BAPU TRUST FOR RESEARCH
ON MIND & DISCOURSE

Gender and Mental Health

A 10 day residential training program

Training Report
2006

Gender and Mental Health
A 10 day residential program

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Gender and Mental Health
A 10 day residential program

Background:
This course has been piloted twice (2003-05) and finalized as a 10 day curriculum and is run every year in Pune. The course was developed in response to a huge need felt by women's collectives, non-governmental organizations, government agencies, research, teaching institutions and diverse kinds of professional agencies to develop perspective and understanding in a core area of women's health. The first of it's kind in India, this course fills an important gap in social science, mental health, development, human rights advocacy and policy thinking on gender and mental health.

Objectives of the course:
The course will enable participants to:

- Use the concept of gender in the field of mental health
- Obtain and use evidence based knowledge relevant to the field
- Make informed linkages between reproductive health, sexuality and mental health
- Critically approach research and educational materials in the subject area
- Develop skills to conceptualize programs in mental health in their organizations and community work
- Develop an approach to creating emotionally fulfilling work environments
- Contribute to policy, human rights and legal advocacy in the subject area

Participants (Max.-25)
Participants may be from the medical, professional, governmental or the development sector. They, or the organizations they represent, would have a keen interest to develop capacity and run community programs or human rights and policy advocacy campaigns in the area of mental health. They may be doctors, health, mental health, social science or human rights professionals, health care providers, policy developers, program managers and researchers. They would have an interest and aptitude for studying the subject areas as a part of their own professional development. They would have experience in health/RH, service delievery, human rights advocacy or other development work.

Course Outline
Module 1- Concepts in Gender/Mental Health
Module 2- Reproductive Health and Mental Health
Module 3- Research, Education and Policy in Mental Health
Module 4- Ethics, Law and Mental Health

Methods
The course is an intensive and interactive academic study program. All participants are expected to stay on campus during the course of study. Teaching methods used are lectures, seminars, work assignments and work groups. Comprehensive reading materials and handouts will be provided to all the participants. The language of instruction will be English.

Course Co-ordinators
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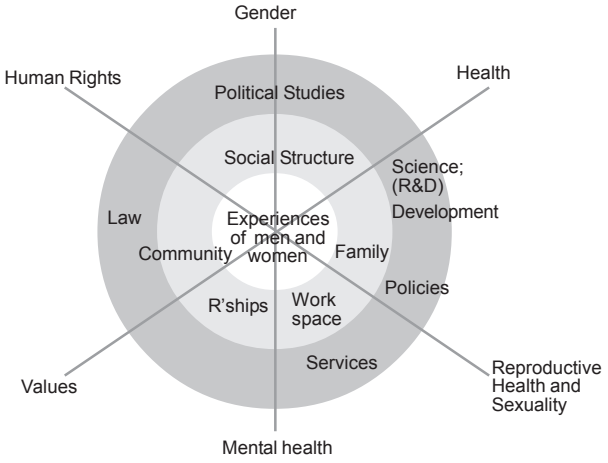
Contents

Foreword

This course was developed as an outcome of a Mac Arthur Leadership Fund given to one of us in the year 2001. Being the way we are, both of us have continually revisited the course every year, experimented with changes and reviewed the results. We are presenting this report of GMH course 2006 as the first experimental results of all our efforts.

Writing this report has for the first time shown us, who have worked on the nuts and bolts of the course, what the whole looks like. We are quite happy, though that little ever critical voice inside us tells us that 'there is scope for betterment'.

We are, however, convinced that the Gender and Mental Health course serves an important need in filling gaps in knowledge and approaches, in the field of women's health, disability and rights. We see this report as a part of the continuing process of educating ourselves and others on the subject.



Gender, Mental Health, Women's health, Values and Human Rights, as perspectival and analytical categories, are placed at the core of each and every module / session of the GMH course. The course builds up from a micro-level understanding of personal and inter-personal work, to more macro-level understandings of program development, planning for public health services, ethics, policy and law. The course was built on the twin foundations of research and experience, theory and practice, and at the center of each module, opportunities were created to connect with women's experiences. A spectrum of areas from 'development' to 'human rights' were covered, along the way addressing dilemmas and tensions, some of which were irreconcilable.

We have not herein presented the minute details of each session, the high quality of discussions and dialogues pursued, or the extensive resource materials provided. The hard shell of the course is given in full view here, and we hope that this view will be persuasive enough for organisations and institutions to engage more with the course in multiple ways. Certainly, the report cannot substitute attending the course!

Bhargavi Davar

Sundari Ravindran

Pune, 10th January 2007

1. Introduction to 'Gender and Mental Health

- A 10-day Residential Training Program (2006)'

The 'Gender and Mental Health' Training Programme started with a brief introduction to the course, in the evening. The objective of the evening was to get to know each other, introduce the course and to set the objectives and expectations.

The course co-ordinators, Bhargavi Davar and Sundari Ravindran, briefly introduced themselves. This was followed by an introduction of the participants. The group spoke of the work, professional and personal, that they were associated with, and elaborated on their interest in issues of mental health, in general, and the course in particular. While some participants had come to the course for inputs into their academic interests and to learn more about the subject, others expressed an interest in using the content of the course in their work areas and creating interventions related to gender, violence, youth, counselling etc. The list of participants and facilitators of the GMH course, 2006, is included in ***Annexure 1***.

The most widely expressed need was the consolidation and enhancement of knowledge about GMH. Participants were also looking for enrichment, in terms of perspective on gender and mental health, and to improve their research skills in the area.

A game was introduced to familiarise the group with each other and facilitate a more detailed sharing about the self. This was felt to be important, as the course was long and intense. The course was structured in a way that demanded group intimacy and cohesion.

1.1 Expectations

Cards were distributed to all participants on which they wrote their expectations. These were put up and summarised by the facilitators.

Conceptual clarification, perspective and information assimilation

Participants expressed an interest in understanding the relationships between Gender, Reproductive health, Sexuality, and Mental Health.

The resource persons clarified that the above mentioned subjects formed the core areas of the course, though sexuality was not dealt with in detail, except in reference to the module on child sexual abuse. The linkages between these would emerge as the understanding about these grew.

Research interests

Participants expected substantiation in terms of research evidence, ideas for research, research methodology, and variables.

The workshop contained comprehensive reading materials and research evidence as examples and readings. Several of the studies mentioned in the readings are in an Indian context and would be relevant to research and in formulating ideas for them. However the course could not be considered as providing training in research methodology. Other courses may be looked at for this purpose.

Content related

Understanding of factors affecting women's mental health and violence was expected. Linkages between these should also be clarified. Interest in understanding the public mental health system, service providers and their roles was also expressed.

This formed the core of the course and would be referred to often and dealt with in detail.

Process related

Participants expressed the need for interactive learning and the use of experiential methods in the training.

The workshop essentially followed an interactive methodology of learning. There were also several readings and presentations to substantiate and build insight into concepts. Concepts were revisited and reinforced through the training, forming learning loops. The emphasis was on processual and recursive learning, and skill based learning, rather than information dissemination.

Personal quests

Some expressed the need to address personal questions.

It was up to the group to utilise the workshop to answer personal questions and fulfil their personal quests. But this per se was not an objective of the course. Our experience in the last three years has been that some experiential aspects of the course touched profound personal chords in participants, and led to introspection.

Discussion

In the ensuing discussion, participants added other areas which they wanted understanding on, through the course. These included:

- Life span and coping strategies
- Psychological processes leading to distress
- Interventions that can be used by social workers in the course of their work
- Traditional healing and healers and their place in mental health

The resource persons explained that some of these topics would be briefly touched upon in relation to other core topics though not in detail, and some reading materials could be suggested for the same. Intervention training was not a part of the course, though they would have the opportunity to meet interventionists. Other interesting topics that would be touched upon in the course would be – mental health in working teams, life style and mental health, etc. The course objectives and the modules were briefly introduced.

1.2 Course Objectives

The objectives of the course were tabled by the resource persons. The learning objectives set by the course were described. The course would enable the participants to:

- Use the concept of gender in the field of mental health
- Understand the social economic determinants of mental well being
- Be informed about the available evidence in the GMH field
- Make linkages between reproductive health, sexuality and mental health
- Make the linkages between violence and mental health
- Get a perspective into CSA
- Critically approach information in the MH sector
- Conceive of MH programs
- Understand MH policy from a gender perspective
- Obtain a perspective about negotiations of values in the MH sector
- Be better prepared for advocacy in the mental health field

Modules


Maheen Mirza; Documentation

The modules in the course were:

1. Gender and Mental health – Concepts
2. Reproductive Sexual Health and Mental health
3. Research, education and policy on Mental health
4. Law in Mental Health

The session outline with details about the Programme and specific objectives of the respective modules are presented in ***Annexure 2.***

Some ground rules were then discussed and unanimously agreed to by the group. Expectations related to reading and study, in preparation for the next day's work was emphasized.

Everyday routines were talked about and set for the group. Three small sub groups were also formed among the participants.

Feedback and Reporting group – collecting feedback from all participants and presenting a short report of the day and the feedback on the next day before sessions.

Hospitality group – internal facilities and arrangements in the classroom, including switching off all lights and fans after session, water in classroom etc.

Social activities group – introducing small energisers between sessions, plan sharing sessions outside the classrooms if required.

Readings for the following day were given out.

