TRAINING MODULE

ON

DOMESTIC VIOLENCE

FOR

PRIMARY HEALTH CARE PROVIDERS

IN

URBAN BENGALURU

(ENGLISH)

DEVELOPED BY

THE SOUKHYA PROJECT

Session-I

Duration of the session: 2 hours

Objectives of the session:

Objective 1: To get to know each other
Objective 2: To explain the definition of domestic violence as per PWDVA-2005
Objective 3: To understand health consequences of living with abuse.
Objective 4: To understand their vis a vis PWDVA and the Soukhya Project

Methods:

Introductions through a game using adjectives
Explaining concepts through PowerPoint presentations
Role-realization through case-studies as a group-work

Steps:

The facilitator welcomes the participants and explains the purpose of training.
The game of adjectives is explained to the participants.
Participants do the round of introductions.
Participants are made to sit facing the screen in chairs and tables with writing space.
Hand-outs on PWDVA-2005 are distributed.
The PowerPoint presentation is made by the trainer.
Presentation is interrupted from time to time for responding to any doubts.
Participants are encouraged to raise doubts and give opinions.
Facilitator sums up the presentation at the end.
Participants are divided into three groups. (Any method may be used)
Each group is given a case study from among those noted below.
Each group is given half an hour to discuss among themselves.
At the end of the stipulated time, the groups are asked to re-assemble.
Each group is asked to make their presentations based on the questions.

Materials:

- A room containing movable chairs with writing space
- A white board with a black and red marker
- A laptop connected with a projector,
- Power point presentations loaded in a USB stick
- A laser beam pointer
- Chart Papers and a stand to hold them

PROCEDURES

For Objective 1: The following activity is to be played among the participants.

The Game of Adjectives

Participants are made to sit in a semi-circle and the introductions shall start from one side.

Each participant is asked to attach an adjective starting from the first letter of their name , which best describes them, before their names. Eg. If ' Harini ' thinks she is 'honest', she calls herself 'honest Harini'.

The person next in line has to repeat all the 'adjective-name' combinations before him or her. Eg. If 'Sheena 'is sitting next to 'Harini' and she thinks she's 'Sincere', she has to say: 'Honest Harini ', 'Sincere Sheena'.

Similarly, if the next person in line is 'Rashmi' and she thinks she's 'Risky', she has to say: 'Honest Harini', 'Sincere Sheena' and 'Risky Rashmi'.

The whole game moves so-on till the last participant has to repeat all the adjective-name combinations. The objective of this activity is to create a warm environment and also to evoke laughter.

Notes for the facilitator:

-> Start with your own name first.
-> Insist on the adjective rhyming with the names.
-> Encourage people to help if a certain participant takes a long time to repeat names.
-> Ensure that no defamatory or unacceptable adjectives are used.
-> Try to address the participants with the adjectives they have chosen for themselves, throughout the sessions.

Role-Enactment (*):

At the end of this activity, there shall be another activity only for the Doctors and Nursing Staff. This shall be carried out by the resource team and consist of dramatization of a scene in a health centre where a pregnant woman walks in wearing a forlorn look.

She is not paid much attention nor is any effort made by the staff to make her comfortable. The act shall consist of the patient's interaction outside as well as inside the doctor's chamber.

This shall be followed by an open discussion among the participants on the rights and wrongs in the enactment of role.

For Objective 2: A PowerPoint presentation shall be provided along with.

Notes for the facilitator:

-> Make the presentation provided.
-> Participants should be clear on what the training is for.
-> It should also be clear on who shall be training them and when.
-> It should ignite their interest to participate.

For Objective 3:

Methods: The group of participants are divided into different groups. Each group is asked to prepare a list of forms of violence, definition of violence and domestic relationships . They are provided 20 mins to complete this task and then each group representative has to present their understanding. The facilitator can then sum it up with a 15 minute presentation. The presentation shall include the following topics:

-> What is DV as per PWDVA.
-> Nature of domestic relationships under this law.
-> Forms of violence as defined by this law.
-> Service providers as per the law.
-> Health system as one of the service provider.
-> Role of HCP under the law.
-> The need to provide treatment free of cost.
-> Informing women about PWDVA.
-> How to prepare a DIR and make referrals.

Notes for the facilitator:

-> A handout on PWDVA is to be distributed among all the participants.
-> Kindly go through the Act yourself first.
-> Pay more emphasis to the role of HCPs in the Act.
-> Encourage discussions.
-> Discuss about the various informational resources available.
-> Provide a copy of the DIR to all the participants.

For Objective 4:

The participants are divided into three groups and each group is given one of the following case-studies. They are given 20 minutes to discuss among themselves and then each group is to make individual presentations based on the questions given along with.

Case Study 1.1: REHANA:

Rehana is a 30 yr 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 15 yrs, 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 neighborhood because they feel safe there. Rehana now has to wear a Burqa, which she never did before, and she 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 labor. 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 gynecology OPD before they could 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 burqa he noticed the bruises on her wrist and made enquiries. But how could she tell him the truth in front of so many people? She said that she had fallen down. She also felt scared to tell the doctor about her husband's behavior because she felt they would give him up to the police. Would the police treat her husband as a terrorist or 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 prescribed medicines and so she does not know where to go.

Questions 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 leave 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?

Case Study 1.2: Maria

Maria is a 27 yr old married woman living with her in-laws in the nearby colony. She married Robert, a 32 yr old auto-rickshaw driver, 8 yrs back. Robert is the younger of the two sons in the family and both brothers stay together with their wives and their parents. The family though is saddened by the fact that both the couples have not been able to have ac child. The elder daughter in law has undergone several treatments but to no avail. They have finally given up on the elder couple.

