openness and trust within the group

When to use

At a stage in the workshop when deeper group synergy is required

Steps

1. Ask participants to form pairs.
2. Ask them to discuss the high spots and the difficult periods of their lives (allow about ten minutes per person).
3. Ask participants to draw the information given by their partner as a "river of life".
4. Participants then present and explain their partner's life to the plenary.

Variations

This exercise is similar to "Mutual interview" described in the VIPP manual, Page 101. It is not recommended to do both games in the same event.

PORTRAIT OF MY JOB

Group size: 10 to 30

Time: 45 to 60 minute

Materials: Flip-chart paper and markers

Objective

To acquire a perception—individually or collectively—of how people see their jobs or their place in an organization.

When to use

At the beginning of an event

Steps

1. Ask the participants to draw themselves and their place in an organization.
2. Then ask them to form small groups and describe the drawings to one another.
3. Encourage discussion in the small groups by using the following questions:
   * How do you see your job?
   * How do you fit in?
   * Has this perception changed recently? How? Why?
   * How do you think your clients or colleagues see your organization?
4. Ask the small groups to bring the results to the plenary and present their findings.

Variations

Relationship mapping: Ask participants to pictorially depict their relationship with other people in their work environment.

MINGLE AND STOP

Group size: 15 to 40

Time: 5 to 10 minutes

Materials: Cards, *** (optional)

Objective

To increase group concentration and participation

When to use

At any time during a group event

Steps

1. This exercise works well with music or by using the commands, "mingle" and "stop".
2. Randomly place cards on the floor, at least two feet apart. There should be a card less than the number of participants.
3. As the music begins or the "mingle" command is given, participants move about freely within a central area.
4. When the music is stopped or the "stop" command is given, players quickly choose a card to stand on. The person without a card is out of the game.
5. The facilitator removes a card and the "mingle" command is given again.
6. This is repeated until only one card remains and two players must compete for it.

FRUITS AND ANIMALS

Group size: 15 to 40

Time: 6 to 10 minutes

Materials: None

Objective

To improve coordination and attentiveness within the group

When to use

When participants are feeling lethargic and tired. This exercise requires everyone's participation and alertness.

Steps

1. Ask the group to form a circle and clap.
2. After three claps, the facilitator says the name of a fruit.
3. After three more claps, the next person says the name of an animal.
4. After three more claps the next person says the name of a fruit, and it goes on around the circle in this fashion.
5. If someone says the name of a fruit when that of an animal has to be stated, or cannot name a fruit or an animal, or repeats the name of a fruit or an animal that has already been stated, then s/he must sit down.
6. Continue until the last two participants are contesting and one wins.

Variation

The exercise can be simplified by asking the participants to name only fruits or animals instead of alternating between the two.

MIRRORS

Group size: 10 to 40

Time: 15 to 20 minutes

Materials: None

Objective

To allow participants to explore methods of non-verbal communication

When to use

As a warm-up exercise, anytime

Steps

1. Ask participants to divide into two groups.
2. Ask the groups to line up in two rows facing each other, about 1.5 metres apart.
3. Ask participants to raise their hands to the height of their shoulders and extend them to almost touch those of their partner in the facing row.
4. Without speaking, the participants in row one (the designated leaders) initiate movements with their hands, arms, legs, and bodies. Their partners in row two mirror the movements, for example, move the left hand while the "mirror" group moves the right. Those initiating the movements can be asked to mime something specific like getting dressed for an important date or building something. After a few minutes, tell the participants in row two to take the lead and those in row one to be the mirrors.

Debriefing

You may discuss what behaviours help or hinder effective communication in the context of leadership.

MOODS

Group size: 15 to 30

Time: 15 to 30 minutes

Materials: Prepared cards

Objective

To explore methods of non-verbal communication

When to use

When group interaction has slowed down

Steps

1. Arrange the group in a circle. Ask them to form pairs.
2. Distribute to each pair a card with a mood written on it, for example: angry, afraid, in love, tired, broken-hearted, excited, victorious, hunted, mad, depressed, etc.
3. Ask them to keep what is written on the card a secret.
4. Each pair will get a chance to perform in the circle by turns. One person will be the clay and the other person will sculpt with his or her legs, hands, and face to demonstrate the mood of the card.
5. Ask the group to guess which mood the pair is portraying.
6. Ask a new pair to come to the centre of the circle and repeat the process.

