

Violence as a Public Health Issue

29th-31st of August, Raipur, Chhattisgarh

Organised by Sama- Resource Group for Women and Health in collaboration with PHRN and Chaupal

Background of the workshop: Sama has been engaging over the past two years with health providers in public health facilities and the private health sector in Delhi, towards improving the healthcare systems response to domestic violence.

While these initiatives with the health system are ongoing, workshops with community based organizations and networks were also envisaged to facilitate exchange of learning from the diverse experiences of and strategies being used by community based organisations.

The third workshop in this series was held in Raipur, Chhattisgarh in collaboration with Public Health Resource Network (PHRN) and Chaupal. It aimed to strengthen the capacities of communities and community based organizations, health workers and others to situate domestic violence in a framework of gender, public health and rights, towards improving our understanding of community and health care response to domestic violence.

The objectives of the workshop were:

1. To understand the impact of domestic violence on women's health
2. To discuss our role in taking forward the work on understanding domestic violence as a public health issue
3. To discuss the challenges facing implementation of the Domestic Violence Act both structurally and at the local level

Participants: The workshop was conducted with community based organizations and networks that Sama has been engaging with through capacity building initiatives on diverse health issues in the past.

41 people from 26 organisations took part in the workshop. Participants were from more than 12 districts of Chhattisgarh. Of these 11 were men and 30 were women.

Facilitators: Deepa Venkatachalam and Preeti Nayak, Susheela Singh, Sama

Workshop Structure

<i>Day 1</i>	
<i>Session 1</i>	<i>Introduction</i>
<i>Session 2</i>	<i>Participant's expectations</i>
<i>Session 3</i>	<i>The institutions of violence</i>
<i>Session 4</i>	<i>Identifying and understanding domestic violence</i>
<i>Session 5</i>	<i>Myth & Fact</i>
<i>Session 6</i>	<i>Cycle of violence</i>
<i>Day 2</i>	
<i>Session 1</i>	<i>Forms of violence</i>

<i>Session 2</i>	<i>Body Mapping- Impact of violence on women's health</i>
<i>Session 3</i>	<i>Working with health systems on domestic violence</i>
<i>Session 4</i>	<i>Working with health systems on domestic violence-role play</i>
<i>Session 5</i>	<i>The PWDVA Act</i>
Day 3	
<i>Session 1</i>	<i>The sexual assault kit</i>
<i>Session 2</i>	<i>The way forward</i>
<i>Session 3</i>	<i>Feedback and closing</i>

Day one-29th August 2011

Session 1: Introduction

The workshop started with an introduction and welcome by Sulakshana, from PHRN and Chaupal. She spoke of how the workshop hoped to initiate discussion on women and violence, as well as act as a means of becoming familiar with each other's work, and create avenues of working together in the future. She also introduced Sama and Madhuri from Chaupal who was involved in organising the workshop.

Deepa, from Sama then went on to explain the objectives of the workshop by talking of the need to establish linkages between domestic violence and health. The objectives were explained as follows:

1. To understand the impact of domestic violence on women's health
2. To discuss the linkages in taking forward the work on domestic violence as a public health issue.
3. To discuss the challenges facing implementation of the Domestic Violence Act both structurally and at the local level.

She further spoke about how all the participants have years of experience which she hoped they would share. She also stressed on the importance of confidentiality with regards to participant's sharing at the workshops. She went on to discuss how Sama has been engaging with domestic violence as a public health issue through community based workshops, as well as through working with Public hospitals in Delhi. The need to come up with strategies for further work was also reiterated as one of the key aims of this workshop.

Session 2: Participant's expectations

The participants were asked to introduce themselves and their work, as well as share their expectations from the workshop. The participants were from varied community based organisations that worked on women's rights, environmental issues, adivasi and dalit community based organisations, the Right to Food campaign, disability, child rights, urban slums and health, panchayati raj amongst others. Expectations largely mirrored the



objectives of the workshop and were as follows:

- To establish linkages between health and domestic violence
- To create networks with other organisations in Chhattisgarh that work on issues of violence and health
- How to use the PWDVA Act in support of people with disability and also children.
- To learn how to bring about change in treatment of women in healthcare institutions, such as hospitals
- To gain information on domestic violence

Session 3: The institutions of violence

For the first exercise, participants were divided into three groups. Each group was given a case study (see Annexure 1). The groups discussed the institutions and forms of violence that came up in the case study, and shared their discussion with the larger group.

Group 1: Asha's Story

The group discussed that institutions such as the family, the government, as well as non-government organisations can be seen as the perpetrators of violence. NGO's were pointed out for not being able to reach the woman (Asha) in time. The different forms of violence such as domestic violence, and violence by the state were also identified. The question of who is responsible for the violation and violence also arose, and the above institutions including the husband and the family were identified. Issues of poverty, illiteracy and child marriage were seen as determinants that further exacerbate and contribute to the violence in women's lives.

Group 2: Rita's Story

Institutions identified as perpetuating violence were seen to be the systems of governance and the government, the society, the men who committed the rape. The different forms of violence were identified as being physical, economic, and mental violence. It was discussed that if due to society's perceptions of a rape survivor, Rita is not allowed to continue with her job or is further stigmatised, this would result in economic and mental violence, above and beyond the sexual violence she has experienced. It was also discussed that the police did not carry out their duties of patrolling, which could have prevented such incidences. Furthermore, their attitude that women should not work at night also stigmatises and inflicts mental trauma on the woman.

One participant expressed the opinion that the hotel is also responsible as it makes women work at night. This statement generated a lot of heated debate, where many participants felt that such a statement is protectionist in nature, and that women *should* work at night. And that it is the government and the employer's duty that they assure women's safety by making safe travel arrangements for all women workers. This led to the question of what safety constitutes, and how can we ensure the same? The notion of shame and scandal/ discredit associated with being a rape survivor was also questioned.

Group 3: Sheila's Story

Sheila's story once again saw various forms of violence. The groups identified emotional, physical, and mental and caste based violence as being present in the story. The law and the apparatus of law (such as the police), were seen as being irresponsible (for locking up the boy, even though he was under age and the girl was not). The family also put immense pressure on the girl, which was seen as a form of violence. Violence was also stemming from the family's need to

have the girl marry a boy of their choosing. The family was seen to be influenced by notions of honour prevalent in their community, hence bringing in the larger societal discrimination and worldviews. The group also questioned how the police registered a case on the basis of caste difference between the boy and girl.