Maria first visited the infertility clinic along with her husband around 3 years back. The doctor had advised a series of investigations for both of them. Citing the cost, Robert made her undergo all the investigations saying he will get his done later. All the test reports came out to be normal for Maria and

this only seemed to further spoil the mood at home. When she did try to persuade Robert to undergo investigations, she was only chided.

The frequents taunts she received from her mother-in-law was becoming more and more unbearable by the day and she had to finally concede to their demands of getting her investigations done all over again, at a different health centre.

This time around the reports pointed that Maria has mild anemia. The treating doctor was categorical to state that this cannot be the sole reason for infertility, while advising that Maria take some pills. The doctor also insisted that Robert should get himself tested at the earliest. Robert though was very casual about getting investigated but at the same time certain that it was Maria's anemia which was the cause of their childlessness. Everyone at her marital home also seemed to be certain that it was because of Maria that the couple could not produce a child. The taunts at home became so severe that Maria could take it no longer and decided to shift to her natal home.

But things only got bad with her parents squarely blaming her for the situation. They said that it was because of Maria's depressive nature that she couldn't eat well and this had led to her anemia. They could see no point when she mentioned what the doctor said.

Maria had by now lost all interest in life and didn't know what to do. She had frequent headaches and her parents also constantly chided her for being a weakling. She was one day brought into the health centre with complaints of headache and loss of appetite.

Questions for discussion:

1. What are the various problems that Maria has faced in her life?
2. Identify the various forms of violence.
3. What choices did she have or not have?
4. What would be your role, if you are treating her?
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?

Case Study 1.3: LAKSHMI:

Lakshmi aged 31 had undergone her first tubectomy after two child births on the doctor's advice, as she had heavy blood loss during both her deliveries. But her husband was unaware of this and Lakshmi had also not informed, fearing his refusal to undergo the procedure. The abusive husband though constantly kept trying and insisting that she gives birth to a son. When Lakshmi did not conceive, he took her to a temple renowned for granting wishes to have a son. Lakshmi managed to confide her situation with the priest there and he gave her a flower which was to be taken back to the doctor who conducted the procedure on her. She was further advised to give this flower to that doctor and to request for reversal of the procedure to be conducted by the same doctor. The priest's prophecy turned true when Lakshmi did conceive and gave birth to a son.

The husband was now happy but his abuses did not deter as he wanted another son. Meanwhile, Lakshmi had gone ahead and undergone another tubectomy this time with a strong warning from her doctor. Under a lot of duress and increasing abuse at home, she had to reproach her doctor for another recanalization. The doctor felt pity for Lakshmi and felt it was best to carry out the recanalization and save the poor woman from further abuse. Lakshmi did conceive again but the child-birth was very complicated resulting in loss of the child as well as severe blood loss necessitating removal of her uterus. It took her a long time to recover and go back to her marital home, which was no solace, considering that her husband had become even more abusive and threatening to leave her.

At last, one day the husband left her to live with another woman, citing that she could not produce enough sons for him. Lakshmi's life is now in a quandary with three children to fend and her own poor health caused by repeated surgical procedures and complicated pregnancies.

Questions for discussion:

1. What are the various problems that Lakshmi has faced in her life?
2. What choices did she have or not have?
3. Why did she leave 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?

Overall/ learning outcomes of this session:

At the end of the session, participants should:

-> Know each other in the group
-> Know the definitions and various sections under the PWDVA, health consequences of violence
-> Realize their role as a HCP vis-a-vis the act
-> Know how to identify cases as well as various forms of violence

Resources for the facilitator:

About the methods:

Lectures

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.*

Group Discussions

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 gets 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.*

Session-II

Objectives of the session:

Objective 1: To introduce the concept of 'gender and sex'
Objective 2: To understand gender-discrimination and how violence acts as a tool to maintain this inequality.
Objective 3: To introduce the concept of patriarchy and to understand the institutions that maintain violence

Methods:

Explain concept of 'gender and sex' through story telling
Illustration of gender discrimination through 'Myth-Breaking'
Role-realization through case-studies as a group-work
PowerPoint presentations for other purposes

Steps:

The facilitator welcomes back the participants.
Provide re-cap of the previous session.
Story telling: The Putta-Putti story is told using situations to build up the story.
Short discussions after each situation is explained.
Larger discussion at the end of the story.
Conclude with the concept of 'gender and sex'
Lead discussion further into the discriminations showed in the story
'Myth Breaking' exercise is done.
Have a discussion after each myth is broken.
PowerPoint presentations for achieving other objectives.

Materials:

- A room containing movable chairs with writing space
- A white board with a black and red marker
- A laptop connected with a projector,
- Power point presentations loaded in a USB stick
- A laser beam pointer
- Chart Papers and a stand to hold them

PROCEDURES

For Objective 1: Story telling based on the 'Putta-Putti story and built up with the help of consecutive situations which looks into how Putta and Putti grow to-gether but are still apart.

The situations for the story are as given below:

(Facilitators Notes: A debate needs to be initiated at the end of each session)

Putta and Putti: 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 Putta is a boy and Putti 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

Putta and Putti are three months old. They are both hungry. Does Putti cry less? Does she sacrifice her share of the milk for Putta? 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. Putta is given a shirt and shorts to wear. Putti gets frocks and dresses. Do the children choose their own clothes at the age of two? We decide that. *'Because'* Putta 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 Putti 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 Putta and a doll with the kitchen set for Putti. What are the ramifications of these presents for the children?

SITUATION 5

Putta plays with the bat and ball. Where is this game played? Out in the open, away from home. Therefore, Putta 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, Putti 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. Putta can enter the house, banging his bat on the staircase, but if Putti 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 gentler. 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 ostracized. She dare not say that she does not like children, because she will be labeled '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. Putti 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 Putta gets tired of going out and wants to play at home with Putti'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 behavioral 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 Putta and Putti when they grow up? A look at another situation in their lives will throw some more light on this matter.