2. Gender and Mental Health: Concepts

2.1 Objectives of the modules

- To see the conceptual linkages between physical health and mental health
- To understand how gender and other social determinants influence mental health
- To be able to process evidence base on gender and other social determinants in mental health
- To see mental illness from the disability perspective
- To know more about the special problems of women with chronic mental disability

2.2 Gender in Health and Mental Health – An Analysis Framework

Sundari Ravindran

The session allowed the group to think freely and get clarity on the core concepts of the course– 'Gender' and 'Mental health'. In this session, we looked closely at the concept of gender and its linkages to health, and introduced a gender analysis tool.

The group was asked to record

- what they would say about 'gender', if they had to convey it to another person,
- also, write down three questions about gender, about which they are still unclear. Points brainstormed on are presented below:

If you had to convey something about gender what would it be

Concepts- Difference between sex and gender

- Biologically present versus socially enforced roles
- General difference made between boy and girl by society
- Clearly not a biological construct but a social one

Manifestation

- Differences in physical and cognitive.

A discussion on the likely cognitive differences between men and women ensued.

- It would be difficult to write off intelligence and emotion as purely sex based. While there are studies to prove this there are probably an equal number of studies to disprove it. Different social expectations result in different ways and levels of expressing yourself.
- In a study it was found that differences in cognition etc., are as large within the same sex groups as in different sex groups.
- Many studies also show that social reinforcement also determines differences in cognition. Boys are encouraged to take technical subjects – maths etc. and girls are encouraged from an early age to pursue arts.

Difference in Social Roles

- Expression and behavior is determined by norms and roles set out as men and women.
- Differentiating work (household work for women and economically valuable work for men), skills (cooking for women, electric repairs for men) and roles (the woman is the carer and the man is the bread winner.
- Socio economic - Women may get into non competitive courses, and low paying jobs. Firms that judge ability to keep a job – even beyond marriage and pregnancy.

Norms

Different norms for different sex / gender groups. These norms are internalized through socialization. Norms change and refine themselves based on cultural, regional and other contexts. Norms are not static but are formed by people and change as per what the society was thinking then. They are also complex and constructed on the basis of power dynamics and patriarchy.

Social constructs

- Marriage to someone is determined by gender.
- Women should marry men who are more qualified, earning more money.

2.3 Discussion and summary

The exercise led to a discussion on feminism, patriarchy, gender and social roles. The role of social hierarchy (gender, caste, other) in dividing people and setting up inequalities among them was discussed. Patriarchy as an analytical concept captured the politics of power in the context of gender relationships. All the systems that are developed reinforce and support this, whether they are scientific, social, economic or legal. They systematically privilege and offer benefits to men.

Feminism offers a different value system. The analytical concepts of gender and patriarchy were given by feminism. Due to this association between feminism and women, it was thought that acceptance of it would disempower the men. Gender and feminism is about addressing power inequality with respect to mobility, education, class, caste, religion etc. Values about gender and equality are about society as a whole, and not just women. Feminism goes beyond the individual and looks at the impact of structures on men and women, for example, the family.

The human rights framework and its challenge to patriarchy were discussed. If we talk equally about both men and women, then why do we need to support women? If we were to allocate resources to women, would we be denying men equal opportunity or would it be gender sensitive? Examples were used to find answers to these concerns, such as in education and housing.

It was felt that sometimes women do not want to live without the protection that patriarchy bestows on them and are content with bringing minor adjustments within that comfort zone. This may especially be true in the case of women who have access to privileges because of accepting the protection. The difference between inter-dependence and protection was discussed. Interdependence is natural to our being human, but when inter-dependence converts into sanctioned protection, someone's autonomy is compromised. This becomes a control relationship.

Feminism gives an alternative vision for the world. It gives us powerful concepts as well as applied, analytical tools for understanding the politics of disempowerment. A basic premise of feminism is that you cannot win equality for any one group unless there is equality to everyone.

Sundari Ravindran summarized the discussions through a lecture presentation. The concept of gender was defined and differentiated from sex followed by an examination of its social construction. The varying nature of gendered social roles depending on the social context and elements like age, ethnic group, class, culture and so on was elaborated. This presentation underlined the need to incorporate diversity in gender analysis, with examples. Gender roles change over time. The need to treat gender as a cross-cutting variable across these various socio-demographic groups was emphasized.

Gender discrimination refers to any distinction, exclusion or restriction made on the basis of socially constructed gender roles and norms, which prevents a person from enjoying full human rights. In order to combat gender discrimination, it becomes important to challenge the ideology which rates men as superior to women (an ideology which women as well as men may help perpetuate). It is about challenging the institutions that uphold these values, such as family. The presentation also covered the impact of patriarchy on men and constructions of masculinity, with examples.

The presentation concluded by challenging the hetero-normative or binary construction of sex. Recognizing only male and female sexes and genders is no longer considered adequate. Sex can be seen as a continuum from male to female, with most people existing anywhere along it. The personal identification along this continuum can also change with time. People can choose to be differentially identified and their biology does not determine any assigned role or expression or behavior.

> 'If we ask the question what is the one distinctive characteristic that defines me or makes me distinctly female, there will be no specific answer because all that signifies female, I realize, is socially constructed.'

Requiring everyone to identify unequivocally with one of the two extreme categories, not accepting deviation from accepted 'norms' of behavior for a given gender including same-sex sexual attraction all have implications on the psychosocial well being of people.

2.4 Gender in Health

Sundari Ravindran

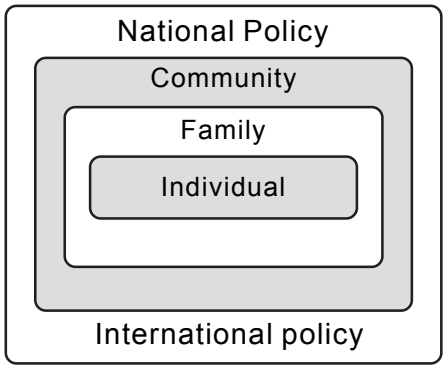
The gender aspects of health were seen as an important prelude to any learning on gender and

mental health. Feminist understanding of health, being well developed, offers learning possibilities on research and evidence, as well as ideology, which can be transmitted into the mental health field. Further, mental health includes physical and social well being as well. The session began with an exercise where the group was asked to list factors that contribute to good health and poor health in men and women.

Factors contributing to Good Health	Factors contributing to Poor Health
In Men ♦ Better nutrition provided in childhood ♦ More attention given by the family ♦ Investment – financial and material ♦ Marriage ♦ Emphasis on physical activity – sports, mobility, exercise ♦ Have a social identity outside of home	**In Men** ♦ They abuse their own bodies – substance abuse and lifestyle ♦ Negligence in access to care by men. There is a delay in care though access is more because they perceive themselves to be stronger. ♦ Occupational health and hazards ♦ Premarital sex, risk taking sexual behavior ♦ Heredity and genetic factors ♦ Biological vulnerability at the time of birth
In Women ♦ Nutrition ♦ Biologically stronger	**In Women** ♦ Poor access to health care ♦ Malnutrition ♦ Violence ♦ Child rearing/bearing ♦ Self neglect – marriage and power relations ♦ No space to express illness ♦ No control over sexuality and reproduction ♦ Multiple roles/ expectations: juggling between the multiple roles and no time for oneself. ♦ Duties of the household: this has to do with work and sex is also another job ♦ Lack of entitlements to rest ♦ Repeated child bearing ♦ Gender roles, norms

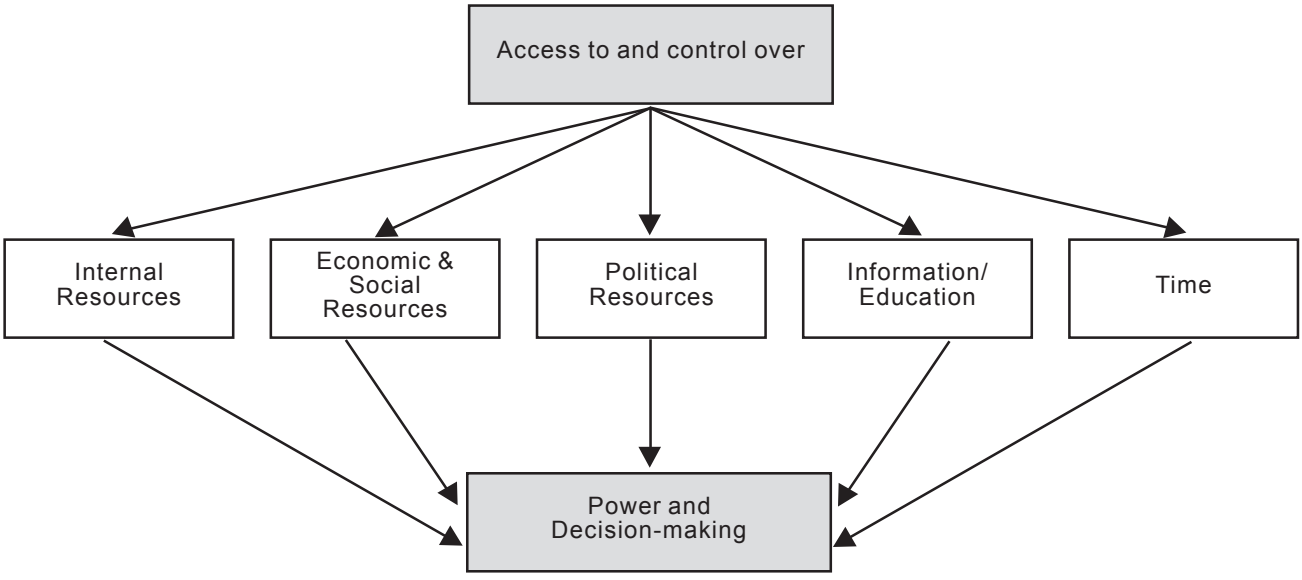
Discussion focused around whether health was a medical, and / or a social issue. Sundari Ravindran presented the evidence base on gender and health and summarized the discussion. Health is a product of the interaction between our biology and our physical, emotional and social environment. There were some external or structural factors that influenced the health of men and women, such as lack of access to amenities, environment, sanitation etc. Where we live, what we do, who we interact with and how we feel – all these factors affect our health profoundly. Men and women are biologically different because of their reproductive functions. This biological phenomenon becomes risky for women, due to their reproductive responsibilities. Very often, to explain the biological difference between men and women, social factors may be attributed.