At this point the group broke for lunch. The discussion resumed afterwards and were summarised by the participants and facilitators.

Discussion:

The discussion after lunch carried forward the discussion from the previous session. The discussion centred on existing social systems, violence and gender. The conversation on caste also was taken forward in this session and situated within a patriarchal and hetero-normative framework. The participants discussed how a caste based society also stems from, and further encourages discriminatory social arrangements and hierarchies. These issues were seen as being the common elements in all three case studies. Other common elements were identified such as inequality, gender based discrimination, and restrictions on girls and women; such as in the manner of speaking, the right to choose and decision making. For example, in Asha's story- whose decision was it to have a child? It was also seen that in a male dominated society it is not as if all men have power, but rather that control and power is situated in the hands of a few men. This concentration of power is often related to caste, class and other such determinants.

The conversation then moved on to look at who are the women whose rights are often ignored, or not spoken of. The participants came up with many such women whose rights are not given priority, such as single women, elderly women, 'widowed' women, bisexual and lesbian women, and trans-identifying people. These groups of women even within a gendered framework remain on the margins.

The facilitator then went on to point out that even within workshops such as this, when we talk about family and society, we only think in terms of male and female and the relationships between the two. Furthermore, the impact of a patriarchal society is felt both by men and women, in different ways and in different degrees. But the impact on women is usually harsher. The question also arose of the fear men have in women being able to exercise their rights. Participant's observed that this could be because they feel that if they individually 'allow their women', to do so, what will their community and the larger society say. Moreover, this could also be attributed to the societal pressures of how men should act and behave as well as the need of the man to uphold his position and respect in society. The fear that the family will lose respect if something happens to the woman further leads to restrictions on women's mobility and behaviour. This was seen to be closely tied to the concept of 'honour' (of the man and the family) which rests in women. Furthermore, economics also leads to violence being inflicted upon women. The decision making power which rests with men also leads to the fear of what will happen if they 'lose' the same. But at the same time, it was also seen that a patriarchal society also puts immense pressures on men themselves. This can particularly be seen in case of men who are socially disadvantaged, i.e. a dalit man. But participants also brought out that however disadvantaged a man might be, he still dominates over women of the family and community. The realisation that even we (as activists) remain entangled in social customs and norms was also brought out.

Women's sexuality was seen as contentious. It was said that women's sexuality is seen as residing with society. An example given to illustrate this was how during war, women are subject

to sexual violence. A question asked in the context of sexual violence was of 'whose shame does the violation of women's rights result in'?

Session 4: Identifying and understanding domestic violence

This session started with a screening of the film Nasreen 'O' Nasreen. Facilitators gave a background on the film and mentioned that it is an old film. Sections where women share their experiences in English were translated alongside the film.

The film was followed by a discussion on what new issues came up, and what the participants felt about domestic violence as depicted by the documentary. Participants discussed that the film showed how the survivor of domestic violence is on one side; the rest of society is on the other. The participants also talked about how the film depicted that domestic violence is not restricted to rural areas, but is prevalent even amongst urban and rich people. Furthermore, women of all ages undergo violence in their homes. The question of difference between violence against women and domestic violence was asked. Questions were also raised about why it is so difficult to come out of a violent relationship. Furthermore, participants discussed that if it is the family that is committing violence, whom do you go to for help? A familial relationship is seen as essential by all of us. Some of the challenges facing women were also discussed, such as not having a house/monetary support of their own, and that both the familial and married homes (*maika/ sasural*) cannot be seen as their own which makes it difficult for them to leave their homes and abusive partners (see annexure 2).

To clarify participants' questions about domestic violence, and tackle certain myths that are prevalent, the ensuing session was in form of a myths & facts activity.

Session 5: Myth & Fact

Statement 1: Domestic violence is a personal issue

Participants disagreed and came to the conclusion that domestic violence is not a personal issue, and that violence inside the house also affects the society. After watching Nasreen O Nasreen, and the ensuing discussion, none of the participants agreed with the same.

Statement 2: Alcohol is a reason for domestic violence

There was disagreement between the participants on this statement. Those who agreed gave examples of how even simple and non-violent men become violent when under the influence of alcohol. It was said that alcohol does not only harm the drinker but also the rest of society. Participants who agreed stated that it is inequality that is the cause for violence not alcohol. And that while it might be seen as an excuse to commit violence, it is not the cause or reason for the same. This was seen as particularly important, in light of strategies to combat domestic violence.

Statement 4: Only poor women face domestic violence

Participants disagreed with this statement. Particularly in light of the movie (Nasreen O Nasreen) screened before and the discussions that had followed it.

Statement 3: Only married women undergo domestic violence

All participants disagreed with this statement. It was discussed that family member such as brothers, mother, father can also be perpetrators of domestic violence, particularly also single women, who have not gotten married, or are divorced or widowed.

Statement 4: Women are women's worst enemies

Many participants believed this statement to be true. Participants said that within a house there is a lot of conflict between a married woman and her mother in law. Further, women often gossip about other women, and this can be very malicious. Similarly a woman official is often very harsh on the women working under her. And a mother is often instrumental in exercising control over a girl child. Participants also shared that often if the husband, son or brother commits a crime; it is the woman who protects them.

Participants who disagreed with the statement spoke about the troubles that women go through when they give birth to a girl child. They explained that women get socialised into a patriarchal society and way of thinking while growing up. It is not the women who are hence responsible but rather a patriarchal society. The example of the furore created because Sania Mirza chose to wear a skirt while playing tennis was also shared.

In light of all these discussions it was said that patriarchy is conditioned upon power. Those who have power, have chances for a better life. We learn how to use this power as we grow up, just as we learn about troubles between the wife and the mother in law in childhood. Such issues are not a fight between men and women, and amongst women but rather about the societal paradigm that we live in.

Discussion also took place about the place and role of children. Women are also seen as responsible for the well being of children, and often in situations of domestic violence, women do not leave as they are scared for their children, or don't have the means to support them. It becomes difficult for a woman to balance her own needs with and that of her child

Session 6: Cycle of violence

This session was followed by a poem called 'He gave me flowers' which illustrated the cycle of violence, which was also shared through a diagrammatic representation (See Annexure 3a & b). The participants identified with the diagram and the group talked about how the 'honeymoon phase' gets smaller with time usually, and it becomes more and more difficult to break out as the violence escalates and time between violence decreases.

Participants shared how it becomes very difficult for a woman to leave her married house, as she firstly does not have a natal home that she can go to, as parents do not agree to take her back, it can also lead to discrimination against the children, and trouble in getting her siblings married.