SITUATION 7

Putta and Putti are now 20 years old. Putti 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 Putta the house and Putti the dowry. Putta has a degree in hotel management and is a chef in a good restaurant. He has a decent salary. Putti's fiancé is a dress designer and designs clothes for a boutique. He also has a good annual income. The dowry from Putti'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 instill 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.

For Objective 2: Breaking the myths by using the following myths and their explanations: (Assisted by a PowerPoint presentation)

MYTHS AND REALITY

(Adopted from 'Breaking the culture of silence: Uniting to fight domestic violence' by Aruna Burte)

There is an inbuilt mechanism based on widely shared myths that lends ethical and moral support to the continuation of social evils like domestic violence. The myths work on multiple levels. Some are part of social memory that perpetuates silence, condone such acts and create barriers to understanding the issue. In fact, both men and women perceive the phenomenon through the prism of popular myths.

It is the feminist movement which undertook evidence-based studies and brought the myths under public scrutiny that helped to dispel some of them.

'It is rare'

This is one of the most widely believed myths. In fact, domestic violence is not rare; talking about it is. In recent years, WHO statistics as well as nationwide and local surveys have revealed how common the problem really is. In fact, it may be much more severe than we can guess at since domestic violence happens within the home and women are still reluctant to talk about it.

To briefly review the scene, women in the reproductive age group of 15 to 44 years are at highest risk; 52 per cent of women in India suffer at least one incident of physical or psychological violence in their lifetime.**(1)** It happens in every class, caste, region and religion. It cuts across age, education and marital status. It happens in both the natal and marital family.

While it remains difficult to assess exact figures, a study**(2)** of the casualty register in the hospital shows that one third of all cases are definitely of domestic violence and another one third are possible cases of domestic violence.

'It is an isolated incident'

When women first began talking about the violence done to them in their homes, it emerged that they had been suffering over periods ranging from two months to 20 *years.* The enormity of the problem was revealed by the WHO in a multi-country study titled *Women's Health and Domestic Violence against Women, 2005. Women from 15* countries as diverse as Bangladesh, Japan, Serbia, Montenegro,Thailand and Brazil were interviewed. It emerged that the lifetime prevalence of

physical or sexual violence or both by an intimate partner ranged from 15 per cent to 75 per cent in the different sites. The survey pointed to the 'culture of silence' that prevailed in the matter of domestic violence. In all the countries, the interviewer was the first person many of the abused women had ever talked to about their partner's physical violence.

The experience of supporting survivors of domestic violence over decades has shown that

- It is rarely a one-time occurrence and tends to escalate in severity over time when there are no direct interventions.
- Almost all-physical violence is preceded and accompanied by emotional violence.
- It is a matter of power and control within the family and marriage and an inherent feature of maintaining the power imbalance.

'Perpetrators are mentally ill'

The problem of mental illness may in some cases play a part but it is not the cause of violent behavior. There are no evidence-based studies to determine the mental health status of perpetrators. But the reports of survivors show that the men who inflict violence are not particularly affected by any mental illness. They function normally in other areas – in their jobs and social circles. In fact, labeling the perpetrators as being mentally ill prevents us from examining the process of how the power imbalance in society is maintained and how it is specifically reflected in the controls exercised in the family and in marriage.

Take the example of a young woman prevented from choosing her life partner just because he belongs to a lower caste. In such cases, the power and control mechanisms that exist within the family and community are activated to the extent of executing an honor killing. These are planned actions. Can anybody term the perpetrators as being seriously mentally ill? In fact, they are exerting their power and controlling members within the family.

Honour killings may be extreme example. What about the incidence of grown-up daughters expected to obey the many dictates restricting their mobility and choices? That is a much more familiar story, and yet the roots of control and power are the same.

It is therefore impossible to separate the violent man from the rest of us as being 'different' or a lunatic. He is one of us, like us and a carrier of the same social structures that give all men privileges in our society. For example, an investigative study done by Sakshi, a group working on sexuality and legal advocacy, showed that of the 109 judges interviewed for the survey, 48 per cent believed that there were occasions where a husband was justified in slapping his wife. And 74 per cent believed that the preservation of the family should be the
woman's primary concern even if she faced violence.**(3)**

'The men can't control their anger'

Most perpetrators are able to control their reactions in social situations, and are abusive only in the home. Most people who are violent in the home cannot be distinguished from other "normal" members of society.

We live in a culture that teaches boys courage and responsibility in working life but not in close relationships. We teach boys football and physical games but we do not teach them how to be stable in their emotional life. Traditions of responsible and caring fatherhood are hardly in evidence, which is why many men in their emotional life are like immature boys. While one can understand the

frustrations that men often experience in the gender roles imposed on them, for instance, as providers, one needs to ask: 'In the struggle for survival, women too are exposed to severe frustrations, but they don't usually beat the men in their lives.

Why?'

Why is it also that men do not routinely beat their co-workers, relatives or neighbours when frustrated? The answer is that they know they can beat their wives and get away with it. Violence is a learned behavior; VAW is prevalent in societies that have distinct gender roles for men and women. (heise et al)

'It is a lower class problem'

On the contrary, domestic violence is not confined to any specific caste, class, community, religion, region, ethnic group and nation. Many evidence-based studies have proved this. Perhaps in poor uneducated families it is not contained in the confines of four walls.

There is less space and privacy, more visibility. Battered women from the low income group are more likely to seek assistance from public agencies such as hospital emergency rooms, the police and shelters because they have fewer private resources than middle and upper middle income women. They are therefore more likely to be counted in official reporting statistics. More middle-class educated women cover up the crime against them because they fear social stigma.