Inequalities in people's health are the result of inequalities in access to the social, economic and psychological resources essential for enjoying good health. Social causes of personal ill health are related to issues of social justice and equity. Social determinants of individual health are amenable to policy interventions. The policy environment and its interaction with the individual through the various layers of implementation were discussed. Connections between the micro-issues and macro-issues need to be made.



Feminism has given us tools for gender analysis. A gender analysis in health would identify, analyze and inform actions to address inequalities that arise from the different roles and responsibilities of women and men, or the unequal power relationships between them, and the consequences of these inequalities in their lives, health and well being. Some common elements in gender-based differences across the world and across social groups are:

- Differences in tasks and activities and often, physical spaces occupied and social networks
- Differences in norms of appropriate behavior and in social expectations: e.g. in terms of dress, games played, interests, emotional responses and skills and competencies, especially pronounced in matters related to sexual behavior
- Differences in access to and control over resources
- Differences in power and decision-making



These differences interact with and influence each other. Because women and men differ in relation to the tasks and activities performed, are bound by differing social roles and norms, have unequal access to financial and other resources, and each of the above affects health, gender becoming an important social determinant of health, and an independent axis for analysis. Since health problems are often caused by multiple disadvantages, 'gender' as a factor rarely operates in isolation. What is biological, and what social, is contested and made political by feminist discourse. The session brought to the fore an understanding of the 'social determinants' model of well being with several examples.

A gender analysis tool and the method of its application were introduced. The learning task before the group was to apply the tool, to a fact sheet on depression circulated to them. The data on depression was to be organized into the matrix from the point of view of gender, health and social determinants, and presented. The matrix aligned a series of questions that needed a response. Factors which affect health are identified and alternatives to intervention – policy etc. can be suggested. A thorough discussion about the use of the tool ensued. Examples were given to apply the tool. Queries concerning the social determinants model were addressed. The linkages between psychological well being and physical aspects were also established with examples. The fact sheet on depression was clarified.

On Violence: A debate

There was a debate on whether violence is a matter of instinct. It was through discussion established as an expression of power and a product of social structure, which placed some individuals over others. Violence was a structural issue.

But does this rule out individual responsibility? Is male violence the same or different from female violence? Is violence legitimate, when it is to protect someone or in self defense? Children in violent homes are likely to bear the violence of both parents. Some saw structural matters in this context: While the father beats up the mother, she may in turn beat up her children. There were many assumptions made about the mother – child relationship and it was almost seen as sacred. Mother's angers and frustrations are not legitimized. Most felt that the mother is the primary carer and even if she were to express violence, her emotional response to it later is very different when compared to that of men. She feels shameful, guilty etc.

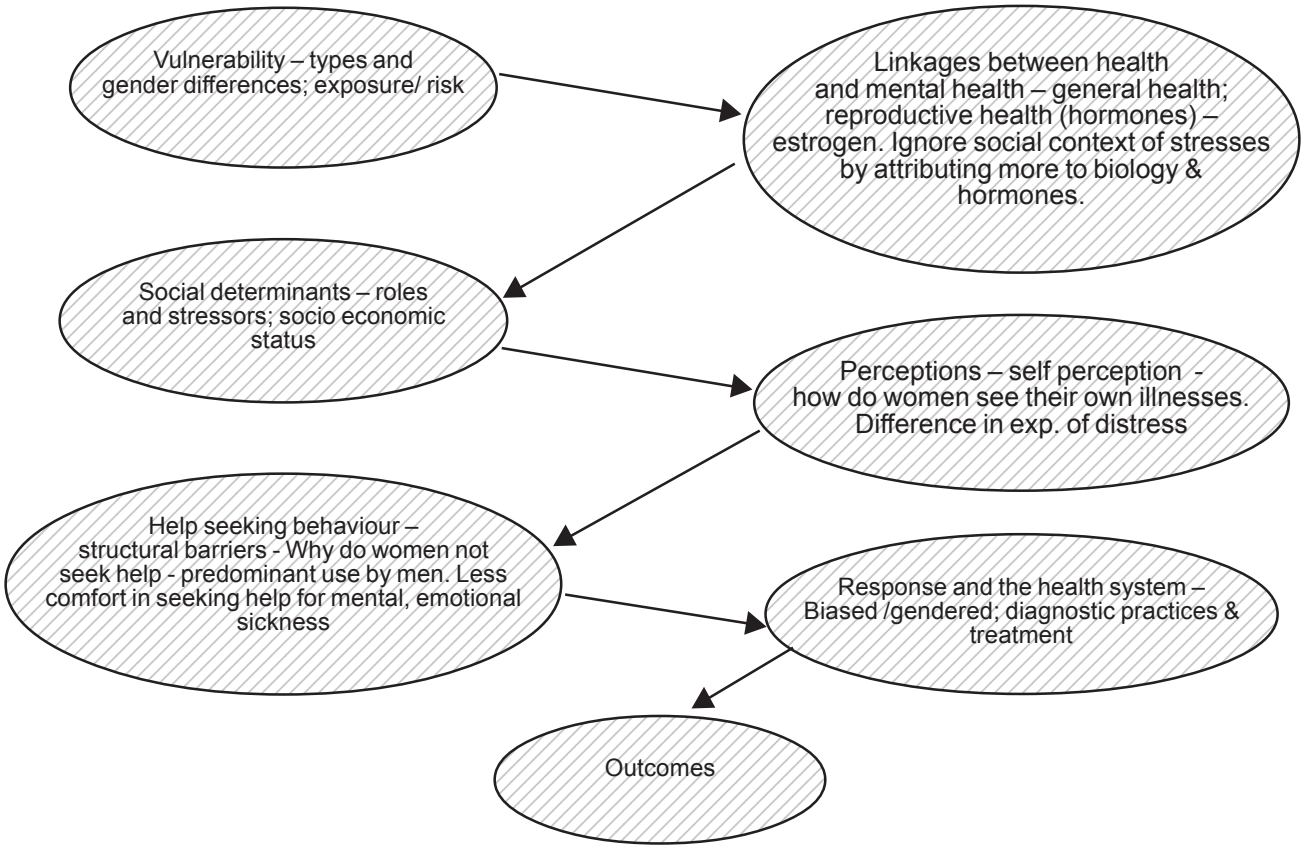
Women's violence was being justified by the training group and several reasons given for this. The facilitators played the devil's advocate in arguing that this approach is no different from those who give excuses for men being violent to women. It was established that violence is linked to power and there is no 'good' and 'bad' violence.

Abusing children is also a form of violence, which becomes 'good', because it is culturally seen to be for a good cause. This is the same argument that men use, when they abuse their wives. It is difficult to rule out individual responsibility.

The human expression of an emotion like anger is essential. However, in what form it gets expressed, and who we take it out on, is a cause of concern which must be addressed, whether man or woman. Ways of dealing with anger should be identified, which causes no harm to the other person and which does not result in control. Anger comes close to becoming a control mechanism, whether used by man or woman. The issue of violence from a position of power vs violence among equals was also discussed.

There is no single answer to the question of violence. There is the question of power and empowerment, anger and its expression, emotion and control, etc. Violence is always contextual and could be a function of any number of factors. The linkages between violence and mental illness were deconstructed.

A summary of the gender analysis matrix was explained diagrammatically, for applying it to the case of depression.



In summary, understanding 'gender' as a concept was an important goal of the session. A wide variety of examples were used to establish the concept. A social determinants model of health was reinforced through evidence and examples. The session underscored the need to look at well being holistically. It introduced tools by which an analysis of gender in the field of health and mental health can be done.

3. Orientation to Mental Health

Bhargavi Davar


Bhargavi Davar

The presentation outlined the way in which, historically, the women's movement has looked at the concept of 'mental health'. In the first phase, the women's movement engaged critically with the myth of 'madness' which pushed people, especially women, into institutions. This was followed by a second phase, where the 'right to mental health care' was emphasised, and further led to a third, recent phase where the movement is talking about the human rights of women with 'psycho-social disabilities'. At every stage, conceptually, mental well being and illness, and later, disability, has been deconstructed and re-defined by the women's movement.

Mental illness initially was seen by the movement as a form of protest against patriarchy and psychiatric labelling or diagnosis was challenged. As this was the near end of the colonial period, the mental institutions were the only option for many women, and the lives of institutionalized and psychiatrically labelled women was politicised. The flimsy scientific foundations of psychiatric diagnosis and the misdiagnoses of physical problems as, '*Its all in the head*' were challenged. 'Madness' was understood by the women's movement, inspired by left politics, as a class issue, and as a concept used by capitalistic societies to further their own ends of commerce and profit.