Variation

To save time, have half of the group to sculpt while the other half moves around guessing the moods being portrayed.

ONE AND TWO-WAY COMMUNICATION

Group size: 15 to 20

Time: 20 minutes

Materials: Diagrams, flip chart paper, and markers

Objective

To demonstrate the many problems that occurs in one-way communication

When to use

Before group work sessions

Steps

1. Prepare two different diagrams on a flip chart or overhead projector.. Do not show them to the group. Ask a volunteer to assist in the following demonstration.
2. Explain to the participants that the volunteer is going to describe something to them and their task is to simply follow instructions and sketch what is described.
3. Provide the volunteer with one of the diagrams. The volunteer turns his or her back to the participants so no eye contact is possible.
4. The volunteer may only use verbal communication — no gestures, hand signals, etc. No questions are allowed from the participants. Only one-way communication is permitted.
5. When the exercise is completed, show the diagram and ask the participants to compare with their drawings.
6. Select another volunteer and repeat the game, using the other diagram. This time allow two-way verbal communication (i.e. questions may be asked) but no visual directions given.
7. Compare the results of the two exercises.

Debriefing

Encourage group discussion with the following questions:

* How many participants were confused and stopped listening?
* Why was one-way communication so difficult to follow?
* Did two-way communication ensure complete understanding?
* How can we make our communication efforts more effective?

VISUAL POWER

Group size: 10 to 30

Time: 3 to 5 minutes

Materials: None

Objective

To compare visual and oral communication

When to use

To introduce sessions on communications

Steps

1. Ask participants to stand in a semi-circle.
2. The facilitator gives the following instructions: “Now I am going to give you very simple instructions. Just do what I say.” Ask participants whether they are clear about the instructions.
3. Stand in front of the group. Give instructions while performing an action. For example: “Raise your left leg. Raise your right hand. Drop your left leg. Raise your left hand too. Spread your fingers. Drop your right hand. Bring your thumb and small fingers to touch each other.”

4. You should change the actions so they do not match the verbal instructions. For example, while saying, “Touch your chin,” you touch your cheek.
5. Notice what the participants are doing. Ask why they followed the actions. They may say, “We followed you!” You answer: “No, you didn’t. I asked you to follow what I said, not what I did!”

Debriefing

Ask for comments on the experience. Why were the instructions confusing? Do you ever get such instructions? From whom?

GOSSIP LINE

Group size: 15 to 30

Time: 10 minutes

Materials: None

Objective

To highlight the importance of non-verbal messages

When to use

Before communication training and/or sensitization exercises

Steps

1. Have a group of participants stand in a line with everyone facing the same direction, but which is opposite yours.
2. Tell them that you are going to tell the last participant in the line an action/emotion, non-verbally. S/he turns around to face you while receiving the instructions. S/he then turns back to tap the next in line on the shoulder who turns around to receive the same action/ emotion, nonverbally. This participant then turns around to tap the next person and convey the non-verbal emotion/action.
3. The process continues in silence until everyone in the line has been “tapped” and has received the action/emotion from the previous person.
4. Ask those at the end and the middle to demonstrate to the group what they think the action/ emotion was. Demonstrate your instruction to the first person.

Debriefing

Questions to ask:

What happened?

What difficulties were experienced?

How can we overcome them?

Are there any parallels in our daily life?

Source: Training for Transformation. A Handbook for Community Workers. Book 2 - Anne Hope and Sally Timmel; Printed & Published by Mambo Press, Senga Rd., Gweru, 1992.

Handout No. 13

Gender Based Violence : An Impediment to Sexual and Reproductive health and a Violation of Human Rights

Amita Verma And Renu Khanna

Violence against women is the most pervasive, and yet, the least recognised of human rights abuse in the world. It is also a profound health problem because it is a greater cause of death and disability among women aged between 15 and 44 years than cancer, malaria, traffic accidents, or war. The WHO estimates that at least one out of five women in the world has been physically or sexually abused by a man at some time in her life.

Gender-based violence is at our very doorsteps: in families, communities, and other social institutions. One of the social tragedies is that much of the violence that women and girls experience occurs in the sanctity of the home—that private space where one is supposed to feel safe and protected. It is hidden and hence very pernicious.

It is often difficult to define gender-based violence, or acts of violent behaviour, because of the varying cultural and sub-cultural views on what constitutes violence.