There is a tendency among the upper-middle educated class belonging to the majority religion to blame all social problems on those belonging to the uneducated lower class, to the poor and to minority communities. The process of 'othering' (blaming others) to explain social problems is very useful and expedient. All manner of social problems ranging from corruption, the population explosion, reservations, communalism, riots and terrorism are attributed to this stratum. The issue of domestic violence is no exception. On this issue, the difference between classes relate to consequences and impact. Economic factors and educational levels play a part in tackling the problem. The studies do indicate that the educational and economic background of the reported domestic violence cases is low. It is likely that the upper class victims do not report it. Therefore it appears as though disadvantaged groups have a higher concentration of family violence, whereas it can and does exist at every level of society

'It is a private affair'

Yes, the family is a private space for all members. Every member has the right to a life free from violence in this private space. This right is trampled upon when domestic violence happens. It is the misuse of this private space that allows domestic violence to continue and escalate. If some members are violated it is a crime. The police are mandated to lay charges when there are reasonable and probable grounds. Domestic violence will rarely stop unless there is an intervention from outside the family. The woman who is beaten and violated needs to have some alternative to change her situation.
Therefore, though the family is a private space, domestic violence is no longer a private affair.

'Alcohol causes a man to beat his wife'

Alcohol is not the cause of violence; it is a cover for violence. It facilitates the use of violence by allowing the offender to abdicate responsibility for his behaviour. Even under the spell of alcohol, the man is less likely to be violent towards his boss, co-worker, stranger or neighbor. He only loses his senses when it comes to abusing his wife. So even under the influence of alcohol a man is fully conscious of whom he can exert his power over. Men who are violent toward their wives or other female members of their family do so even when they are not drunk. All alcoholics are not abusers and those who abuse are not necessarily alcoholics.

'The real problem is women's liberation'

When the power imbalance within the family and marriage is challenged, many people feel insecure and threatened. They fear women's freedom. They believe that the institution of family and marriage will disintegrate. The material privileges and dominance of men will be undermined.

The mainstream media also projects a certain image of women's liberation. It conveys the impression that liberation is freedom without any corresponding responsibilities. But to reduce women's liberation movement in this way is to sideline the range of issues it has addressed.

The women's liberation movement has highlighted the injustice done to women in the private and public spheres. Women form half the population. Neglecting them bars the growth of both men and women. It is not the women's liberation movement that is the problem, but the many issues that women face within the family, many of which are still unaddressed, that form the crux of the matter.

'Women's education and employment is the real cause'

Education and employment are social development indicators. 'Education and employment for all' is one of the fundamental rights enshrined in our Constitution. Education and employment are important ways of asserting oneself.

Even six decades after independence, 60 per cent of women are not literate (2001 census results) and the majority work in the informal, unorganized, poorly paid, agrarian sector. Despite their disadvantages, millions of uneducated women work hard for their survival and that of their families. But they are unable to save themselves from domestic violence.

Middle class women have the advantage of being educated and employed, which enhances their capacity for assertion. But domestic violence occurs even in this section of society. They too may be affected by dominant cultural norms regarding 'women's place' and afraid of the social stigma of being separated or divorced.

When a woman is educated and employed, her capacity to negotiate non-violence can increase if she overcomes the cultural norms to some extent. The consequences of violence decrease in severity when the woman is educated and employed compared to the woman who is uneducated and unemployed.

'The woman is responsible for the violence'

This myth has many interconnecting dimensions. For example, it is easy to blame the victim and say that if the woman wanted to she could get out of the violent situation. There is also a presumption that the violence could not be that bad otherwise she would have left.

Women encounter a judgmental attitude for not leaving and also for leaving!

But we must remember that poverty and lack of protection are real problems for women who choose to leave an abusive relationship. Single women with children can get impoverished. There is a threat to life and limb. The husband may threaten to maim or kill the woman and children if she attempts to leave. The victim's greatest loss is her self-esteem. Without that, she does not have the internal resources to take the drastic action necessary.

For the perpetrator this knowledge provides him scope to abdicate responsibility for his action. He ascribes his violence to the woman's failure to 'comply' with what he considers reasonable demands. He believes that it is she who provokes him and is the real cause of his violent behaviour. The woman herself begins to believe what society at large and her male partner dins into her, and she begins to blame herself for the violence she suffers. Self-blame is very difficult to overcome. Since the alternatives to change her situation are so hard to come by, she prefers to blame herself and take responsibility for 'lapses' she never committed. She may also blame her fate and undertake fasts and other rituals to seek relief.

Victims of domestic violence do not leave their abusers for a variety of reasons. These include fear and the lack of a range of services: affordable housing, reliable childcare, employment opportunities and effective legal protection from the abuser. Religious and cultural beliefs, family pressures and the desire to keep a family together also make leaving an abusive relationship difficult.

'Women are women's worst enemies'

This is a very deep-rooted myth. In many cases, the mother-in-law and sister-in-law are named as perpetrators in police complaint. This is given wide coverage by the media. The electronic media thrives on
women-against-women themes in all the popular serials, yet the truth is that all the crime records show that male members outnumber female members in perpetrating violence. Recent research on child sexual abuse also shows that it is men who are the abusers. This general truth aside, we must take a closer look at the power structure within the family, for while women are rarely the prime abusers, they aid and abet the abuse of other women only when they have support of male members of the family. Thus, by blaming women, men escape accepting responsibility for their actions.