The political economy of 'madness' was described in this presentation through four phases:

- The colonial economy and the custodial period
- World war II, the growth of professional power and the first diagnostic manual (DSMI, 1952)
- De-institutionalisation and the community mental health ideology
- Prozac nations, and the rule of 'Pharmacocracy'

However, in the next phase, there was an insight that mental illness cannot be dismissed as a 'myth'. It would deny care to those who are distressed and alienate women's experiences of mental illness. Women who were distressed mobilised and articulated their needs and expectations from the mental health system as well as expressed the need for support from the women's movement. Some women suffered psychologically and the degree and quality of distress was an experienced reality. This was not a state of empowerment as implied by the word 'protest'. These women needed sensitive and good quality mental health care and the right to mental health care was linked to right to life and to health care. A critique of the biomedical perspective and a renewed feminist definition of mental health were done. Classic feminist research and thinking which contributed to this definition were presented. There was a clear gender bias in diagnosis, how it was developed as well as applied. Mainstream research did not take into account gender differentials in the prevalence or causation of psychological problems. The need was felt for a holistic perspective which addressed the mind + body + society together, not treating each as a separate entity.

Discussion focussed on the diagnostic status of common mental health problems and more severe problems, in the context of developments in diagnoses and their critiques, from the point of view of women's experiences. The question of whether 'medical' or 'social' was revisited with respect to mental distress. The 'social determinants' model of understanding women's health and illness was applied to mental health. The effects of social structures, gendered roles and expectations, socialisation, and powerlessness (economic, social and political) on emotional health, were highlighted. Mental health has to built up on a baseline of women's health (e.g. anaemia, malnutrition) and should also include a sensitive analysis of traditional / cultural practices (e.g. possession). The restoration of human rights was also discussed as a mental health intervention. There is very little research done on women's mental health especially in India. A need for more research and information on women's mental health was emphasised. The recent shift to a 'disability' language, from an 'illness' language was described, underscoring the benefits of the shift.

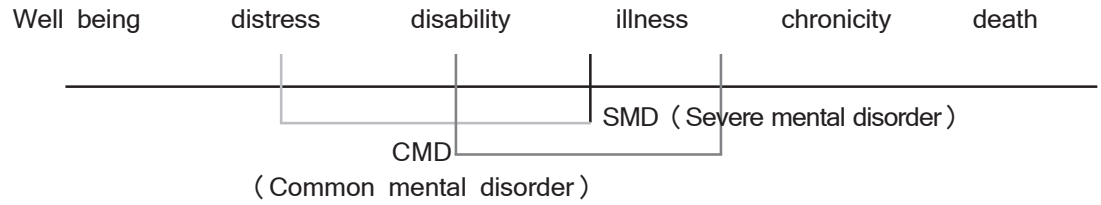
The presentation concluded by putting forth the following questions to the group, leading to animated discussion.

- Did we create a pharmaceutical market in talking about CMD / SMD?
- Is a medical framework at all necessary, or can we imagine another framework (one of disability?)
- Is 'empowerment' an elite NGO discourse of modernity, just like the promise of 'cure' in psychiatry? (e.g. possession) If the world achieved total equality, on socio-economic parameters, would there be no psychological suffering?

3.1 The continuum of well being

Bhargavi Davar

After reporting by the group of the previous day's learning, doubts and queries were addressed and the disability perspective in mental health, consolidated. As in health, there is a continuum from well being to psychological disability and people can fall anywhere on this continuum depending on the stage of disability and quality of their lives. The concepts of normality and abnormality take on different meanings as they have a basis in social approval and are not strictly psycho medical conditions. The continuum of wellbeing and disability is roughly illustrated below:



In 1990's within disability (which largely included physical disability), psychosocial or psychiatric disability was also introduced and added. There are many reasons for this.

- While illness would refer to a medical condition with some amount of clinical robustness and severity, disability describes a non-medical life oriented situation. If we speak of mental illness, there are very few options in terms of interventions, other than medical / curative. When we speak of disability, however, explanations as well as interventions are many and individualized.
- Not many of us see ourselves as having a mental illness. Several stages would pass before we reach a stage of illness. Many of us do not see ourselves as mentally ill, however severe our disability. '*Feeling bad but not sick*' is a more common feeling. Disability gives space for these experiences also.
- The disability language normalizes the condition with respect to life. With a label of mental illness there is widespread stigma, it signifies a total dys-functionality and incapacity in medico-legal terms. The notion of disability restores a person's dignity and capacity.
- There are some legal benefits that are otherwise not available to persons with a mental illness, which persons with disability can benefit from.

These sessions helped to make the linkage between the concept of 'gender', health and mental health, situating it within the growth of ideas and politics within the women's movement.

4. Gender and Schizophrenia

Dr Shantha Kamath

Dr Shanta Kamath gave a lecture presentation on 'Gender and Schizophrenia', after introducing SCARF, a voluntary, non-governmental, non-profit registered society working in Chennai since 1984.

The definition, diagnostic features, and vulnerabilities to schizophrenia were described. 'Schizophrenia' in mental health has been absorbed into a medical, rather than psychosocial model. However, the causes of the illness are many and emerge as a complex interplay between a host of environmental, social, biological and genetic factors. The presentation provided a rich data base on the subject of gender and schizophrenia.

Research on sex, gender and schizophrenia is negligible, and the possible reasons for the lack of gender based research were explored in the presentation. Some reasons related were the gendered development of diagnoses, gendered sites of study, recent advances in reproductive biology, and a blind spot in the mental health system on sex and gender. The sex differences between men and women were cited, including aspects such as age of onset, hospitalisation, prevalence, causal factors, precipitating factors, treatment, prognosis and outcomes. Factors that may influence gender differences in the age at onset of Schizophrenia were presented. These include sampling biases, biases introduced by diagnostic criteria and biases related to the method used to compute the mean age of the sample.

Studies suggest that men with schizophrenia, exhibit poorer pre-morbid social competence than women, and due to this, women have a better long term outcome. Further, there are differences in the clinical symptoms of schizophrenia in men and women. The diagnosis of schizophrenia is difficult to establish in women because of later age of onset and more prominent affective symptoms. It is also complicated with co-morbid conditions such as thyroid disease and it is often clarified over time, aided by the patients' response to treatment. A number of studies carried out in the seventies and eighties demonstrated consistent gender differences in the course of schizophrenia. Women had fewer hospitalizations, shorter hospital stay and better social and occupational functioning. SCARF's data on women and schizophrenia were presented, including clear gendered outcomes relating to marriage. The social construction approach to gender analysis was applied to this data.

Different responses of men and women to medication were discussed. Several studies have reported that females with schizophrenia respond better to neuroleptics than men with schizophrenia, and do so at lower doses. Gender differences in body composition, weight and ratio of fat to total body water may affect absorption, distribution, bio-transformation and excretion of drugs. The effects of neuroleptics on the reproductive health of women, and other side effects as well as social effects of neuroleptics were discussed. The need to treat sex differences and gender related factors with respect to drug prescriptions was emphasised.

The presentation concluded with suggestions for planning gender sensitive mental health practice that looks at the illness in the context of overall gendered and social experience of the client. In India, women face greater adversity in relation to marriage, pregnancy and menopause, resulting in gender specific issues that one needs to keep in mind, in treating women with schizophrenia.

On alternatives in therapy

The role of counselling, psycho social support and community based activities were discussed. Even in severe mental illness, it is usually environment factors that trigger breakdowns. Cognitive remediation to correct deficits in memory and thought are activities to be undertaken. Various examples of non-medical interventions such as drawing 'Kolam' (Rangoli), grain sorting, chess, attention training, anger management, life and social skills training, working with family, expression through art forms like street plays etc. were provided. Severe mental illness should be looked upon like any other illness, as a part of life. Life does not stop because of the illness. Livelihood issues were discussed.

On capacity

Clients are sometimes unable to articulate and advocate for themselves due to the disability. It is then up to others around them to assist them in advocacy, instead of dismissing or ignoring them. For this robust advocacy and community mental health programmes are required. Having said that, there is also a need for respite facilities, especially for clients, who do not have their families staying in the cities. There is also a need for community structures alternative to family. People are able to function independently if we give them the space.