In 1993, the United Nations offered the first official definition of such violence when the General Assembly adopted the declaration on the Elimination of Violence against Women. According to Article 1 of the Declaration, violence against women includes:

> "Any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such act, coercion or arbitrary deprivation of liberty, whether in public or private life.

We use the term gender-based violence because it covers violence against females throughout their life cycle.

Violence against women throughout the life cycle

Phase	Type of violence
Pre-birth	Sex-selective abortion; effects of battering during pregnancy on birth outcomes.
Infancy	Female infanticide; physical, sexual, and psychological abuse.
Girlhood	Child marriage, female genital mutilation; physical, sexual, and psychological abuse; incest; child prostitution and pornography.
Adolescence	Dating and courtship violence (e.g. acid throwing and date rape),
Adulthood	Economically-coerced sex (e.g. school girls having sex with "sugar daddies" in return for school fees), incest, sexual abuse in workplace, rape, sexual harassment, forced prostitution and pornography, trafficking in women, partner violence, marital rape, dowry murders, partner homicide, psychological abuse, abuse of women with disabilities, forced pregnancies.
Elderly	Forced "suicide" or homicide of widows for economic reasons; sexual, physical, and psychological abuse.

Gender-based violence is present in most societies. It is not confined to certain countries or sectors of society. It happens in all countries, cuts across all socio-economic sections, and all religions. Violence from family and intimate relations is not new; one finds cases of such violence throughout recorded history. However, viewing family violence as a social issue and a problem is a relatively recent

phenomenon. It often goes unrecognised, because it is accepted as a part of the order of things. Information about the extent of this violence has been documented for all countries and socio-economic environments, and available evidence suggests that it is much more pervasive than was believed earlier in different parts of the world.

Violence between loved ones, and in intimate relationships, has literally and figuratively occurred behind closed doors. Women everywhere are more at risk from husbands, fathers, neighbours, and colleagues than they are from absolute strangers.

People have failed to address this topic because it is too private, and there is a great deal of fear and anxiety regarding how to respond to it. Since much of the gender-based violence is hidden inside the house, it is extremely difficult to document it, and even more difficult to prevent it.

The police, the judiciary, and even the health system often refuse to intervene, arguing that the privacy of the home is sacrosanct, and often the response of these services is to blame the women.

Although the recorded number of women against whom violence is perpetrated is small, and not always reliable, there is evidence that it is a problem of huge dimensions, affecting women and girls everywhere. Claudia (Gracia) Moreno of the WHO in her opening address to the Members Assembly of IPPF in Prague 1998 said, "Gender-based violence affects women's physical and mental health, their sexual and reproductive health, their self-esteem, their ability to work, to make decisions about their fertility, and all other dimensions of their lives."

The causes, consequences, and remedies of gender-based violence have to be seen in the context of a society that permits violence or condones it, and/or fails to deal with those individuals who perpetrate violence against women (this sort of violence is tolerated, condoned, and at times encouraged in many societies), societies that permit treating women as a commodity, or an object that must be dominated.

Gender-based violence can be conceptualised as an issue of power and social control over women, and forms the background for understanding various forms of violence as a continuum—from sexual harassment to homicide. A pervasive factor at the heart of violence is the inequality between men and women, and the discrimination women face. A Canadian panel on violence against women eloquently states, "It is clear that women will not be free from violence, and the threat of violence is eliminated from women's lives."

Much of our research has focussed on the personal characteristics of men who abuse women. However, it must be noted that men's behaviour is greatly influenced by the society that they live in. Laws, cultural values, social structures, and local and family relationships also determine whether members of a society, both men and women, are violent or not.

In all societies there are cultural institutions, customs, beliefs and practices that undermine women's autonomy and contribute to gender-based violence. Many marriage customs and traditions can disadvantage women, for example: dowry, or bride wealth, or undermine the ability of women to escape abusive relationships.