In the Indian family, the woman is supposed to 'merge' with the matrimonial family on her marriage. Strict gender roles drive female members to control the kitchen. The woman who enters a new family has to confront this power ladder where she is on the lowest rung. The mother-in-law has to accept and concede, at least to some extent, her earlier exclusive control. This is cause for tension. Besides, the two women also compete for the attention of the man who is husband and son. This psychological minefield is very difficult to negotiate.

Both think that they need to have exclusive possession and attention of the man which in itself is a flawed situation. In such a situation, men do not want to give up their privileged status of pampered son and husband, and may revel in the increased attention from both quarters. It is this skewed arrangement sanctioned by patriarchy that forms the root cause of strife between daughter-in-law and mother-in-law. The women are placed in such a way on the power ladder that they begin competing with each other. Instead of
recognizing the flawed foundation of our family arrangement, a convenient myth is created that 'women are each other's enemies'.

The woman who gets the status of 'mother-in-law' little realizes that she is the gatekeeper of patriarchy. Any movement which takes up issues of the oppressed classes of society has to face such myths. For example, workers were blamed for the violence unleashed on them when the labor movement pressed for better working conditions. When the women's movement makes significant gains, blaming women is a sure way to diffuse the gains.

Woman gains status when they produce a son. So a mother of son gains further status and power when her son gets married. She has power over the daughter in law because of the patriarchal structure that we iive in. Mother of a daughter does not yield same power over her son-in-law. So this needs to be understood before we conclude that women are women's enemies. The root cause needs to be understood.

1. International Centre for Research on Women (ICRW) (2000), Domestic Violence in India: A Summary Report of a Multi-site Household Survey, New Delhi
2. Domestic Violence against Women. An Investigation of Hospital Casualty Records, Mumbai. By Achala S. Daga; Shireen J. Jeejeebhoy; Shantha Rajgopal. 1998
3. Gender and Judges: A judicial point of view; Sakshi 1996

For Objective 3: A session on patriarchy as explained below.

The trainer has to ask the trainees on what they think are the root causes of women's subordination. She then goes on to point the fact that discrimination against women or violence against them exists only in 'bad' homes. She also points out to the gathering that the general belief is that most homes are happy and no inequality exists in 'good homes'.

She then goes on to ask 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?

This leads to the fact that in spite of being 'good homes', all 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, files, children and women belonged to men, one would need to question this power imbalance. The trainer then talks about the terms of '**male dominated society**' and '**patriarchy**' and asks the participants opinion on them.
The fact that our society is male dominated has become evident in the earlier sessions. For 'Patriarchy', the trainer may explain in simple terms to be '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 sphere of politics, religion or the economy are all taken by men. This power gets transferred from 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 the society and this is exactly what 'patriarchy' yields.

PATRIARCHY:

Subordination of women to men is prevalent in large parts of the world. Gender differences are manmade and they get legitimized in a patriarchal society.

Patriarchy literally means rule of the father in a male-dominated family. It is a social and ideological construct which considers men (who are the patriarchs) as superior to women.
It is women's oppression not just by male but of class, society and economical differences and men benefit from women's oppression due to the fundamental biological differences between the sexes.

This can be defined as male domination.

The nature of control and subjugation of women varies from one society to the other as it differs due to the differences in class, caste, religion, region, ethnicity and the socio-cultural practices.

Patriarchal societies propagate the ideology of motherhood which restrict women's mobility and burdens them with the responsibilities to nurture and rear children.

The biological factor to bear children is linked to the social position of women's responsibilities of motherhood: nurturing, educating and raising children by devoting themselves to family.

"Patriarchal ideas blur the distinction between sex and gender and assume that all socio-economic and political distinctions between men and women are rooted in biology or anatomy"

(Excerpts from: Ray S, Understanding Patriarchy. *Foundation Course: Human rights, gender and environment.* University of Delhi 2008)

Session-III

Objectives of the session:

- Objective 1: Learn how to respond in cases of domestic violence.
- Objective 2: Learn how to use the present public health settings for such interventions.
- Objective 3: Learn about the various levels of prevention and about similar experiments.
- Objective 4: To know about the available tools.

Overall learning outcomes of this session:

At the end of this session, participants should:

- Have knowledge of the various tools of intervention
- Understand the role of health care providers in responding to domestic violence.
- Have skills to play an appropriate role (raising awareness, screening, counseling, referring)
- Know how to make a safe environment in the clinic for women
- Know the tools of creating awareness, the best method of creating awareness and how to utilize them in their day-to-day activities.
- Be aware of how primary, secondary and tertiary care settings can respond to DV

Methods:

- Recap through an open discussion.
- Introduction to concepts using PowerPoint presentations with periodic discussions.
- Introduction to various tools through distribution of laminated pamphlets
- Awareness tools to be discussed through display of posters and introduction to visual aids

Steps:

1. The resource person starts off with a brief introduction.
2. Ask a volunteer from among the participants to provide recap of previous session.
3. Aid the volunteer and encourage others to add-in.
4. Sum up the whole procedure so that the participants have a clear understanding of where they stand.
5. Start the PowerPoint presentation and give breathers at every half an hour.
6. Encourage participation through impromptu discussions.
7. Distribute the laminated pamphlets which are supposed to aid them in their practice.
8. Explain how to use these visual-aids.
9. Divide into groups for role-play activity.
10. Each group is given a situation and 20 minutes to discuss among themselves.
11. They are asked to come back and make group wise presentations.
12. Introduce the concept of awareness through PowerPoint presentation.
13. Lead the candidates to the space where the posters are displayed.
14. Make the participants form a circle and ask their inputs on awareness building.

Materials:

- A room containing movable chairs with writing space
- A white board with a black and red marker
- A laptop connected with a projector,
- Power point presentations loaded in a USB stick
- A laser beam pointer
- Posters and a stand to hold the posters
- A set of laminated visual aids for each participant.