A question was raised about the role of cultural and religious values when it comes to perpetrating violence. Some participants felt that emphasis on values can be a way of combating domestic violence. But this was seen as problematic as values in themselves are configured and are based on societal attitudes and trends, which are often discriminatory against women. It was felt that it is necessary to understand cultural values and move forward with a clear and critical mind. This led to the question of what strategies we can adopt as we work on domestic health. The facilitators informed the participants that day three was devoted to this very purpose. Participant's believed that it's important for women to know that work and discussion is taking place on these issues, as it would give them courage to break out of the cycle of violence.

Participants shared their difficulties in working on domestic violence, as it is seen as a personal/family matter or is not accepted or recognised at all. The role of women's economic freedom was also highlighted as being very important in terms of affording her choice. The mental health ramifications of violence were also discussed as being extremely harmful. The damage to one's sense of self and self esteem was also mentioned.

The first day of training ended with the participants expressing the necessity to work on these issues and the need to take concrete steps and create strategies to work with domestic violence in their communities.

Day Two: 30th August 2011

Day two started with feedback on the previous day. This led to the first session of the day aimed at clarifying the different forms and types of domestic violence.

Session 1: Forms of violence

The participants were asked what they understand as violence, responses were as follows; to harm anyone in any way, to trouble someone. Any sort of discrimination or prejudice. This could be physical, emotional, economic or sexual in nature. The difference between discrimination or prejudice and violence was also discussed, where the line between the two was seen to be very thin.

Participants then listed out what constitutes each of the above mentioned forms of violence, which was as follows;

- Economic Violence
 - For dowry
 - Stealing or taking away any material wealth
 - Not giving the partner any money for everyday and personal expenses
 - Not letting the woman work
 - Not letting the woman take any decisions regarding her property and/ earnings.
- Physical Violence
 - Beating
 - Denying treatment for illness
 - Burning
 - Not giving enough water, food etc.
 - Throwing acid
- Emotional Violence
 - Cursing
 - Showing pornographic images/ videos without consent
 - Using bad language and yelling
 - Putting pressure
 - Defaming her character
 - Harassment over not having children
- Sexual Violence

- Rape
- Molestation
- Marital rape (recognised by PWDVA Act)

Participants were also directed to resources which formed part of the workshop kit, which had a detailed list of the above.

Session 2: Body Mapping- Impact of violence on women's health

The next session explored domestic violence and its impact on women's health in an in depth manner. This was done through body mapping, where the group was divided into 4 smaller groups. The men were in a separate group for this exercise. Each group was asked to draw a life size body and discuss and mark how violence impacts women's bodies and different limbs/ parts of the body. The exercise looked at both short term and long term effects on the women's health.

The group then came together to discuss and present the discussions they had. These were as following;

Group 1

The long term impact of violence was seen to be;

- Impact on mental health because of demands of dowry can be manifested through; anxiousness, withdrawal, depression, sadness and other more serious illness etc.
- Violence results in the entire body hurting and feeling pain
- Cancer, Blindness, disability, deafness
- Kidney or Liver damage
- Cancer because of repeated abortions
- Preventing the women's mobility

Participants marked out the following body parts and the type of violence and its impact on the health of the woman;

- Hair is pulled during beating
- Hitting the ear while slapping or beating results in partial or full deafness
- Squeezing the throat can result in trouble in breathing and talking.
- The cheek can be hit in anger or can be clawed at
- The mouth can be used to stop speaking, the mouth can be used to forcible feed the woman alcohol, or poison her, oral sex can be forced upon her, wood and water can be denied to her.
- Heart break
- The breasts are clawed, bitten and pushed
- The skeletal structure can be damaged by pushing the woman against the wall or on the floor
- The hand can be broken



- The finger can be bitten or and broken
- Hitting the knees
- Hitting with a rod or *belan*
- The kidney can suffer damage through poisoning
- The stomach is hit resulting in damage to the uterus, losing the child if the woman is pregnant
- Any limb of the body can be hit
- Snatching jewellery
- Pulling nails from the fingers
- Burns are inflicted on the vulva and vagina through a bidi or cigarettes

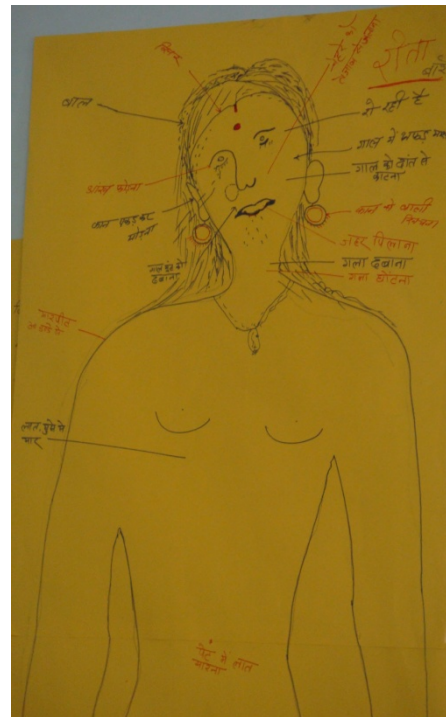
Group 2

The long term impact of violence was seen to be;

- Mental illness which can be mild to extreme
- Breast ache stays for a long time
- Marks on the face
- Damage to the wind pipe
- Constant worry can be seen on the face
- Cutting the breasts
- Vulva and vagina can be damaged through beating, as well as abortions
- Domestic violence also results in death.

Participants marked out the following body parts and the type of violence and its impact on the health of the woman;

- Pulling the hair
- The wind pipe and the oesophagus in the throat can be hurt or damaged
- Breasts can be hit, clawed
- The hands, stomach, feet can be punched and kicked resulting in injury (threats are often made to curtail women's mobility and violence inflicted to prevent the same.)
- The woman is held by the hair causing damage, which includes swelling of the skull.
- The vagina is cut by a blade; the woman can be raped using a rod/ stick.