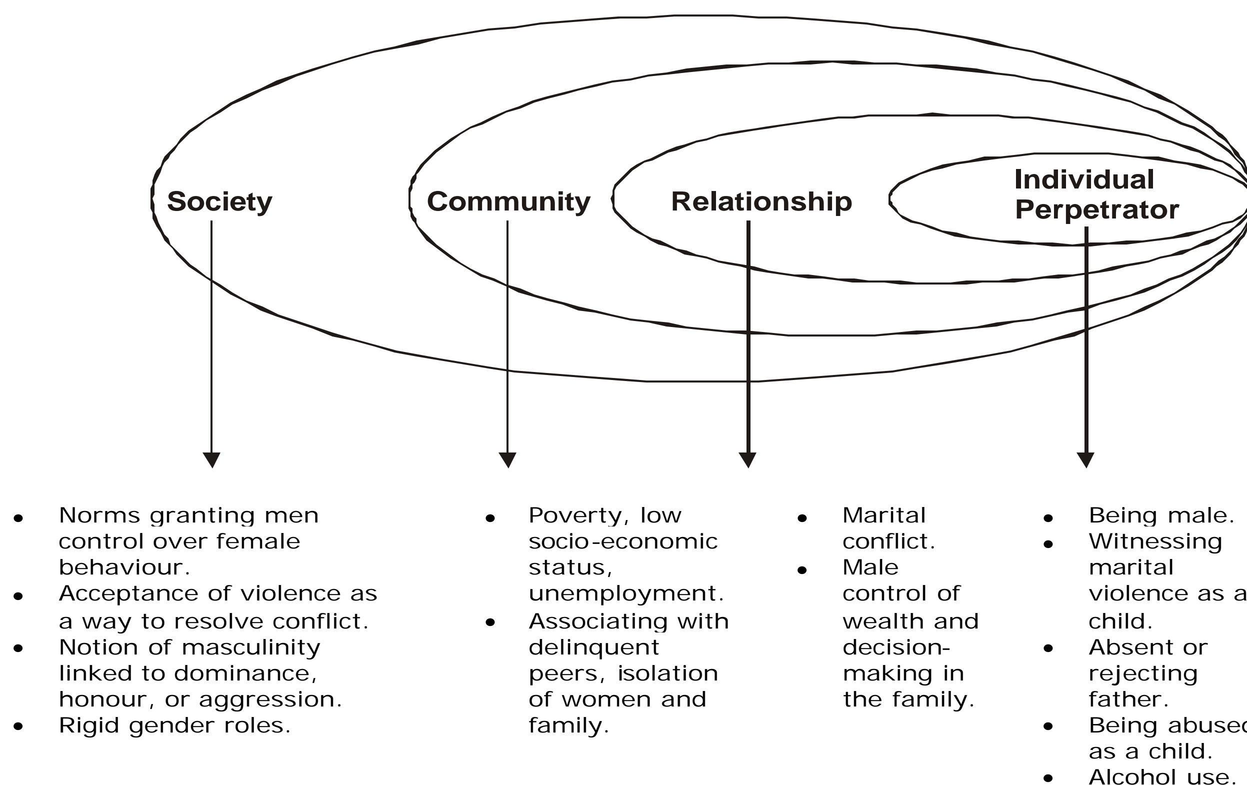
Cultural attitudes towards female chastity, male honour, and family 'Izzat' justify violence against women and exacerbate its consequences. Women in the forefront of the women's Human Rights movement point out that appeals to cultural norms are more often than not an excuse to justify practices, which are oppressive to women. Nahid Toubia, a Sudanese doctor says, "Why is it that only when women want to bring changes that benefit them that culture and custom and tradition become sacred and unchangeable?" A Ghanian lawyer opines, "A culture that teaches male mastery and dominance over women must be altered."

Many cultures believe that men have the right to control their wives' behaviour, and those women who challenge that right must be punished. In many countries, studies find that violence is frequently viewed as a physical chastisement, and the husband's right to correct his erring wife.

In fact, in these cultures, such acts are justified, and this justification of violence evolves from gender norms, that is, social norms about the appropriate roles and responsibilities ascribed to men and women. In many developing countries, women themselves share the notion that men have a right to discipline their wives, even by using force. Such societies often distinguish between just and unjust reasons for violence, as well as acceptable and unacceptable amounts of aggression.

Increasingly researchers are using an "ecological framework" to understand the interplay of personal, situational, and socio-cultural factors that combine to cause gender-based violence and abuse. In this model (adapted from Heise 1998 and used in CHANGE/POPU report), violence against women results from the interaction of factors at different levels of the social environment.

ECOLOGICAL MODEL OF FACTORS ASSOCIATED WITH PARTNER ABUSE



Source: Adapted from Heise 1998 (210) *Population Reports/CHANGE*

The model can best be visualised as four concentric circles. The innermost represents the biological end of personal history that each individual brings to his/her behaviour in personal relationship.