PROCEDURES

For Objective 1: A lecture with the aid of a PowerPoint presentation, which shall explain about how health care providers can play a role in preventing domestic violence. The lecture will describe the role of different health care providers – who will screen for domestic violence and the need for inquiry among women, who will educate women about the health impacts of domestic violence and the sources of help and support in the community.
The Doctors and nursing staff are to provide support to women experiencing domestic violence, in terms of providing counseling and informing them of the available facilities in the community.
Link Workers on the other hand shall be responsible for creating awareness in the society with the help of aids such as posters and flip charts which shall be provided.

For Objective 2: The facilitator shall divide the participants into three groups and distribute the situations for role-play. After 20 minutes of discussion amongst themselves, each group will enact their role play. Each presentation shall be followed by a short discussion among all participants.

Notes for the facilitators:

- Have a short discussion after each role enactment
- Have a bigger discussion at the end of all role plays.
- Allowing ample interaction and discussion of the topics
- Allow sharing of personal experiences only if the person is comfortable

For Objective 3: A lecture with the aid of a PowerPoint presentation.

Notes for the facilitators:

- Be prepared about the various levels of prevention with the aid of the resource material provided with this document.
- Be aware about the DILAASA model (which is at a secondary/ tertiary level)
- Have the participants speak about their understandings of the various levels of prevention at the end of the lecture.

For Objective 4: Posters are to be displayed in a corner of the lecture hall. Ask the participants to assemble there and have a look at all the posters. Start the lecture on awareness and its importance. Lead on to a discussion asking participants about their views on the topic. Also encourage participants to speak on how they intend to use the posters provided by the project.

Also for Doctors and ANMs, a PowerPoint presentation on the visual job aids.

Notes for the facilitators:

- Have a look at all the posters before-hand.
- Participants should be encouraged to share their ideas on spreading awareness.
- Discussion should also be on how to optimize the available tools on awareness.

The Roles

Situation 1:

Sheeba a house wife aged 35 years, married for the last 19 years having seven children. Her husband works as a rickshaw driver. There have been many problems in Sheeba's marriage. Her husband does not earn enough as a rickshaw driver to feed all of them. She works as a rag picker. They fight over how to use the little money they both earn. One day after a fight, Sheeba goes to the health center. She describes her injuries on the left shoulder, right hand and two small fingers, which are fractured as being the result of bricks falling on her.

Identify the types of violence.
What are the probable health consequences in this case?" for each of the roles?
What would you do when Sheeba approaches you?

Situation 2:

Zarine is a middle class, educated woman aged 32 yrs, married for the last 12 years and having one child. She came to the hospital reporting consumption of sleeping tablets. After her marriage, she never felt fully accepted by her husband's family. Other family members always criticized the food she cooks and also constantly criticize her appearance. Her husband is currently unemployed as his company is locked out. She is employed as a clerk in a private company.

Identify the types of violence.
What are the probable health consequences in this case?" for each of the roles?
What would you do when Zarine approaches you?

Situation 3:

Janet, a 34-year-old mother of twins, bursts out crying when she meets you and is seeking advice for insomnia. After you ask a few questions to take her history, she tells you that her husband speaks very harshly to her all the time, and will not allow her access to any money. She can't look after the children, the house or herself properly. He threatens to hit her if she does not do exactly as he says. She's scared, anxious, not sleeping, and doesn't know what to do.

Identify the types of violence.
What are the probable health consequences in this case?" for each of the roles?
What would you do if Janet approaches you?

Resource for the facilitators

About Role Plays (1):

[i]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.

The Public health system as a site for intervention of domestic violence (2)

Violence often occurs when there is an imbalance of power between individuals or groups of people where domestic violence, torture, and caste and communal violence are a few of the predominant manifestations of these hierarchies and inequalities. Within the public health framework, violence is conceptualized as a problem that can be prevented and its consequences alleviated through social and health based interventions. Public health strategies can function at various levels in responding to violence – at the individual, community, and societal levels.

Domestic violence has severe consequences for the physical, emotional, and social wellbeing of women experiencing violence. It should be emphasized that the relationship between domestic violence and health is not unidirectional; violence produces negative health effects while certain health conditions can increase a woman's vulnerability to victimization.

Why should the public health care system respond?

- First, the health care system is often the first contact for women experiencing domestic violence, who approach health care providers for treatment of the resulting physical and psychological trauma.
- Second, the public health system occupies an important role in the struggles of women experiencing domestic violence to achieve justice. It serves as the only institution that can produce medical and forensic evidence formally recognized by the criminal justice system.

Within the public health system, doctors, nurses and community outreach workers, program planners, and policy makers play specific roles in both responding to women experiencing domestic violence and contribute to violence prevention efforts at all three levels.

The following are specific tasks that can be accomplished in primary health centers:

1. Sensitize, educate, train, supervise, support and monitor health personnel to improve their knowledge, attitudes and practices around domestic violence.
2. Develop, introduce and monitor domestic violence management protocols and guidelines.
3. Screening to timely identification and response as an integrated part of reproductive and sexual health services, as well as in other parts of the health sector, especially when there are signs and symptoms such as physical injuries, certain health conditions and client behavior.
4. Emotional support & counseling including listening with respect to women and acknowledging their autonomy, the abuse and injustice.
5. Personal examination and enquiry in privacy and ensuring confidentiality.
6. Providing necessary treatment and response to women experiencing various forms of violence including domestic violence, post exposure treatment and counseling on HIV/AIDS/STIs and pregnancy including emergency contraception.
7. Referral to legal, social and community services in recognition of the need for safety, legal justice and social services.
8. Sensitive inquiry among women about domestic violence in health settings. Sensitive inquiry means ensuring confidentiality and privacy, respecting autonomy of a woman and her right to disclose to whom and when she feels appropriate etc.