5. Social determinants in mental health

Bhargavi Davar & Sundari Ravindran

The participants prepared an analysis of depression based on applying the data on depression to the gender analysis tool discussed the previous day. A consolidated presentation is given below:

Relation to Problem of Depression	Are there sex differences in	How do biological differences between men and women influence their	How do different roles & activities of Men and Women affect their	How do gender norms/ values affect men & women	How do access and control of resources affect men & women
Vulnerability to Depression • Incidence • Prevalence	- Lifetime risk is greater for women than men. - Women are twice more likely to suffer from depression than men. - Domestic Violence is an important factor in women's depression. - Incidence of alcoholism is a relevant fact to explain male depression. - CMD (women) - Epidemio-logical studies show high incidence of depression among women.	- Gynecological morbidity, RTI, nutritional deficiency are all linked with depression & are higher among women. - Family History - Risk of depression is increased in the reproductive years (14 - 45) particularly during childbirth and in post partum period.	- Mother without child care support	- Gender discrimination - Vulnerability to domestic violence - having too many children without child care support - Fear of having girl child - Increased vulnerability of women	- Mother without child care support - disaster - displacement - separation and conflicts - Age - Disaster - Displacement
Social determinants			- Stressful life events- Chronic stress- Absence of confidence- Socialization- Relationship with parents	- Nutritional deficiency - Marital status - Marital discord/conflict - Isolation, desertion - Divorce, socialization - Gender discrimination has been cited as a major causative structural factor for the greater prevalence of depression among women. - Displacement - Recent studies in India from Mumbai, Tamil Nadu and Goa on postnatal depression and on mental morbidity associated with gynaecological morbidity have shown that actual incidents of MH problems is increasing in the community than reported.	- Nutritional deficiency and - Socio-economic status - Residence - Poverty - Social position and inequality - Poverty - Homelessness - Disaster
Health seeking behaviour	-Men are more likely to seek help for alcohol problems. -Women are more likely to seek help for emotional problems. -CMD (men) -Traditional healers			- Men are more likely to mask depression. - Women are more likely to be more vigilant towards emotional states.	- Poor access for women to information about services - Poor availability of services - Women seek relief from emotional problems by using traditional healing centers and by trying out various home remedies. - Traditional healing systems are very widespread in India and cater to mental health needs of women.

Relation to Problem of Depression	Are there sex differences in	How do biological differences between men and women influence their	How do different roles & activities of Men and Women affect their	How do gender norms/ values affect men & women	How do access and control of resources affect men & women
Ability to access health services	- Service settings are utilised more by men than by women.		- In India, services are not accepted by women, they seek help in common ways: – by presenting psychological problems as physical problems. – Medical problems such as anaemia, abdominal pain get psychiatrized due to poor availability of healthcare providers.		- Child care support- Service settings are utilised more by men than women.
Preventive and treatment options • Responses to treatment • Rehabilitation	-Women less motivated towards healthcare -More hospitalisations and medical crises -Women seek relief through traditional healing -Women less inclined to pay attention to health and overall well being				
Experience with health services and health providers	- Attitudes and perceptions of service providers towards women limit their services - Physicians more likely to diagnose depression in women rather than men despite similar symptoms - Gender different treatment by service providers - Medical problems such as anaemia, abdominal pain are psychiatrized due to poor availability of healthcare providers. - They may be given a range of drugs and tranquilizers or other invasive treatments in healthcare settings leading to over medicalisation.		- Deprived of scientific treatment - Gender is itself a structural factor. - Limiting the service available to women, because of attitudes and perceptions or service providers towards women mental health patients.		- Access to health services and information - Availability of health services - Western literature suggests that women are more vigilant of their emotional states and report at service settings more easily than men. - Traditional healing systems remain an area of doubt and are not integrated into mental health service system.
Outcome of health problems • Easy recovery • Disability • Death	- MDD is the first, major leading cause of years of life lived with disability in all ages among women - Rates of suicide are higher among men than women - Risk of medical crises, hospitalisation - The WHO report suggests that women with depression may feel less inclined to pay attention to their overall health and wellbeing; they may have less motivation to seek healthcare.	- Anaemia	- Anaemia	- Presenting psychological problems as physical problems- The mental health problems of women get needlessly medicalized through unnecessary medicines, surgeries, etc.	- They lack the motivation to continue healthcare and may not comply with their treatment, thus leading to greater number of hospitalization and medical crises.

Relation to Problem of Depression	Are there sex differences in	How do biological differences between men and women influence their	How do different roles & activities of Men and Women affect their	How do gender norms/ values affect men & women	How do access and control of resources affect men & women
Consequences -economic and social (including attitudinal)					Women who suffer from psychological difficulties or psychosocial stress may be perceived to be possessed by evil spirits or may enter altered states of consciousness to overcome/recover from the illness
Perception	- Self-neglect - Depression among men is masked, as they do not seek help until the suffering reaches a very high level	- Misreporting of illness	- Cognitive	Cognitive Stigma CMD, especially major depression among women remains a private suffering	
Linkages between health / mental health		PMS; PPD; Gynecological infections and morbidity; Outcome of pregnancy; RTI Sex of the child Chronic physical ill health may lead to depression Estrogen deficiency during post partum period may bring on depression			Nutritional deficiency, malnutrition is linked with depression particularly severe anemia, and deficiency of proteins and essential fats.

Discussion and Critique by Facilitators

The discussion emphasized, with examples such as child marriage, the need to negotiate cultural rights within the context of more universal human rights and women's rights. The need to deconstruct culture into laws, customs, morals and folk lore was discussed. The access to resources was seen as a psychosocial determinant by the group, which was an interesting finding. It was difficult to classify and categorize gender expectations, roles and norms, as these were felt to be subtle. The tool helped to make these notions concrete. The tool also helped to see that many factors of causation of depression could be looked at biologically, normatively, or psychosocially. The group placed an accent on gender norms and resources, in the context of psychosocial health. The discussion ended with acknowledging the possibilities of the tool and giving suggestions and examples of how it can lead to richer analysis, provided by the facilitator. How it can be used in order to develop heuristics in the mental health sector was also learning for the group.

Application of the Gender Analysis Tool

➲ The gender analysis tool enables users to understand the gender differences in a study or a set of studies. It helps in meta-analyses. It is an analysis synthesis tool. The tool allowed the generation of questions as well as high levels of abstraction and generalization, and complex analysis of the given data.

➲ It also helps to identify gaps in knowledge.

➲ To allow for richness in analysis it is best to repeat information in different cells. Information should not be treated as mutually exclusive and pertaining only to one level of analysis. By putting it wherever relevant, a complexity in analysis is built.

- Also, sets of facts should not be treated as one fact but deconstructed into smaller pieces and applied to the relevant cells. Details that are relevant to gender should not be left out.
- Gender is never an isolated factor and it is important to relate it not just to health but also to factors such as poverty, labor, work, nutrition etc. Factors can be added to the vertical axis if required.
- The gender analysis tool can be used in community research work. If we go by this tool, we will be asking the right questions with regard to gender. The tool also finds its use in generating research questions if gender is included as one of the variables.
- The tool can be used to do a statistical analysis. It is both qualitative and quantitative in that sense. Its utility is most seen when identifying gaps in information related to gender.
- If we remove gender and replace it with any other concept of vulnerability associated with marginal groups like caste the tool can still be used. All categories of hierarchy or subordination can be put in the tool
- It can also be used to inform policy, if data is organized in a comprehensive manner.

Following this discussion, reading material for group work for the next day was distributed. Participants were to look at the given evidence and put it up on charts to discuss gender barriers in Reproductive Health Care.

6. Value Clarification in the Mental Health sector

Bhargavi Davar

The fourth module was introduced as it was thought important to do this exercise before taking the course forward. In this module on Values Clarification, learning objectives were that participants will be able to:

- Articulate value related issues in mental health
- Negotiate values between different stakeholders in the mental health sector
- Articulate ethical issues in the mental health sector

The concept of values was discussed, along with their meaning, application and properties. The group was asked to enlist some values and the following was generated. A gender analysis of values was discussed and how values work in the lives of women was determined through this exercise, with examples. Values are the governing principles of our lives. These are not mutually exclusive. Some values may translate into different behaviours or norms for men and women.

Men	Women	Both
Hard work/ industry	Forgiveness	Respect
Freedom/ autonomy	Honour	Truth
Honour	Dignity	Honesty
Friendship	Loyalty	Diversity
Justice	Faith	Democracy
	Love	Empathy
	Acceptance	Openness
	Patience	Kindness
	Help/ compassion	Sincerity

- It was established that it is not always possible to quantify values.
- Values are contextual. In some situations we apply them but in other similar ones we may not.

- Their application depends on resource availability.
- They originate from our preferences.
- Values are negotiated – no value is complied with by everyone and at all times.
- Values are always weighed in balance.
- Prioritisation of values – some are dearer than others.
- In conflicting situations we prefer one value over another.
- We establish our values against real or likely harm.

The discussion focussed on the idea that values are intrinsic to human decisions. Also, in the social development sector, we do not deconstruct our own values. We take them for granted. The group was pushed to recognise the limits of their own preferred values. This exercise was a prelude to a role play exercise to clarify how values are applied, negotiated and influence decision-making in a mental health setting, with multiple stakeholders. A negotiation role play was conducted to establish the diversity and negotiability of values.

Participants were divided into four groups and given different role briefs. Group 1 was the patient group, group 2, the carer (or case) group, group 3, the activist/ social worker group and group 4, the psychiatrist group. Each group has values about and versions of a "case" from the point of view of their respective communities.

The case

The "case" (or the main protagonist in the story whose problem you will resolve) is a 55-year old woman, caring for a 64 year old man, who she says is suffering from a psychotic illness. The "case" has asked for a joint meeting with all concerned parties mentioned above to resolve her issues. You have to prepare for a full meeting with all concerned people.

After strategizing, negotiations were set up in a common room. Each negotiation had a representative from each of the stakeholder groups. In each negotiation meeting, the "case" had to be resolved.

Each stakeholder group discussed their approach and strategies for the situations given to them with their peers. Each group had to assess their allies and their opponents, and decide upon their own negotiables and non-negotiables. They would role-play with members from the other stakeholder groups. The group that eventually came together for the role-play had no interaction with the other members in the role play.