The second circle represents the immediate context in which abuse takes place - often the family, or other immediate and close relationship.

The third circle represents the institutions and social structures—both formal and informal—in which relationships are embedded, i.e., neighbourhood, workplace, peer group, etc.

The innermost (4th) circle is the social and economic environment, including cultural norms.

By combining individual-level risk factors with findings from cross-cultural studies, the ecological model contributes to the understanding why some individuals and some societies are more violent than others, and why some women are consistently the victims of abuse.

Today, we have sufficient evidence to show that women's experience of violence has direct consequences, not only for their own well-being but also for their families and communities. In addition to broken bones, third degree burns, and other physical injuries and abuse, the violence leaves mental scars that last long, and at times leads to depression, suicide attempts, and post-traumatic stress disorders.

Violence against women can also have intergenerational repercussions, that is, boys who have witnessed their mothers being battered by their male partners, are more likely than other boys to resort to violent acts to resolve conflicts in their own lives. Similarly, girls who have witnessed gender-based violence are more likely than other girls to become involved in relationships in which their partners abuse them. Thus, violence tends to be carried over from one generation to the other. The indirect costs of gender-based violence to development are extremely high. Unfortunately, there are few studies on the economic cost of gender-based violence. Accurate data, which is of a comparable nature, are just not available. Measuring the correct prevalence of gender-based violence is a very

complex task, because statistics obtainable through available records in the police or hospitals, or other formal institutions, are unreliable, as they are a gross underestimation of the situation due to under reporting, or not reporting at all. The World Bank Development Report gave the estimate of 9.5 million disability-adjusted life years (DALYS) lost worldwide due to rape and domestic violence. Rape and domestic violence are considered as risk factors for disease conditions, i.e., STIs, HIV, intentional injury, and depression (Lynn Steven).

Health Risks	Health effects
Childhood sexual abuse	Gynaecological problems, STDs, HIV/AIDS, early sexual experience, infertility, unprotected sex, unwanted pregnancy, abortion, revictimisation, high risk behaviours, prostitution, substance abuse, and suicide.
Rape	Unwanted pregnancy, abortion, pelvic inflammatory disease, infertility, STDs, partial or permanent disability, HIV, suicide, loss of 4.7 million years of productive life, death.
Domestic violence	Poor nutrition, exacerbation of chronic illness, substance abuse, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, PID, gynaecological problems, low birth-weight, miscarriage, adverse pregnancy outcomes, maternal morality, depression, suicide gestures or attempts, loss of 4.7 million years of productive life, death.

The negative impact of gender violence on women's reproductive and sexual health is only just beginning to be recognised. Gender-based violence is a reproductive health problem, because it is intertwined with sexuality, fidelity, pregnancy, and child bearing. Research has indicated that physical and sexual abuses are linked to some of the most intractable reproductive health issues of our times.

Impact of GB violence on reproductive health

* High-risk sexual behaviour (including multiple partners, adolescent pregnancy, inability to use contraception, drug abuse, and alcohol abuse)
* Lower age of first intercourse
* Lower contraceptive used or misuse
* Increased risk of STDs, HIV/AIDS
* Adverse pregnancy outcomes, e.g., low birth-weight, total distress, miscarriages
* Unwanted pregnancies - unsafe abortions
* Reduced sexual autonomy
* Gynaecological disorder, including PID

The section above described aspects of domestic and family violence against women, and the impact on their reproductive health. Gender-based violence occurs not only in families, but in a variety of situations.

Other categories of gender-based violence are those occurring due to:

* Traditional and cultural practices, for example, branding women as *dakins* or witches in certain societies
* Female circumcision and female genital mutilation among some communities, even in India
* Torture and rape of women in custody

* Armed conflict and displacement: in times of caste, communal and ethnic conflicts, women's bodies are seen as bearers of cultural identity and are perceived as a territory to be conquered.

* Violence against women is used to increase men's control over them, thereby subjugating and humiliating them further

* Prostitution and trafficking

* Sexual harassment at workplaces

The health system has to recognise violence against women in the different situations outlined above, and evolve different strategies to address each situation. For instance, in situations of armed conflict and in refugee camps, the health services, which are already over-stretched, need to recognise rape and sexual abuse, and be prepared to deal with trauma associated with it.