Domestic violence is common and affects physical, mental, reproductive, and sexual health. Sensitive inquiry in healthcare settings can reduce the effects of abused on women's and children's health. Research has found that sensitive inquiry regarding domestic conflict and violence is acceptable to women. Inquiry must be accompanied by information on women's rights, support services and safety planning. Health professionals need training and protocols to establish sensitive inquiry safely.

<u>Advantages of sensitive inquiry</u>

- Uncovers hidden cases of domestic violence
- Changes perceived acceptability of violence in relationships
- Makes it easier for women to access support services earlier
- Changes health professionals' knowledge and attitudes towards domestic violence and helps to reduce social stigma
- Helps maintain the safety of women experiencing domestic violence

(*) SCREENING QUESTIONS:

Given below are certain imaginary situations which are commonly encountered in our health care practices. These may be used as an aid to identify cases of DV. Users of this chart need not exclusively use the queries mentioned here but may also have their own set of questions as and how the situation demands.

The initial set of indirect questioning must be used only in patients where there is a 'trigger of suspicion'. The second set of direct questioning must be used only if the suspicion is proved true by indirect questioning. We should always remember that routine screening is not recommended for all women.

SEE THE VISUAL AID CHARTS PROVIDED ALONG WITH

LEVELS OF PREVENTIONS:

The public health system can minimize the prevalence and impact of DOMESTIC VIOLENCE through improved:

1. Primary prevention: promote community awareness and prevent DOMESTIC VIOLENCE

a. Gender sensitive IEC – including boys and men.

b. Target children and young people.

c. Address the societal and cultural norms underlying domestic violence to create increased public awareness of gender inequities, GBV and the human rights of women and children.

d. Inform and educate; civil servants, teachers, police, lawyers, social workers, public media and others on GBV.

e. Mass Media education entertainment programs.

2. Secondary prevention: Secondary prevention strategies involve efforts to minimize harm already done and to prevent further injury from occurring. Such strategies to combat violence against

women include policy changes criminalizing all forms of violence against women and prosecuting the perpetrators of that violence. Some secondary prevention approaches are: early identification, confidentiality, monitoring and respectful treatment of survivors addressing physical, mental and reproductive health care needs. An important secondary public health prevention strategy is to develop a trustworthy, accessible, and co-ordinate reporting system that protects the safety, confidentiality and anonymity of women reporting violence, their supporters and advocates, and those witness to the acts of violence. Such a reporting system should involve not only the public health system but should also include the police and other constituents of the criminal justice system, and should incorporate elements and approaches that are gender-sensitive and rights-based.

3. Tertiary prevention; e.g. more long-term counseling, mental health care & rehabilitation and referral to social, economic and legal support. There is also a need to integrate selective or comprehensive services for women experiencing of GBV into primary, secondary and tertiary care, as part of overall or selective health care services, especially sexual and reproductive health, including adolescent health, ANC, Postnatal care, Family planning & HIV/AIDS/STI; Child health care, emergency medicine; mental & psycho-social health; ear, nose & throat care; dental care; Include males in sexual and reproductive health and childcare, not only as providers, but as true partners.

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1. Process documentation. DIlaasa: Training of Trainers. Published by CEHAT, Mumbai.
2. Deosthali P and Maghnani P. Domestic violence and the Role of the Public Health System, Sec 3: Review of healthcare in India (Eds. Gangolli L V, Duggal R, Shukla A) Published by CEHAT, Jan 2005.
3. IPPF Western Hemisphere's website www.ippfwhr.org.
4. Feldhaus et al. Accuracy of three brief screening questions for detecting partner violence in the emergency department. Journal of the American Medical Association 277(17): 1357-1361, 1997.

SESSION-IV

Objectives:

Objective 1: Recapitulation of the previous sessions.
Objective 2: Learn the concept of a Referral Network and its functioning.
Objective 3: Clearly understand the process of documentation.
Objective 4: Recognition of participation.

Overall learning objectives of this session:

At the end of this session, participants should:

- Know the roles and objectives of a referral network
- Know the partner organizations and the services they provide
- Know how to make and document a proper referral
- Know about the DIR and how to maintain internal documents at their health centre.

Methods:

A brief introduction and recap of previous sessions.
A PowerPoint presentation to explain about referral networks and documentation.
Enactment of a plot involving referral from the health center.

Steps:

1. The facilitator shall make a brief introduction.
2. This shall be followed by a concise recap of all the previous sessions.
3. PowerPoint presentation by the resource person about the referral network and proper documentation.
4. Enactment of a situation at a health center, where referral is needed.
5. An interactive session and discussion on the topics which were presented.
6. Feedback to be taken from the participants for all sessions.
7. Talk by the chief-guest and distribution of certificates.

Materials:

- A room containing movable chairs with writing space
- A white board with a black and red marker
- A laptop connected with a projector
- Power point presentations loaded in a USB stick
- A laser beam pointer
- Chart Papers and a stand to hold them

PROCEDURES

For Objective 1: A lecture using a PowerPoint presentation, posters and charts. Participants are given ample opportunities to recollect their learning. This shall end with a summing up by the resource person.

Notes for the facilitator:

- This should ideally cover all important topics from the previous sessions.
- If people fail to recollect certain areas, any of the previous presentations may be revisited to clear the doubts.

- Ideal to have participants volunteer for summarizing their learning till now.
- Spend more time in recollecting the case-studies and role plays as it shall lead to instant recollection.

For Objective 2: A resource person from the project team shall make this short PowerPoint presentation on how the referral system shall work. It shall also introduce the participants to the referral network organizations and the services they provide. Distribute a copy of the inventory and the map to all participants.