Group 3

The long term impact of violence was seen to be;

- Mental health problems
- Ache in the breasts
- Difficulty in eating
- Deafness
- If the girl is young, the vagina can tear
- Disability

- Cancer
- Knee pain
- Body ache

Participants marked out the following body parts and the type of violence and its impact on the health of the woman;

- Swelling and pain in the eyes
- Squeezing the throat
- Broken teeth
- Ear drum bursting
- Bleeding
- Hitting or slapping the cheek and swelling
- Denial of food
- Fracture
- Difficulty in eating
- Hitting a pregnant woman in the stomach can result in induced labour, losing the child as well as difficulty in pregnancy and possible damage to the child such as malnutrition
- Marital rape
- Bleeding and damage to the vagina
- Problems and pain in breastfeeding
- Burning the woman by using cigarettes or boiling water
- Marital rape
- Damage to the uterus and womb

Group 4 (Men's Group)

The long term impact of violence was seen to be;

- Head injury
- Burning the face, throwing acid
- Causing the ear drum to burst
- Damage to the skeletal structure
- Bursting the eye
- Beating makes the body weak

Participants marked out the following body parts and the type of violence and its impact on the health of the woman;

- Pulling the hair
- Twisting the ear
- Biting and slapping the cheek
- Squeezing the throat
- Pulling earrings
- Throwing acid
- Hitting with a rod
- Hitting with a shoe
- Beating or hitting the breasts
- Damaging the knees (which can also result in permanent damage)

Participants also mentioned that the back was not mentioned, which is damaged through violence and can have very adverse effects of a permanent nature on women's health.

After the presentations, the facilitator explained that the aim of this session was also to attempt to speak freely with each other about the body and sexual organs. The importance of talking about sexuality and the body while working on domestic violence was also stressed.

Some participants shared their feeling to say that while it was difficult to draw sexual organs and the vagina particularly in front of the men, it is essential, or how would they share and speak with the doctors? They also shared that it is very difficult to find appropriate words to talk about sexual and reproductive organs. The other point that arose was that all four representations of women were able bodied. But does that mean that violence is not inflicted upon differently abled women?

It was also discussed that all the representations of women were wearing jewellery, and 2-3 had *sindur* in their hair. Why was this so? Furthermore does it mean that women who face violence are all married?

The women in the group also voiced their appreciation about the men's attempt to project the violence that women face. The group also felt that this particular exercise brought out the terrifying consequences of violence on women's health very clearly. They shared that even they had not thought of domestic violence and its effects in this manner, and that such awareness is completely missing in Primary Health Centres (PHCs).

Some participants shared their experiences of working in their communities. Some other related issues that came up were problems in dealing with menstruation, how women do not get any rest and restrictions on food and diet after and during pregnancy, which results in nutritional deficiencies in women.

The facilitator also briefly took the participants through a diagram which outlined the effects on violence on women's health (Annexure 4).

Session3: Working with health systems on domestic violence

After analysing the impact of domestic violence on women's health, the workshop moved on to looking at the interconnections between domestic violence and the health systems. This was initiated through screening another film called *Dilaasa*, which is a fictionalised account of a Domestic Violence Centre being run within a hospital in Bombay by CEHAT. The film follows the journey of a young married woman who is admitted to the hospital after consuming poison because of domestic violence. The film screening was followed by a discussion which has been described below:

The facilitator initiated the discussion by asking participants what they saw in the movie, and what had struck them. Participants noted that Meera (the protagonist) was admitted into the hospital after poisoning herself, and that even when she was unconscious, she was scared of her husband, and reacted with shock to any touch or movement. The role of both nurses was discussed, including how one nurse prevented a case from being filed at the urging of Meera's husband. Participants said that they feel that while working with health care providers such as in *Dilaasa* is very difficult, it is possible. There are always a few people who they could work with.

Further, participants noticed how Meera felt herself to be responsible for the violence inflicted on her. The usage of words such as *kismet* and *aatm-vishwas* were seen as significant in context of X's sense of self and understanding of her situation. It was discussed that the cycle of violence was also reflected in the movie. And the impact of violence on Meera's child also came up, as the

violence occurred in the child's presence. X's interaction with Dilaasa and the counsellor gave her the self esteem and support (both economic in terms of alternate housing and emotional support) required in breaking out of her relationship.

Participants noted that while in places such as Delhi and Bombay it is possible to work with healthcare providers, how would such work translate into their own community setting, where such facilities and infrastructure is not available? The facilitators then initiated a discussion to map who possible sources of help for women would be, in situations where violence is inflicted on them, and they need medical assistance.



The participants reported that while for minor injuries the women might not go to anyone, in situations where help is needed, they would go to a friend, or then go to their natal homes for some time. The next step could then be a NGO, and then the Sarpanch. For medical assistance usually a local quack is the most popular option, and government health centres are not favoured by people as it is expensive, and the treatment is not done properly. Participants reported that while the smart card facility (where 30,000 rupees worth of treatment can be done through the smart card) has been implemented in Chhattisgarh, it does not work. The smart card can be used at all public health facilities and identified private facilities. Both IPD and OPD treatment can be accessed through the same. Participants reported that when poor people go to health centres with the smart card, the card is kept to register treatment while the patient is returned home without any treatment or check-up. It was said that this scheme is operating in name only.

A participant then questioned what facilities are available for disabled people. She spoke about how disabled people face many difficulties and are also troubled by the community. She further talked about how there is no unity between women and people who are differently abled. She spoke about how she believes that disability has been created by society, and reinforced through how they are seen as a burden to parents, and given no opportunities to be independent, or learn how to be so. It was discussed that to provide for people who are differently abled is also the states responsibility, so that the disability is lessened. But what is also needed is a fundamental change in how we think about disability, and people who are seen as disabled.

This then led to a discussion on access to healthcare and the injustice which is present in healthcare facilities. Participants reported that there is violence towards women in healthcare centres, such as when delivery happens. Women are cursed, are beaten or hit during labour. Because of such behaviour many women do not want to go to healthcare facilities. A participant spoke about his own experience of women in his community refusing to go to the govt. Hospital because of the nurse's behaviour.

Participants from the Shaheed Hospital spoke about how there is a high demand for BP check up's, and how breathing problems, loss of appetite and swelling of hands and feet are some common complaints.

The group then broke for lunch.

Session 4: Working with health systems on domestic violence-role play

The next section of this session was in the form of role plays. The participants were divided into three groups and given different situations of women coming to Govt. Healthcare providers for treatment (see Annexure 4). The role plays were created and acted out by participants with great enthusiasm. All groups added different elements and interpretations to the story and its resolutions.

Broadly the following issues came up from the role play and were discussed further;

Counselling- This came up as an area of concern in all three groups. It was felt that while counselling is very important, it is not a simple process, and can't be compared to giving and taking advice. It was felt that people who are involved in counselling need to have some level of training and need to be sensitive to women's needs and wishes. Moreover, the decision to leave or stay in an abusive relationship needs to be the women's, the counsellor is only meant to help the woman in understanding what she wants and in finding alternative options.