Violence Against Women - The Human Rights Dimension

There seems to be two aspects to the Human Rights dimension of gender-based violence. Firstly, gender-based violence is a violation of the most basic human rights of women. The Universal Declaration of Human Rights of 1948, and subsequent international covenants and conventions have spelt out rights to equality, dignity, and security of a person, as some of the fundamental rights of all individuals. Health personnel need to be made aware of how these, and other rights, are grossly violated in instances of violence against women. There is yet another aspect to the dimension of human rights. Violations of human rights occur when the health system fails to carry out its obligations and duties with respect to citizens, specially women, and thereby inflicting violence on them.

Table 3a and Table 3b summarise the international conventions and conferences and the evolution of specific rights, which have a bearing on gender-based violence.

TABLE 3a : Human Rights Related To Violence Against Women

In International Conventions

International Conventions, Global Documents	**Contents / Right to....**
1948 Universal Declaration of Human Rights	* Freedom, equality and dignity (Article 1) * Life, liberty and security to person (Article 3) * No one shall be subjected to torture, cruel, inhuman, or degrading treatment (Article 5)
1966 International Covenant on Economic, Social and Cultural Rights (Economic Covenant)	* Right to enjoyment of just and favourable conditions of work, which ensure safe and healthy working conditions. * Enjoyment of the highest attainable standards of physical and mental health (Article 12)
1979 Convention on the Elimination of All forms of Discrimination Against Women (Women's Convention)	* Many of the anti discrimination clauses protect women from violence. e.g article 2.
1992 Committee on the Elimination of Discrimination Against Women (CEDAW)	* Monitor implementation of Women's Convention * Recommendation 19 deals with violence against women and measures to eliminate this. State should provide services for all victims of gender based violence.

1949 Geneva Conventions	* Persons taking no active part in hostilities shall be treated humanely, without adverse distinction on any of the usual grounds, including sex (Article 3), and offer protection to all civilians against sexual violence, forced prostitution, sexual abuse, and rape. * Related to international armed conflict and internal conflicts.
Additional Protocol I and II	* Parties to a conflict are obliged to treat humanely persons under their control — women have to be protected against rape, forced prostitution, and indecent assault.
1989 Conventions on Right of the Child	* State parties have to take all kinds of measures to protect the child from physical or mental violence, abuse, maltreatment, or exploitation (Article 19). * States have to prevent exploitative use of children in prostitution, other unlawful sexual practices, including use of children in pornography (Article 34).

(Adapted from WHO, 1997)

TABLE 3b: Declaration at International Conference Related to Violence Against Women

Conference	**Contents**
1993 Declaration on the Elimination of Human Rights Against Women - United Nations General Assembly	* Affirms that violence against women violate and impair the enjoyment by women of their rights. * Concerned about failure to protect and promote those rights, in relation to violence against women. * Provides clear and comprehensive definition of violence against women.
1993 World Conference on Human Rights - Vienna Declaration	* Declares gender based violence is incompatible with the dignity of the person and must be eliminated.
1995 World Summit for Social Development - Copenhagen	* Condemned violence against women.
1995 Fourth World Conference on Women - Beijing	* Recognised that elimination of violence against ment, women is essential for equality, development and peace. * Highlighted the vulnerability of women belonging to groups such as refugees, displaced persons, migrants, and persons with disabilities.
1996 Second UN Conference on Human Settlements - Habitat II	* Dealt with GBV within the context of shelter and urban environment
1996 World Congress Against Commercial Sexual Exploitation of Children	* Declared high priority action is needed against the commercial sexual exploitation of children, and allocation of resources is required for this purpose.

1996 49th World Health Assembly	* Declared violence is a public health priority. (WHA 49-25)
1997 Commission of Human Rights	* Condemned all acts of violence against women. * Emphasised governments have a duty to refrain from engaging in violence against women, and to prevent, investigate, and punish acts of violence (Resolution 1997/44). * Expressed concern about continuing reports of abuses against women migrant workers by employers in host countries (Resolution 1997/13)

(adapted from: WHO, 1997)

The second issue of human rights violation against women pertains to the violence done on women by the state when it does not fulfill its obligations towards them, and which many writers have discussed. Sullwan (1995) suggests that women's right to health is constituted by an array of rights, some of which are core rights to health, for example: access to adequate health care facilities, including information, counselling and services in family planning, and others which are enabling rights or pre-conditions necessary for the realization of this right—for example, adequate living conditions, particularly in relation to housing, sanitation, electricity, and water supply. The health-related needs and rights of women create a set of obligations that can be broadly characterised as obligations to respect, to protect, to assist, and fulfill those rights.