Notes for the facilitator:

- Encourage participants to go through the inventory and map.
- Ask them to identify organizations and services available close to their health center.
- Ask them to visualize their individual plans on dealing with cases.
- Reiterate the points on documenting referrals.

Role-Enactment (*):

This part shall only be for the doctors and nursing staff. It shall recollect the role-enactment of the scene at the health-center, which the participants had witnessed in the first session. This time though, the actors shall be from among the participants and they shall enact the situation in a way that they feel is apt and ideal.

Notes to the facilitator: Ask for volunteers from among the participants.
Give them some time to discuss on how they would like to enact.
If there are no volunteers, staff should be ready with an alternate script.

For Objective 3: This lecture shall also be aided by a PowerPoint presentation and shall briefly inform the participants about the documentation that they are required to maintain at the health centre level e.g. Filling of the necessary forms, distributing the Soukhya cards, maintaining confidential registers, etc. Special emphasis shall be paid to the filling of DIR (a copy of which shall be distributed to all participants). This shall be followed by role-enactment of a situation in a health centre. The resource team shall carry out this enactment and this shall be followed by a short discussion among the participants.

Role for Enactment:

Jahnvi has walked into the clinic and starts crying softly and talks in a whisper. Her husband Pramod is a local goonda and apparently sleeps with a pistol under his pillow. The previous night, he came home and announced that he had lost his job at the motorcycle factory and began drinking heavily. He smacked Jahnvi and then tied her up for about 2 hours. He forced her to have sex with him and would threaten to kill her if she didn't. When he was finished, he tied her up again. He fell asleep and she managed to wriggle out of the restraints and come to the clinic in the morning before he woke up. She is very worried about her teenage daughter who is in their bedroom on the back side of the house.

Notes for facilitator:

- The talk on documentation should be short and crisp, dwelling into only absolute necessities.
- Devote more time to the discussion following the enactment.
- Encourage new ideas from the participants.

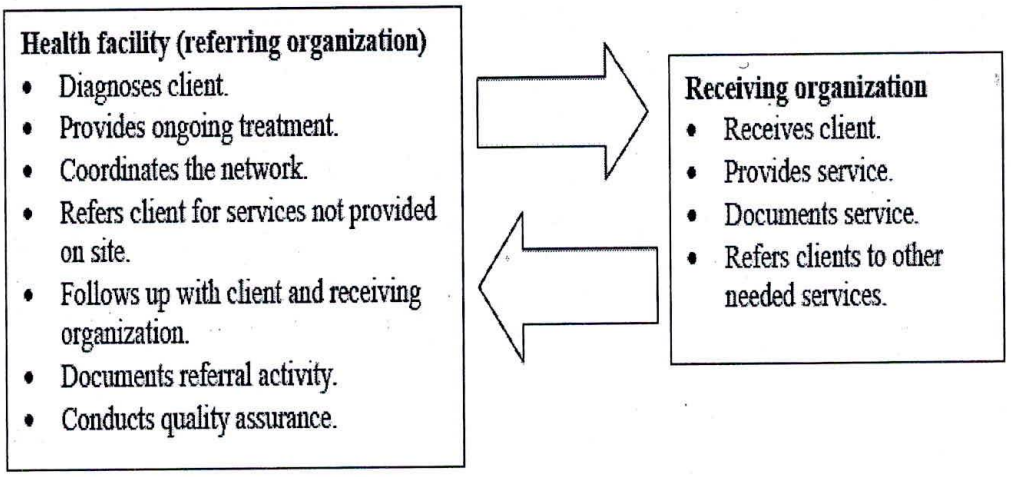
For Objective 4: A representative from the resource team shall thank all the participants and introduce them to the chief guest. The chief guest shall then give a short speech. The facilitator shall then sum up the entire training module for that particular group. This shall be followed by distribution of certificates to all the participants.

Notes for the Facilitator:

- Try to summarize the take home points from training for each group.

Referral Network & Documentation

- The main aim of the Referral Network is to help us direct women experiencing domestic violence and their families to the appropriate organizations
- The referrals can be made from health centers to organizations, vice-versa and also between the organizations



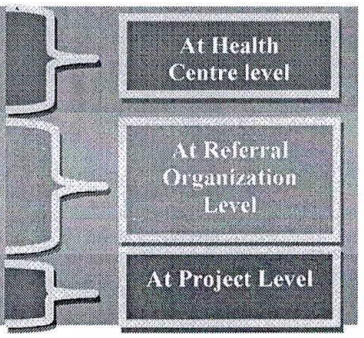
The documentation process for referrals:

- The referral is either made by a doctor or an ANM at the PHC.
- A referral register is maintained at the PHC as well at the referral organization which has to follow a standard format and must be updated regularly.
- There will be Referral Network Guide provided to all the PHC's in Bengaluru. This will contain an inventory of all the referral network members. Similarly an inventory of the location of all the Primary health care centers shall be circulated in all the referral network organizations.

Making a Successful referral

Nine Steps towards successful referrals

1. Find the appropriate service provider for the client.
2. Fill out the Standard referral form and update the referral register.
3. Discuss with the client and respect her decision.
4. Review details given by client and provide the services ensured.
5. If necessary, fill out a second form for re-referral or for cross-referral.
6. Update the referral register.
7. Suggest other organizations and services to client if required.
8. Monitor and evaluate the system on a periodic basis.
9. Try to obtain a feedback from clients.



These steps shall ensure:

- The most suitable service in terms of distance, cost, culture, language, gender, sexual orientation and age to the clients.
- Tracking of the clients and proper documentation.
- Improvement in the quality of services provided by the organization.