Compromise; the question of compromise also came up; it was felt that to hold a joint meeting towards finding a compromise, with all actors present such as the doctors, the woman who is undergoing domestic violence, the partners, partners family etc (as was depicted in the role plays) is not supportive of the woman's right to decide. Such a step taken suddenly could also lead to a worsening of situation at home for the woman. Furthermore, the understanding and meaning of compromise in a situation of domestic violence was questioned. Moreover, it was discussed that often in life while dealing with such situations, there are no easy solutions.

Emergency Care; it was also clarified that treatment in case of a poisoning can be provided without registering a police case, and that no govt. Hospital can deny emergency treatment. A medical-legal case can also be made in the hospital.

The facilitator then informed the audience that all three situations were of the same women, at different stages in her life, who is undergoing domestic violence, until finally she attempts to take her life. The group greeted this with silence, and participants expressed surprise, as well as the realisation that healthcare providers could play a defining role in preventing such situations. It was felt that doctors and nurses need to be made aware of such issues, and that different stakeholders and people can come together to work on such issues. The role of the Mitanin (female community health worker) was also stressed upon in such situations, and she played a role in all three role plays.

Session 5: The PWDVA Act

The next session looked at discussing the PWDVA Act and its provisions (Annexure 5).

. The Act came into being in Chhattisgarh in 2008-2009. Before this Section 376 covered rape, 304 covered Dowry related death and 498 A covered Dowry and violence against women. The role of the women's movement in the passing of this Act was also discussed.

The difference between criminal and civil law was explained, as they differ in structure, burdens of proof, and penalties. A civil case involves a dispute between two people, or parties, on a certain issue. And punishment is usually through paying compensation. Criminal law considers a crime an act against society rather than an individual and if found guilty, the defendant may have to pay a fine, serve time in jail or prison, or be placed on probation. The provisions of the Act

were also discussed (see annexure 5). The PWDVA Act is a Civil Act, but can also be used to start criminal proceedings, if rules of the Act are violated.

It was discussed that the Act also covers live in relationships. Here, the word *rakhel* was used by a participant to describe an extra-marital relationship, to which the group protested vehemently, as it was seen as being derogatory. The distinction was made between extra marital relationships and live- in relationships. A participant shared an article she had read, where the judge said that such relationships should not be promoted. This was in spite of live-in relationships having been recognised legally in some cases. It was shared that in Chhattisgarh the role of protection officers have been assigned to Aanganwadi supervisors and not much action is taken by the same. Participants further shared that the Women and Child Commission does not do any work at the state level.

A participant from Jharkhand then also shared her experiences about the Women and Child Commission. Her mother had been branded a *dayan*, or witch and was being harassed by the community, the participant wrote a complaint to the Commission in May, and they reacted by coming to the village by October and ensuring that the harassment stops. She told the group that they also run a helpline, and respond to complaints.

The participants from Chhattisgarh then shared about how *dhongi pratha* (witch hunting) is very prevalent in their state as well. Participants also shared information and views on the murder of activists such as Anita who was killed along with her husband. Sheila Masood's case was also discussed in this context. It was said that while there are many big officials, the conditions in Chhattisgarh has been worsening. This is particularly due to the demand for minerals and medicinal herbs that the state has in great quantities. Raman Singh was seen as seemingly promoting 'development' in Chhattisgarh and as having a good media image, while in actuality being nepotistic and causing a lot of damage to the state and its people.

Day 3- 31st October 2011

The day started with a song and feedback on the previous day

Session 1: The Sexual assault kit

The facilitator started by asking the group about what they understood by sexual intercourse. It was clarified that sexual intercourse in context of the rape law indicates non-consensual penil-vaginal intercourse and penetration of the anus or vagina, by the penis, by a stick, a vegetable or any other object.

The group then went on to discuss what happens when a girl is raped and is taken to the hospital. A FIR is then meant to be registered, which states what happened in simple words. A female police officer is meant to be present along with a female doctor. The medical report is to be filed after the medical examination.

It was seen that often women are too ashamed to talk about what happened. As a result of this no FIR is filed. The facilitator then told the group about the High Court judgement which makes it mandatory for all hospitals to keep a safe kit. The group was told about why it is important to take the rape survivor immediately to the hospital, as bathing and urinating can remove signs of rape. The sperm stays in the body of the woman for 72 hours and it is important that the medical

examination happens within this timeframe. Any intoxicating substance stays in the body for 10-12 hours and this can also be detected by a urine test.

The rape survivor's pubic hair and clothes are taken and brushed with a comb so as to collect any evidence that might be on them. Any mark/ signs of assault on the victim's body are noted down as part of the medical examination. A Swab-Saliva test is also done to test for any infection.

The group also discussed the connection between the hymen, virginity and the two finger test, as there was confusion about the same. There was not much information amongst participants about the two finger test. It was clarified that the hymen has nothing to do with rape. Participants shared their experiences such as when a young girl was raped by four boys for a whole day. When she was taken to the doctor, he was dismissive of the case on account of there not being blood. The participant questioned why there should be so much reliance on the medical testimony, above and beyond that of the woman. The treatment of women by doctors also was disparaged. A sexual assault cell has been made mandatory in government hospitals in Chhattisgarh as well, and this session received excellent participation and feedback from the participants, as they did not know of such issues and the procedure in detail before. Many participants expressed that this information is extremely important in their line of work.

Session 2: The Way forward

The concluding session was meant for the participants to discuss and strategise amongst themselves on how they could take forward and incorporate work on domestic violence and public health in their own communities and area of work. The group was divided into 4 smaller groups on the basis of districts. After working in their smaller groups, the discussions and strategies were shared with the rest of the participants.

Strategies which the groups shared were as follows:

Group 1: Bastar Group

- Discuss issues of domestic violence and health at district level meetings with the D.R.P
- Including discussion on domestic violence in various meetings such as the Block meeting, the VHSC meeting, household level meetings and the Maha Samkul
- Organise a sensitisation session with Mitans, who cover approximately 40-60 houses
- Identify women undergoing domestic violence and organises sensitisation sessions with them, which includes information about the PWDVA Act
- Create counselling centre for women at the district level
- Use posters, graffiti, and leaflets to disseminate information about domestic violence at the village level.
- Organise meetings with female doctors, female police officers and other providers



Group 2: Bilaspur, Kavirdham, Janjgir

- Meetings with Self Help Groups and VHSC at the village level

- One day training workshop with the panchayat
- Meetings with women's groups
- Workshops with young girls
- Meetings with aanganwadi workers and Mitatin workers and ANM workers
- Awareness through posters, leaflets, banners etc. with the help of Sama
- Many of the organisations are working with women's health, education and empowerment programmes; they will attempt to add issue of domestic violence and public health to their existing work.