The duty to respect requires that the state "refrain from carrying out violations of the rights to health." This can be interpreted as the duty of the state to respect women's opinion about the quality of care, in order to respond to their specific needs for health services. For example, it could be counselling for fertility, treatment and counselling of partners for STDs, etc. Further, the duty to respect also requires that the state health system provides services to all, without discriminating against them on the basis of their marital status, sexual orientation, and such like. The duty to protect demands action by the state "to prevent violation by non-state actors, including individuals, groups, and organisations." For example, the state may need to regulate private practice to ensure minimum standards of health care for women, and regulate drug and contraceptives testing and marketing. As their protective duty, the state may need to take measures to eliminate violence against women in the family.

The duty to assist requires that the state may need to take measures that will "improve the capacity of individuals and groups to achieve and maintain a state of health." This can include educational and health promotion measures. Health care providers in public hospitals, where medico-legal cases are referred, can also play an important role in identifying and referring to counsellors the survivors of sexual assault, child sexual abuse, and battering. The duty to fulfil these obligations requires the state to take those measures necessary to "ensure full realisation of people's right to health." This would mean that it is the duty of the state to make adequate budgetary provisions to meet a broad range of women's health needs, and not just contraceptive needs.

The failure of the state to fulfill the obligations and duties outlined above amounts to violations of the human rights of women, and can also be construed as violence on women. By focusing its attention mainly on women, the family planning programme in India violates the principles of non-discrimination and equality of men and women. A target-driven family planning programme, based on a system of incentives and disincentives (it is still there in India despite the policy change since October 1997), nullifies the notions of choice and decision, thus violating women's right to self-determination.

By failing to maintain the quality of care in its Family Welfare Programme, as well as in the larger health care system of the state, the health system not only violates the basic human dignity of women, but also ends up increasing the violence that women suffer at the hands of the medical establishment. This violence is due to the lack of adequate technical competence, and shortage of equipment and supplies (Mavalankar, 1999; Khan et al, 1999). Poor technical competence of health care providers amounts to the creation of direct hazards to women's health.

ROLE OF HEALTH CARE PROVIDERS

Health care providers generally seem to believe that the causes of physical injuries that battered women present with are not their business. They perceive their role as limited to dressing the wounds and prescribing medicines. Some view domestic violence as a private issue, and fear that patients would be upset or offended if asked directly about violence. Others do not quite know how to ask, and how to respond, if a woman does admit to being abused. Yet, others feel that they have no time or space (within the context of overcrowded dispensaries and out patient departments) to deal with the needs of the victims of violence.

Another barrier to health workers addressing violence is that they belong to the same cultural and social milieu as their patients. They share the values and attitudes towards abuse that are prevalent in the larger societal context. For instance, many women and men believe that a woman is the property of her husband, and so an occasional beating is quite acceptable. Or, the constructs of sexuality in many cultures define that women have to be available for sex whenever their husbands 'need' it. Male clinicians may hesitate to accept a woman's account of violence because they identify with the offender. Female health workers who have been victims of abuse may not find it easy to discuss violence with their patients.

Another major barrier to health workers addressing violence against women in India is that these are medico-legal cases and doctors are reluctant to get involved in legal liabilities and procedures. Lack of referral services, and poor coordination between the health, legal, and social welfare departments also act as a deterrent.

The agenda of violence as a health issue has to be accepted at various levels. The leaders and mangers of health programmes have to publicly acknowledge that they are committed to dealing with violence against women. Then they have to create enabling providers at various levels so to respond sensitively to the issue. Polices, procedures and protocols will have to be established so that violence against women becomes an integral part of the health agenda. Allocation of resources for training, coordination with other agencies, and effective monitoring space for privacy will have to be done.

Health care providers at each level have a role to place. Health promotion and prevention work will have to be done within the community. The community health worker, who is closest to the women in the community, will have as her task, organising women around the issue of violence, identifying legal and social support agencies in the neighbourhood where victimised women could be referred to. The community health worker, as a link between the woman and the health care system, can also provide valuable information to the doctors and nurses about the violence inflicted on the woman. Since the CHV (Community Health Worker) lives in the community and understands the cultural mores, she can be a credible vehicle of the educational efforts directed at adolescents and men on reconstructing masculinity and femininity.