Debrief of Role Pay, Sharing and Discussion

The case study involved making some "simple" treatment decisions. However, only one group had a resolution. The group resolved to send the patient to a half way home.

Psychiatrists

Most felt that the psychiatrists were not sympathetic or fully understood the problem. In one case, the psychiatrist had prescribed depression medication to the (carer) woman whose husband (patient) was abusive and violent. While the psychiatrist had tried to resolve the situation by assuring the carer that the patient would also be put on medication, this was not acceptable to the carer.

The psychiatrist in the group who had reached a resolution said that it was because she understood the right to health care, personal identity came in the way and she could not be an unsympathetic doctor, and from her point of view she did what she thought would help. In the role-play institutionalisation as an option was given and agreed upon. The right to liberty versus the right to health care was discussed.

Activists

The activists felt that they were trying to be neutral and also to give space for the rights of the patient and

the carer. The activists also felt that negotiating was at all levels, with the psychiatrist, the carer and the patient and when resolution was being sought quickly it was difficult to pack the perspectives of each of these together. Also there was a constant pressure to dissipate a situation of conflict and try and get something positive out of it.

There was a dilemma between the patients' care and the safety of the carer. It was felt that the activist should have played a greater role in the case of a patient who was 67 years old and tried to resolve it at home instead of sending him to a half way home. There are two reasons for this. Firstly half way homes are few and usually too full and secondly, the patient was quite old (67 years). Adaptation to another environment would be difficult considering his age and mental state.

Carers

Carers felt that they were in a mess and needed help. They were also clear that they did not want any more violence from the patient even if it meant legal separation. Their safety and the end to the violence they were facing was a priority to them. They needed protection and they felt good to receive support from the others on the issue.

Patients

They felt they were not being understood. They felt some amount of betrayal by their carers who had put them in this situation. They were looking for acceptance and support from their carers and felt that her assertion may not get a good outcome for them. In one of the cases where the patient was physically abusing his wife, he felt that he would not get support from the activist but it was relieving to find her giving him some support as he really was attempting to change. There was also a fear that there may be legal separation from their wives, which was not acceptable to any of them.

Values that were at play in the negotiations including safety/protection, wellness, love, rights/justice, trust, participation/ process, and honour, were put up for further discussion and clarity. The choice of institutionalisation was discussed from a value perspective. The facilitator emphasised that decisions are made about patients like the ones in the role-play every hour and minute by the community and care givers in the mental health sector. As the role play had shown clearly, these decisions were difficult to make. In situations like these it is important to be conscious about the values at stake for each party.

29th January 2006, Day 3, Morning- Debriefing

In the role-play exercise, a rule established was that there should be no communication between the stake holder groups (patient, carer, activist and psychiatrist). Dialogue was allowed only between peers: This is the way it happens in reality as well. Communication between communities and forums is negligible and the facilitator was playing the role of the state when she insisted that actors not to talk across group but only with their own. The state has set up many barriers for inter group communications and dialogues. However, these dialogues are very important. It becomes very difficult for values to be applied because of the way the state has prepared and organised the different stakeholder groups. This is a structural issue.

The other observation was that when resolution was being sought it was mostly institutional. This makes it difficult for the values of freedom and liberty to come into play in spite of it being a fundamentally granted right. We can be aware of values but in practice the issues are very complex and we need to demonstrate the application of values in these situations. The idea of self-determination on the one hand and forced treatment on the other were constantly surfacing in every group, including the one that managed to reach a resolution about institutionalising the patient. The issue of institutionalisation is also structural. The script had nowhere stated that the group could not look for alternatives. However this freedom was never utilised by any group and the conventional answers of institutionalisation were proposed. Yet everyone believes in those values. When we try and juxtapose facts in the domain of values, we need creative application tools, which may not exist today. It is only then that there will not be such a chasm between ideology and practice in the sector. There are no ready-made solutions. We have to create them.

7. Reproductive Health, Sexual Health and Mental Health

Objectives of Module 2

- To understand the ways in which gender influences RSH
- To identify the mental health aspects of RSH and learn the evidence base on RSH / MH linkages
- To understand the mental health impact of violence
- To be able to work with gender concepts in the area of sexual health and mental health
- To understand the linkages as well as the process of developing a program in the area of violence and mental health

The previous day's learnings were shared by the group. A few participants felt that some inputs into the course had been very medically oriented. This led to a discussion of the role of medicine and having a medical health orientation in mental health. The need to understand, assimilate and process medical information was emphasised. This exercise helps to question and counter the narrowness of the medical perspective. Also, among the aspects influencing health, medicine was one. For example, in the case of malnutrition, it is accepted that other than the socio-economic conditions, there is a biological and medial basis which needs to be addressed and treated with good quality medical care. The need to develop an integrated health care discipline, including medicine, in mental health was emphasised. The social model of mental health, while subverting existing medical paradigm, does not negate it *in toto*.

7.1 Reproductive Health as a Gender Issue

Sundari Ravindran

This session sought to clarify concepts of reproductive and sexual health. The evolution of the concept was examined along with its history.

Is reproductive health a gender issue? Group responses

- The feminist movement started to question the choices of contraception, reproduction, control over the body, etc. Who made these decisions became an important question to ask.
- It was in response to the lack of attention paid to women in population policies. The emphasis was on population control in under-developed countries.
- The right of women over their bodies and their control over reproduction. Their choice to have or not have children – the issue of abortion.
- The burden of work balanced against the duties of reproduction
- A change in women's politics: the values of equity, freedom for women etc. started being recognised.
- Improved educational standard, leading to higher level of expectations: Though education cannot be seen in isolation, there are several other factors that influenced it.

Sundari Ravindran made a presentation of the history and the evolution of concepts of sexual and reproductive rights and health, within the women's movement. The ICPD definition of RH, "Reproductive health is a state of complete physical, mental and social well-being, not merely the absence of disease … in matters relating to the reproductive system…", was inclusive and gave much interpretive scope. The Life Cycle approach looks at reproductive health as part of a continuum in the life span of an individual. The term "Reproductive Rights" was voted by 600-700 women in the fourth IWHM meeting in 1984 and encompassed the right to decision making with regard to reproduction, which would include a voluntary choice in marriage and family formation, deciding number, spacing, timing of children, and the information and means to do so along with access to safe contraception. Sexual and reproductive security and safety in

childbirth and from infections, sexual coercion and violence are also a part of reproductive rights. The political process of this achievement was described.

How the women's movement processed the data on maternal mortality and morbidity was also described in the presentation. The need to develop notions of sexuality and sexual health, separate from reproductive health, was presented. Sexual health encompassed sexual well being, freedom from infections (STIs, HIV), violence and coercion, impact of chronic illnesses and physical disabilities on sexual functioning, and sexual / mental well being among others.

Reproductive Rights: Evolution of the Concept

1830: Right to decision-making regarding childbearing was raised by Owenite Socialist women.

1908: Alexandra Kollantai in her 'Social bases of the Woman Question' claimed not only women's right to fulfilling work but also their right to sexual freedom and control over their own fertility.

1915: Emma Goldman and Margaret Sanger defied obscenity laws in the US by distributing pamphlets on birth control, initiating the US 'birth control' movement.

1918 onwards: In England, women workers organisations supported the development of a 'birth control' movement under the leadership of women's suffrage groups, because of concern over high rates of maternal mortality and to free women from the bondage of unwanted pregnancies.

1960s and 1970s: New wave feminist movement in the West: Right to abortion, violence against women, medicalization of women's bodies, are major issues of concern.

1980s: Women's health movement becomes truly international, drawing feminist groups from developing countries, chiefly Latin America and Asia. 'No to population control, women decide!' becomes an important campaign message alongside right to abortion and contraception.

1984: The term 'Reproductive Rights' coined in the fourth IWHM held in Amsterdam, and 'Women's Global Network for Reproductive Rights' formed to reflect the changing agenda and priorities of the movement.

1987 - 1993: A dynamic women's movement supported by a favourable political climate succeeds in putting in place women's health policies, in Brazil, Columbia and Australia. Several meetings held in WHO specifically for women's health advocates to meet with scientists for dialogue on contraceptive research and safe motherhood.

1990-1994: A part of the women's movement engaged in 'dialogue' with the establishment. They lobbied with international donor organisations, technical and professional organisations to expand the MCH / FP agenda. They systematically strategized to introduce the Reproductive rights and health language in the ICPD.

1994: ICPD adopts the language of reproductive rights and reproductive health, due to a very specific configuration and alignment of political forces and Vatican's extremist position.

The negotiations with the Indian government and the World Bank, in the post-ICPD era were presented. Because of the World Bank involvement, some women's groups in India withdrew from the negotiations, even though the acceptance of the agenda of RH was because of the pressure exerted by the women's movement. The needs and gaps in RH research and services were highlighted against the robust notion of RH developed at the ICPD. The presentation highlighted the fact that reproductive health was at the core of gender equality. The presentation concluded by discussing the position and mixed response of the women's movement in the country to RH agendas.

Discussion

The reason for resistance to Reproductive health was discussed. It is mainly due to the politics of control over women's reproduction. Acceptance of reproductive health rights would mean forgoing the power that men have over women's reproduction as a product of patriarchal values. There is also a resistance to allow women to enjoy their sexuality. Homosexuality, extra-marital sexuality, adolescent reproductive health etc., are constructs that are away from the acceptable mainstream position on sexuality. Further, in countries that are still struggling with issues of basic health care provision, privatisation of health care, pressures of drug companies, irrational drug dispensation, addressing sexuality and reproductive health become difficult and complex. The stand of different countries on reproductive health in recent times was discussed. An interesting case in point was an initiative called "Women on Waves" (WOW) where women took boats and docked on international waters by countries that did not allow abortion and performed them on the boat for women from these countries.