Group 2 decided to concentrate on awareness work with Self help groups, Aanganwadi and ANM workers in their districts, as well as work with young girls on sensitisation and awareness on domestic violence.

Group 3: Sarguja, Jashpur, Koriya, Raigadh

- Conduct a training t the Block level
- Organise a meeting with the Village Health and Sanitation Committee
- Discuss domestic violence and health at the gram sabha meeting
- Raise demands for female doctors at the Community Health Centre
- Raise demand for women police officers at the Block level and District level
- Take initiative to start conversations with the appropriate government departments
- Discussion at the Maha Samkul meeting
- Discussions at the household level
- Awareness raising through posters, graffiti writing, street theatre etc.

Group 4: Raipur, Dhamtari, Durg, Maharmund

- Organise a workshop with the Women's Health Committee
- Engage with the media on domestic violence and public health
- Organise a workshop with Mitatin worker's
- Organise discussions with lawyers and encourage them to take cases on behalf of poor women
- Organise a meeting with 12-15 members of the VHSC
- Information sharing and sensitisation workshops on schemes pertaining to domestic violence and health with women's and women and children departments in the state

Group 5: Jharkhand group

- Decided to spread awareness on domestic violence in whatever forums that could be used
- Organise discussions with women in different villages
- Conduct discussions with Saiyan workers and Health Committee members
- Organise a meeting with Panchayat members
- Organise discussions with aanganwadi workers
- Put up posters at strategic public spaces in their villages
- Use theatre as a means of sensitisation
- Learn about the PWDVA Act and its implementation in Jharkhand

The facilitators then provided inputs on the sharing by the groups. Sulakshana pointed out that when we work with women who are undergoing domestic violence, we need to ensure that we listen to their needs and only file cases if they agree to do so. Other strategies could be to work with health providers, protection officers (where they exist). She also pointed out that the Mitatin Worker's and Panchayats have great power at the village level and we have to be careful

that we don't utilise this power in a manner which is detrimental to the women. During this session a participant shared with the group, that a film supported by her organisation called 'Andhere se Pehele' had just won the National Award.

The facilitators voiced that we keep in mind that the Mitanin and Saiyan is also a woman from the village, and suggested that the work with Mitanins/ Saiyan could take place along with other health service providers, so that she does not get overburdened or alone in her work, and further that strategies need to be designed so as to work with them. Facilitators from Sama also spoke about how they and PHRN will keep attempting to work with the service providers, such as doctors and nurses.

Session 3: Feedback and Closing

The next closing session was a round of feedback which the participants wrote and then voluntarily shared with the larger group.

Feedback from the participants was as follows:

- The session on the sexual assault kit was very new and exciting for many participants, many felt that this was very useful in their areas of work. They also felt that the Safe Kit should be present at the district level as well
- The participants enjoyed the structure of the session and the interactive nature of the workshop
- The film screening and poem were appreciated, but some participants also felt that more films should be screened, maybe after the sessions.
- Participants also felt that such workshops should take place at the district level
- Participants liked the staying arrangements, but did not like the food
- Participants voiced that a follow up session to the workshop should also be held after a few months
- Participants felt that the time of the workshop should be increased
- Sessions on the forms of violence were appreciated, and participants wrote that they did not have a full understanding of what constitutes domestic violence and how it affects women's health and lives.
- Many participants wrote that the issue of domestic violence in itself, as well as its connections with health were very new to them, and that they want to take forward this work in their villages and communities.
- Feedback was also received on how domestic violence is seen as a personal matter, and how the workshop helped them see that it is a public or societal matter as well.
- A participant also shared her own experience of undergoing domestic violence, and wrote about how the workshop had a strong impact on her.

Some quotes from the feedback forms were as follows;

'I knew about domestic violence from before, and domestic violence was happening about which we would have meetings, and all the women along with the Mitanin would try to reach a compromise, without knowing too much about domestic violence. I will go back now with more information, particularly about how to utilise the law to stop domestic violence'.

'I really liked the programme as there is a great need to tackle such issues in my area'

'I had some information about domestic violence but was very hesitant in sharing and talking about the same, after this workshop I feel that I will be able to do so, particularly with women in my community'

'I was informed about Sexual assault and the Safe Kit for the first time'

The workshop was closed with thanks to PHRN, Sama and the Pastoral Centre, which provided a venue for the workshop. A song and slogan shouting session was initiated by the group which saw the end of the workshop.

Annexures

Annexure 1: Case Studies for the exercise on Institutions of Violence

Rita's Story

Rita is a 28 year old single woman, living in a big city. She often has to work the night shift in the hotel where she works. One day when she is going back after a night shift, she is forced into a car and raped. She is left in the same condition on the road. Rita calls a friend for help, and both of them decide to go to a nearby police station to file a FIR. The police registers the report, but also tells Rita that since such incidences have increased recently, women should not stay out late at night, and that women should also take care of their behaviour and wear appropriate clothing. The police also reminds them that recently the Chief Minister also said that women should not move around at night. Especially young working women should be very careful.