Male health workers are the second level of health functionaries who have a key role to play in addressing men on issues of violence against women, and transforming the notions of masculinity and male sexuality from the currently accepted social norms to more gender equitable constructions. The role of the male health worker has not been given much importance until now, it is time that his role is recognised, and thought is given to how he can be prepared and equipped to become a role model for men in the community.

Finally, doctors and nurses need to address violence during their consultations. Doctors and nurses form a part of society and it is very likely that they have internalised the given social and cultural images of marriage contracts and gender roles, and therefore identify themselves with these images just like their patients do. Enabling them to reflect on their perceptions of gender identities, and how these influence their work, will help raise awareness about the suffering of women, and sensitize them to the problem. Sensitised health workers then might be better able to address issues related to violence in their day-to-day practice.

Assessment of all forms of violence against women should take place for all women entering the health care system. A thorough assessment gathers information on physical, emotional, and sexual trauma from violence; risk for further abuse; cultural background and beliefs; perceptions of woman's relationships with others, and the woman's stated needs. Women should be asked directly if they have been in an abusive relationship, either as a child or as an adult, or are currently in one. They should also be asked if they have ever been forced into sex that they did not wish to participate in. Shame and fear often make disclosures difficult. Verbal acknowledgement of the seriousness of the

situation, and emotional and physical support, assist women in talking about past or current circumstances. After the assessment, the interventions should be decided on the principle of helping the woman to make decisions and take control of her life. Counselling of women in situations of domestic violence should move away from the paradigm of *samjhauta* or compromise to a paradigm of helping women exercise autonomy, and look for alternative solutions.

IMPLICATION FOR TRAINING

Training on issues of violence against women has to be somewhat different from the existing training approaches. This training has to have components that are:

* Experiential, promote self-reflection and analysis of each person's own relationship, to assess their use of power and control and construction of their gender identity
* Build a perspective within which to understand the nature and structure of gender-based violence.
* Develop skills of talking and listening to women in situations of violence: history taking and counselling, and skills of assessment and examination.
* Help them recognize and manage their own stress through yoga, meditation and so on. Care given to victims of violence and trauma need to maintain their sensitivity and at the same time prevent themselves from burning out. Health care providers in different situations, e.g., refugee camps, armed conflict zones, around red light areas, and so on, need to be sensitised to the nature of gender-based violence in their specific contexts so that they can recognize the particular dynamics of that violence. This will help them evolve suitable strategies for addressing gender-based violence in that context. Health care providers also need to inform themselves of the basic legal and social welfare aspects so that they can do appropriate referrals.

To conclude, guidelines and protocols for in-service training should be developed to assist physicians and other health staff to address the issues of gender-based violence. Gender-based violence should also be included in the basic and post-graduate training curricula of health practitioners: doctors, nurses, ANMs, MPWs, etc.

ETHICAL CONSIDERATIONS

While addressing violence as a health issue, health care providers may face several ethical dilemmas. For instance, getting abused women to move out of culturally defined roles of wives who accept violence at the hands of their partners, may stand in conflict with principles of autonomy and self-determination. Or, the CHW giving information to the doctors and nurses about abuse suffered by a particular woman, who refuses to talk about it herself, can be construed as violation of the confidentiality principle.

Researching issues of gender-based violence and getting women to talk about their traumatic experiences may result in causing greater pain and discomfort to women.

These are a few examples. In research and interventions related to violence against women as a health issue, health care providers should build in their practices some space for the discussion of ethical issues.

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Dilaasa-Crisis Centre for Women

Dilaasa, in hindi means reassurance. *Dilaasa* is a public hospital based crisis centre for women survivors of domestic violence. It provides social and psychological support to women facing domestic violence. Training, research and advocacy are other core activities of the centre.

It is a joint initiative of CEHAT and the Public Health Department – K.B. Bhabha Hospital, Bandra (W).

CEHAT, is the research centre of Anushandan Trust established in the year 1994, stands for research, action, service and advocacy in health and allied themes. 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 right to health care.

K.B. BHABHA HOSPITAL

K.B. BHABHA HOSPITAL, Bandra is a 436 bedded, well equipped peripheral hospital with all major clinical departments and is centrally located in the Western Suburb, "H" ward office of Bandra (W), Mumbai.