Population control has taken on the function of controlling women's reproductive rights and often endangering their health. The role of new technology in the control of women's bodies and the phasing out of traditional methods were discussed. International politics of dumping intrusive contraception methods on developing countries to control their population has a large role to play in this.

The issue of sex within marriage, the degree of control or choice that women have over their sexual lives, and the use of contraception, were also discussed. While a 'rights' language prevails within the women's movement, the burden of having children as well as avoiding bearing children is borne by women. A universal rights language does not situate itself within the complexity of day to day women's sexual and reproductive lives. A responsible intervention creates an environment where she can actually decide and choose as a right, and not because of coercion of any kind. Vigilance over our own interventions need to be kept up relentlessly, so that our empowerment initiatives remain grounded in women's lives. When we speak of women and mental health, similar issues of control as well as the lack of it, presents itself before us. While on the one hand feminist dissenters have treated mental illness as a myth, on the other, we have to recognise the need of women wanting and needing mental health care. Their needs and rights have to be recognised.

7.2 Reproductive health and mental health

The discussion was followed by presentations by groups on "Looking Back, Looking forward" – A Profile of Sexual and Reproductive Health in India prepared by Population Council, New Delhi (January 2004). A reading guide given to groups helped them to organise their presentations. A critical reading of materials from the point of view of treating research data through a gender lens was encouraged. Each group presented data from their readings, and critically discussed it.

7.2a Group 1 - REPRODUCTIVE TRACT AND SEXUALLY TRANSMITTED INFECTIONS

The paper offered the following data and perspectives, summarised briefly.

(I) PREVALENCE?

- In 2002, 3.82 - 4.58 million adults are estimated to be living with HIV. 57,781 people have been diagnosed with AIDS as of Nov. 2003. 83% of the spread is by sexual transmission (both heterosexual and homosexual) and 3% by infection trough injections, drugs use, infected blood transfusion and mother to child transmission.
- Number of cases of women infected within marriage is increasing. This is evident through antenatal clinic testing.
- Endogenous and iatrogenic infections contribute significantly to high prevalence of RTIs among women.

(II) RISK FACTORS FOR HIV, RTI, STI TRANSMISSION

- Sexual activity of men seeking premarital and extramarital sexual relations have led to widespread and sustained endemic of STI's.
- Sex workers are a core group for transmission due to multiple partners, early initiation into commercial sex, expose to multiple STI, non use or limited use of condoms and delayed and faulty treatment.
- Clients of sex workers form a bridge population spreading infection from core group to the general population which includes – male below 25 years (2 in 5 – ever married, more than one in two currently married living with spouse), truck drivers - 80%, drug users and men who have sex with men (MSM). Low risk population included adolescents other than 10% girls and 15-30% boys who experienced premarital sex.
- Limited use of condoms by married couples i.e 3% and that to mainly for contraception. Vast majority of school going, colleges going adolescents engage in unprotected sex. 50-80 men never used condoms during non marital encounters.
- Iatrogenic causes of infection, including use of intrauterine devices are reported to have significant risk of pelvic inflammatory diseases.
- There is limited / no knowledge / awareness of mode of transmission or means of prevention among rural people. Incorrect knowledge and misconception are major barrier to consistent condom use.
- Women being socially, economically and culturally dependent on their partners find it difficult to make decisions of having safe sex within and outside marriage due to lack of communication and negotiation which make then vulnerable to STIs.
- Dominant masculine ideologies prevent boys and get men to seek information for fear of appearing ignorant and unmanly and try out experiencing sex with girl friends and sex workers.

(III) HEALTH SEEKING BEHAVIOR:

- Pattern of treatment seeking is wide. Significant proportion of symptomatic men and women do not seek treatment. Women seek when they are too weak to work. Men suffer in silence or resort to self treatment by consulting someone.
- Quality of service provided is adequate to meet the challenges. Recommended care management guidelines are not found in diagnosis, quality of counseling is inadequate in both private and public sector. Majority of men seek care from informal providers for reason of secrecy, absence of physical examination or follow up. Intimidating and judgmental attitude of service provider prevent many from seeking care from formal heath service providers.
- Access to services: 1/6th of PHC provide RTI, STI services as most of them lack trained staff.
- High cost of seeking care could be a major obstacle to seek treatment for both men and women

(IV) PROGRAM RESPONSES

- HIV surveillance includes a total of 34 sites in which 165 – STD Clinics; 200- Antenatal clinics; 14 Injecting drug users sites; 3 MSM sites; 2 Sex Worker sites are included
- STI care management is done by syndromal management focusing on counseling, condom promotion, treatment of STIs and behavior change communication
- Voluntary counseling training center facilitate HIV test with counseling facility
- Care and support for people living with HIV/AIDS by collaboration of NACO, WHO and local NGO conducts pilot study to provides care and support to HIV + patients

Suggested interventions

Current understanding of RH behavior and STIs is limited to a select high risk group

Programmatic responses: narrow focus on selected population, ineffective documentation & evaluation

Further exploration of how endogenous factors e.g. antibiotic over use, poor nutritional status influence RH & STIs

Build association between invasive trans-cervical procedures and transmission of RTIs

Highlight pathways through which prevailing norms predispose men & women to engage in high-risk practices-or adopt protective behaviors

More research is needed to understand people's perception of dual protection- across all population groups- help promote use of contraceptives.

Design holistic programs for improving women's reproductive health.

With a view of obtaining real results, there is a need to standardize laboratory methods

Further exploration as to how gender integrally increases women's vulnerability to STIs (e.g. access to information)

REPRODUCTIVE HEALTH SEXUALLY TRANSMITTED INFECTIONS

ADDRESSAL

Important information can be elicited by systematic research in the pattern of health seeking for RH/STI symptoms, the socio-cultural and system level constraints faced by males & females in acquiring services

Appreciate and build linkages between the influence of monetary, geographical, gender-based relations and perceptions on the quality of care.

Inclusion of non-brothel based sex workers migrants as study samples

In addition to syndromal management of RTIs & STIs, importance should also be given to assess clinical, cost and operational effectiveness

Strengthen infrastructure, ensure availability of trained manpower, delivery of high quality human services.

Current understanding of RH behavior and STIs is limited to a select high risk group

Design critical interventions, adopt a continuum approach, more focus on care and support

SEXUAL & REPRODUCTIVE HEALTH OF YOUNG PEOPLE

CONTEXT:

- Illiteracy (Higher in women)
- Economically active group

ONSET OF SEXUAL RELATIONS:

- For women–within marriage
- For men pre–marital

RISK IN SEXUAL RELATIONS:

- Lack of awareness about safe sex practices (higher in women)
- Forced sexual relations (on boys by adult men, on married & unmarried women)
- Multiple & casual partners (for men)

REPRODUCTIVE HEALTH OUTCOMES

- Pregnancy & childbearing – Adverse health of women (anemia, morality, pregnancy complication)
- Induced abortions– Large % among married & unmarried adolescents

- Reproductive tract & sexually transmitted infections

  Transmission due to husband's behavior

  Gender discrepancy in awareness abut STI & RTI (HIV)

RISK & PROTECTIVIVE FACTORS

- Awareness programs in schools don't focus on broad sexuality issues
- Mass media is most cited source of information
- Lack of communication & support from parents & gate-keeping attitude of parents is hindrance
- Gender & power imbalance in marital/pre-marital relations

  Pressure on young brides to prove fertility
- Pressure on young men to prove their masculinity
- Empowering intervention for girls have positive outcomes

Issues and Suggested Interventions

Education on sexual health remains irrelevant to young people

Take into account young people's own perceptions & priorities with regard to appropriate and acceptable delivery mechanisms for SH & RH services

Keep in mind that young people face the impact of a changing social environment. Balance technology vs fundamentalism, and there is a questioning of traditional norms & values.

Accept young people's needs & lives in an acceptable and non threatening manner. Involve them in program design, implementation monitoring and evaluation.

Help parents understand that rather than imposing close supervision & controls on young people, focus should be on enhancing informed choice

Youth's RH & SH vulnerability is exacerbated through contextual factors- poverty, gender imbalance, lack of education and livelihood experiences.

Services remain inaccessible unacceptable and unaffordable

Intervention programs can focus on transition to safe- sex life

More focus on manifold needs of marred adolescents

Important to eliminate gender double standards, imbalances

Young People's Sexual & Reproductive Health

ADDRESSAL

Disseminate information which helps overcome discomfort and helps enhances knowledge

There is a need to involve parents, teachers, religious and community leaders for effective dissemination of info.

Process oriented drawback – programs remain poorly tested, little is known about feasibility acceptability, effectiveness and replicability. Future programs can be directed accordingly

More research needs to be done on the formations and conduct of sexual relationships. This will help understand sexual dynamics of young people.

Sensitively explore the levels, patterns, nature and extent of sexual coercion and violence & its influence on RH & SH

Think why? Why needs are unmet / why informed choice continues to elude them

Throw light on factors that focus on abortion behavior, decision making etc.