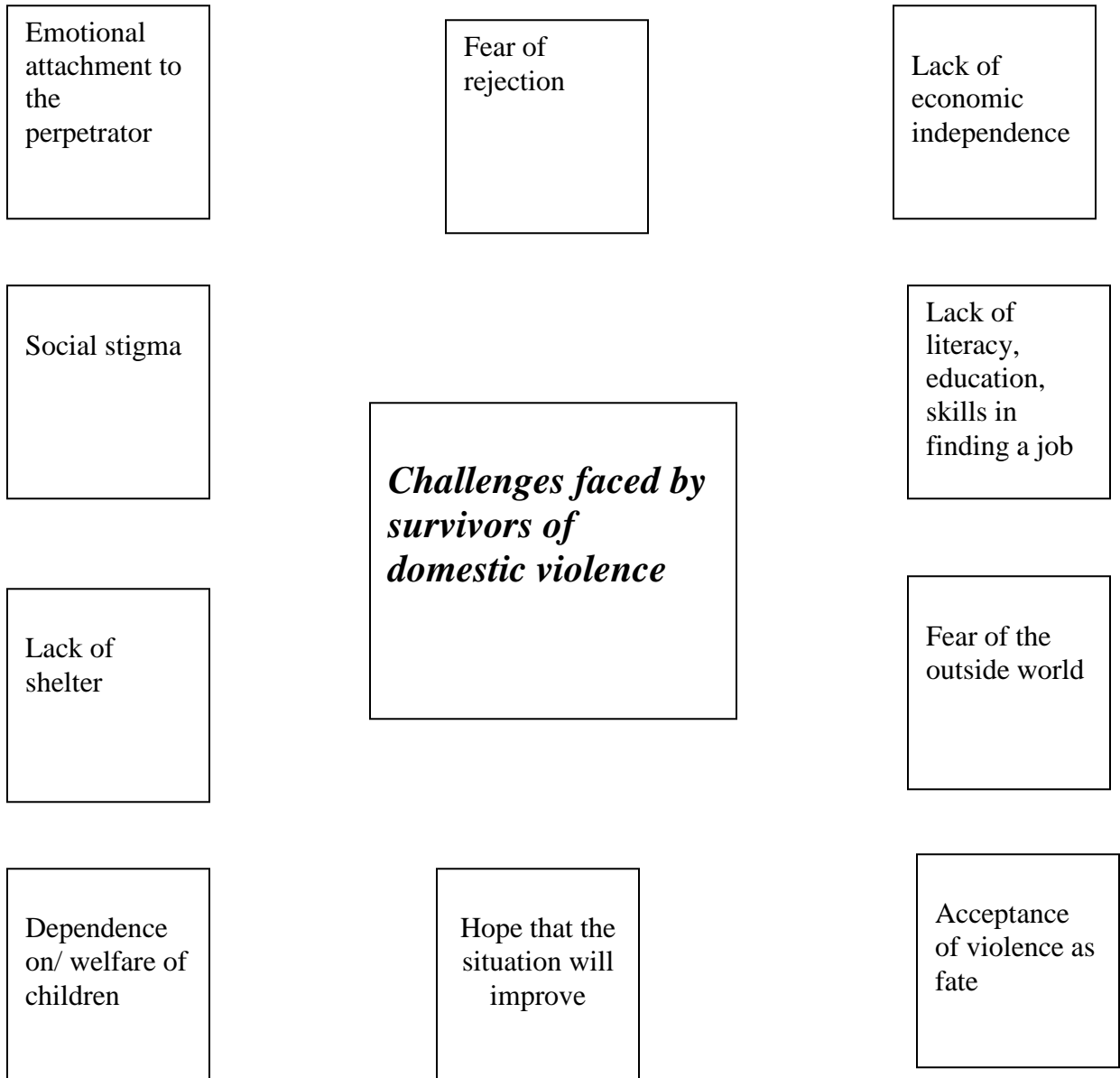
Asha's Story

Asha is 28 years old and is nine months pregnant. One day she gets badly beaten by her husband on the pretext of not making food on time. She is badly wounded in the eye and stomach. She goes to the district hospital for treatment where she is admitted into the hospital. Asha's husband is a contract labourer and his income is very less. They already have three girl children and one boy. The husband does not accompany her to the hospital, and her parents are with her. Asha soon gives birth to another boy. But due to a government policy, which fines couples who have more than 2 children, she has to pay Rs. 500 to the hospital. Asha's family is also very poor and do not have money to pay the fine. Due to her inability to pay, the hospital refuses to release her. She tries to find a way to run away. Even during her stay Asha has to hear taunts from doctors like 'these people have so many children and mis-utilise the facilities at the hospital. She is finally told that if she has a tubectomy, she will not have to pay the fine.

Sheila's Story

A case came to the hospital where a 18 year old girl named Sheila consumed poison by mistake. When she was brought for counselling at the crisis centre, they found out that she had tried to commit suicide. Sheila told the counsellor that she was in love with a 20 year old boy named Raju, who belonged to the Dalit community. Both of them were in love and wanted to get married. But her parents did not agree to this. Sheila and Raju decided to run away from home, but Sheila's family filed a case with the police, and both of them were arrested soon after. Raju was put into jail, and Sheila was forcibly returned to the family. Her parents locked her in the house and refused to let her leave or meet or speak to anyone. They made her do household work, and decided to forcibly marry her off to someone of their choosing. Sheila was helpless and did not know what to do. She didn't even know what had happened to Raju. Seeing no other option, Sheila decided to take her life.

Annexure 2: Challenges Faced by Survivors of Domestic Violence



Annexure 3: Cycles of Violence

He gave me flowers

I got flowers today. It wasn't my birthday or any other special day.
We had our first argument last night and
He said a lot of cruel things that really hurt me
I know that he is sorry and didn't mean to say the things he said –
Because he sent me flowers today

I got flowers today. It wasn't my birthday or any other special day.
Last night he threw me into a wall and then started to choke me.
It seemed like a nightmare but
You wake up from nightmares to find out that they aren't real.
I woke up this morning sore and bruised all over.
I know he must be sorry- because he sent me flowers today.
I got flowers today. And it wasn't Valentine's Day or any other special day.
Last night he beat me and threatened to kill me.
Makeup and long sleeves didn't hide the cuts and bruises this time.
I couldn't go to work because I didn't want anyone to know
But I know he is sorry- because he sent me flowers today.

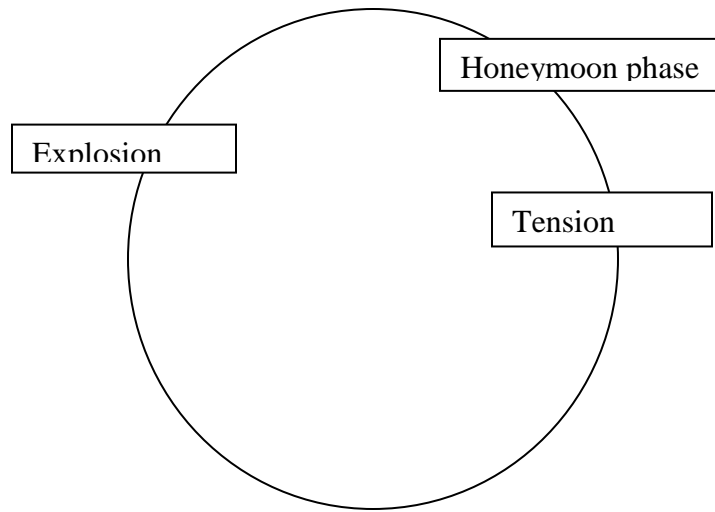
I got flowers today and it wasn't Mother's day or any other special day.
Last night he beat me again and it was much worse than all the other times

If I leave him what will I do? How will I take care of the kids?
What about money?
I'm afraid of him and scared to leave him!
But he must be sorry- because he sent me flowers today.

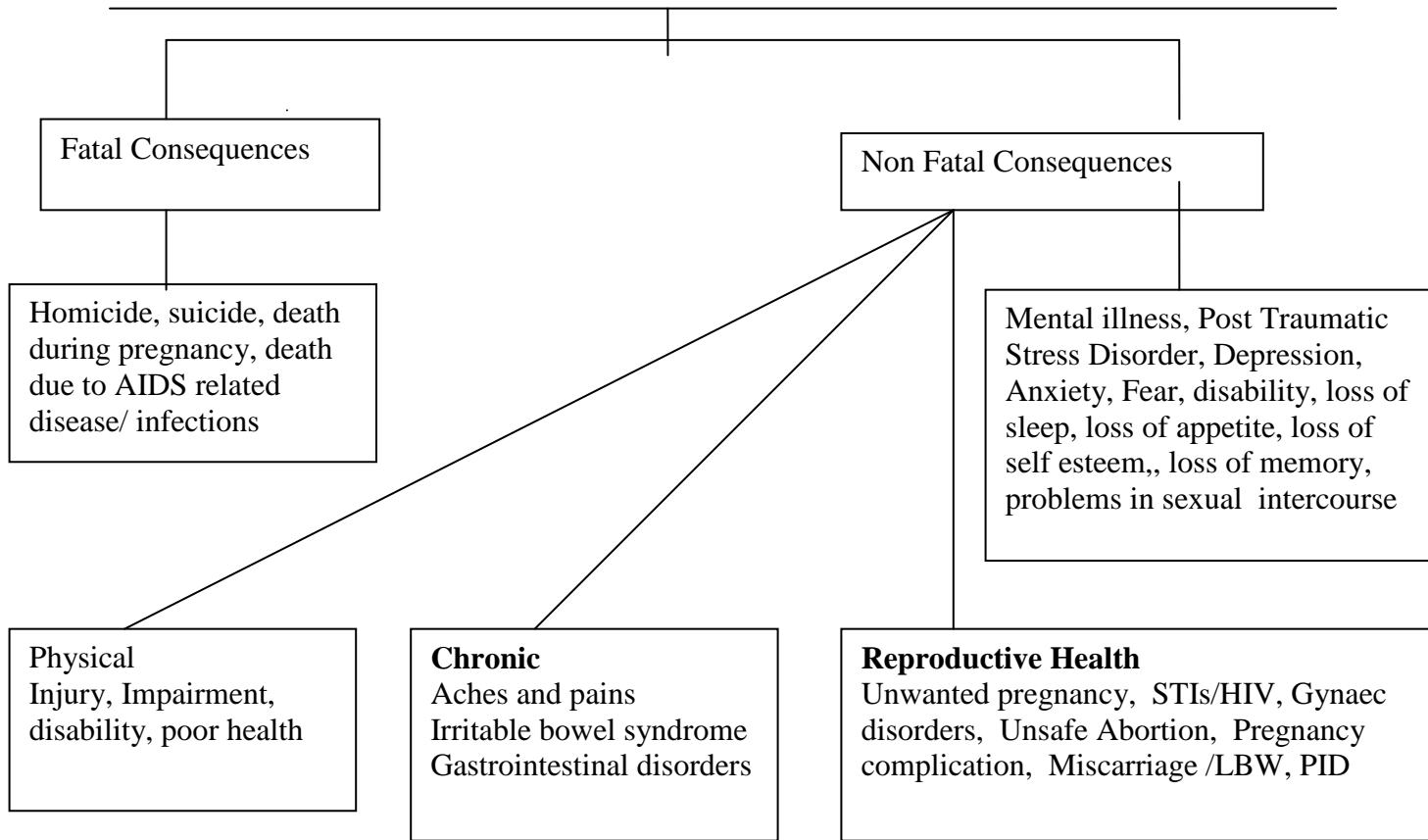
I got flowers today. Today was a very special day.
It was the day of my funeral.
Last night he finally killed me.
I was beaten to death.
If only I would have gathered enough courage and strength to leave him.
So I got flowers today – for the very last time.

Author Unknown

Annexure 3: Diagram of the Cycle of Violence



Annexure 4: Health Consequences of Violence against Women



Annexure 4: Role -Play Situations

- One 20 year old woman comes to the PHC. She tells the doctor that she has had a headache for many days and has lost her appetite as well.
- One 22 year old woman first goes to the PHC, and then the district hospital as she has a broken hand and swelling on her face.
- A 25 year old woman is brought to the district hospital by her husband and brother in law, as she has consumed poison.

Annexure 5: PWDVA Act in a Nutshell

What is Domestic Violence?

- Mental, physical harm and endangerment;
- Includes sexual, verbal and emotional and economic abuse
- Dowry-related harassment

Who benefits from this law?

- Women in domestic relationships
- Wife/ ex-wife/widow/ omen in relationship in the nature of marriage/mother/ sister/daughter/ joint family members/children (male and female)

Who can the complaint be filed against?

- Any male adult person who has been in a domestic relationship with the aggrieved person.

Who can file complaint?

- Aggrieved party (woman/ on behalf of child)
- Any person who has reason to believe that an act of DV is being/likely to be committed – neighbours, social worker, relatives etc.

With whom can the complaint be filed?

- Police
- Protection Officer
- Service provider
- magistrate

What remedies are available?

- Residence orders
- Monetary orders- maintenance, monetary relief, compensation
- Protection orders
- Custody (temporary)
- Ex parte orders
- Interim & final orders
- Penal- 1 year imprisonment + fine up to Rs. 20,000/- for disobedience of court order

Implementing mechanisms

- Protection officers
- Service providers
- Medical facilities
- Shelter homes
- Police
- Courts

Other salient features

- Speedy trial
- Magistrate may direct aggrieved person and respondent to undergo counselling
- Provision of shelter, medical facilities etc. to be made available to the aggrieved woman

How is the law different from previous laws?

- Includes women in relationships in the nature of marriage
- Includes women in domestic relationships Other than as wives
- Provides remedy for women's shelter in the household while accessing the law
- Law works at preventive and remedial level
- All remedies in 1 court
- Is a combination of civil + criminal remedy