In addition to syndromal management of RTIs & STIs, importance should also be given to assess clinical, cost and operational effectiveness

Design critical interventions, adopt a continuum approach, more focus on care and support

7.2 b GROUP 2 - INDUCED ABORTION

BENEFITS - Safe & effective - No extra infrastructure required - Non-invasive - No hospitalization - gives independence, control and privacy to women	Two types of Abortions 1. **MEDICAL** - Approved in 2002 - Used for early abortion (upto 49 days from last period) - Oral drugs used
DRAWBACKS - Can be misused - Over the counter medicines - Unsupervised - Impact on declining sex ratio	2. **SEX-SELECTIVE** Used to limit family size For desired sex combination of children Alternative to female infanticide No. of such abortions has increased
PREVALENCE - In all socio-economic groups - Varies between 3-17% - Higher in women who already have one or more daughters - Lower in women who have no sons or no children - Found as high as 40% in facility based study	**MAGNITUDE** Official figures - .6 million Indirect estimates – 6.7 million

OUTCOMES

MORTALITY MORBIDITY
9% maternal
deaths in 1998
57% Rural women
46% Urban women
15000-20000 annual deaths

Morbidity includes:
- Menstrual Irregularities
- Backaches
- Excessive bleeding
- Pelvic inflammation
- Secondary infertility
- Risk of future ectopic pregnancy

REASONS FOR ABORTION
- To limit family size
- To space children
- Risk to women's health
- Problems with foetus
- Contraceptive failure 5%
- Unwanted pregnancy 6%

PROFILE OF ABORTION SEEKERS
Majority – 20-29 yrs
1-10% - adolescents
33% - adolescents

Registration of MTP centers shifted to district level from state

Changes since 1990s
- New legislation
- New techniques (to ensure safety of women)
- Yet 6 million performed in unauthorized centres

- MTP act of 1972
- Act amended in 2002
- Reproductive and child health programme 1997
- National population policy
- PNDT act of 1994 amended
  - Pre conception banned
  - Pre implantation banned
  - Written records compulsory
  - Legal enforcement

FACTORS UNDERLYING PERSISTENCE OF UNSAFE ABORTIONS

LACK OF AWARENESS ABOUT THE MTP ACT

- 4 out of 5 men and 1 out of 2 women believed that it is illegal
- 9% women know about period under which it is legally permitted
- No awareness about registered facilities
- Misconception of abortion services leading to delay in seeking authorised services

LIMITED ACCESS TO SERVICES:

Although there is increase in facilities

- Some clauses lead to restriction on availability and access
- Stringent criteria for approval of registered facilities restrict expansion
- Decentralization of authority for approval of MTP centers may improve availability
- Lack of trained providers and equipments
- Limited number of PHCs have abortion facility

POOR QUALITY OF SERVICES

- Poorly trained or untrained providers
- Few PHCs have MOs trained in MTP procedure
- Lack of sufficient practical experience in training centers- do not feel competent to do the procedure
- Teaching hospitals prefer other methods than the manual vacuum option
- Due to attitude of providers women seek informal sector providers
- Providers disregard need of respect the privacy and confidentiality
- Women refuse to go to the PHC as they link PHC with sterilisation
- Providers insist that the husbands consent though law does not mandate it
- 40% provider refuse services to unmarried and separated young women in 24% legally recognized MTP centres
- Low priority for post and pre abortion services
- Not informed about risk, complications, follow up treatment, post abortion contraception to prevent repeat abortion
- Only half the women were informed about a possibility of infection
- Follow up care in selected cases only

COST OF SERVICES

- Women were willing to pay for their needs
- Financial burden of abortion services is substantial
- Economic constraints may compel women to seek services from the unauthorised sector
- Women incur hidden cost (medicines, illegal fees to staff) from the free public sector facilities

INFERTILITY

1- Levels of patterns:

- Primary 3%, secondary 8%
- Range 3.8 – 6%

2- Causes of Infertility:

- Women: Tubal Factor (30%), ovulation (22%)
- Men : Accessory gland infection (8.8%)

Causes reported in Asian countries:

- Women: Unsafe abortions, STIs, PID
- Men: STIs

3- Socio cultural context and consequences:

- Women: Stigma, isolation, threatens identity, status and economic security
- Anxiety – Low self esteem, sense of powerlessness
- Social strains, relationships, divorce, abandonment, loss of social and economic security
- Victims of violence, abuse and social exclusion

4- Treatment seeking behavior:

- Complex- including traditional, religious practices, allopathy and other ISM practices
- Time- waiting period 1-4 years
- Delay in help seeking, fear of final diagnosis, emotional stress, physical, discomfort of the test, admitting failure
- Duration- 24- 30 years

5- Barriers:

- stigmatizing beliefs limited mail participation cost, indifferent quality of care, lack of services in public sector.

6- Factors influencing treatment seeking:

- socio-economic decision making within the family
- level of information, accessibility of treatment
- high cost leading to discontinuation / unqualified practitioners
- traditional approaches inhibit modern treatment

7- Role of public health system:

- absence of effective treatment
- little co-ordination between- gynecologists, infertility specialists, surgeons, lab technicians promotes private sector (Varying quality and cost)

8- Seeking ARTs:

- last resort
- demand for artificial insemination (Sex selective)
- hope to couples to bear biological child
- non availability in the public sector, expensive, exploitative and exacerbate women's vulnerability in private sector

9- Intervention needed

- information on ARTs
- selection of doctor

10- Concern of present ARTs:

- quality of care- Services not regulated
  - : Quality treatment is variable
  - : Repeated use of technology
  - : Women endure many cycles of testing/ experimenting/treatment
- ARTs like IVF are physiologically, emotionally, financially stressful
- Success rate: Unclear-ICMR (20-30% per IVF cycle) leading clinics (30-40%)
- Misuse of technology: Inadequate monitoring and regulation – IVF related sex selective unethical practices

GOVERNMENT POLICY ON INFERTILITY

- National guidelines for regulation of ARTs clinics is being drafted by ICMR
- Preventive programmes:
  1- Services on larger reproductive, child packages
  2- Analysis/ evaluation based policy
  3- Couple counseling
  4- Diagnosis and treatment training
  5- Infrastructure and awareness regarding technology
  6- Women's rights

7.2c GROUP 3 - Contraceptive use and dynamics

Contraceptive scenario

Method mix

- Cafeteria approach skewed towards female sterilization

- Sterilization is the most common method
- Spacing method like oral contraceptives and IUD used more often
- Traditional methods- 10%
- Direct evidence on the use of new male methods is scarce
- 21% are using male or couple dependent contraceptive measures (higher in Delhi, Punjab and West Bengal)

Contraceptive discontinuation and switching

- Younger woman (15-24 yrs) are more likely to discontinue contraceptives than older woman
- Contraceptive discontinuation, higher in northern and north eastern states
- Higher discontinuation for oral contraceptive pills and condoms than IUDs
- Discontinuation of contraceptives more common in rural than urban areas

Unmet need for contraception

- Emphasis on sterilization and the neglect of people who want to delay and space pregnancy
- Young couples despite community norms prefer delaying first birth until they have more time to get to know each other

Barriers to meeting contraceptive needs

Limited knowledge

- Awareness of reversible methods is limited
- Only 71% of married women are aware of condoms
- Young women were even less aware of specific reversible method suitable for them
- According to various studies, inadequate knowledge of contraceptive methods, incomplete information about where to obtain methods and how to use them are the main reasons for not accepting family planning

Gender inequalities and limited male involvement

- Studies show the importance of the role of husband in decision making related to the use of contraception, especially during early years of marriage
- Most couples do not discuss when to have their first child, birth spacing and contraception
- Nationally less than 1 in 5 married women report discussing family planning
- Most men approve of contraception only after having the second or third child
- The role of men is not defined in the government programs
- Male health workers could play an important role, but 2/3rd of PHCs do not have male health workers

Limited access and availability of services

- Several studies reveal shortcomings in the frequency and regularity of outreach services
- Outreach services non-existent in remote or tribal areas
- Health workers at the community level were looked upon with distrust and identified as interested in only recruiting cases for family planning
- Post partum checkups are almost non-existent and family planning being given lowest priority in post partum care
- Review of RCH program reveals that training focuses on technical aspects of service delivery giving little importance to client needs and quality of services

Limited informed choice

- Those relying on the public sector do not have access to a wide choice of contraceptives
- (76%) rely on the public sector
- Providers have a bias towards sterilization and only a minority is informed about reversible methods
- Incomplete pre-acceptance counseling, no information on side effects etc.
- If provided detailed information on contraceptive methods, women do make informed choices overriding the providers' bias

Poor quality services

- Service providers are insensitive and disregard women's need of privacy

- Pre acceptance counseling or check-ups are limited
- Little attention given to post-acceptance follow up services

MATERNAL HEALTH AND PREGNANCY RELATED CARE

Mortality (Causes)

- Hemorrhages, sepsis, obstructed labour, toxemia, unsafe abortion, increased proportion of cesarean deliveries
- Neo-natal infections (sepsis, meningitis), birth asphyxia, trauma, and low birth weight

Morbidity

- Severe anemia, malnutrition
- Depression, gender disparity in feeding practices, presence of HIV
- Prolapse, fistulae
- Maternal and neo natal mortality are influenced by poverty, access to health care and overall levels of development

Pregnancy related care

Care during pregnancy

- 2 in 3 pregnancies, women availed anti natal checkup
- 35% recently delivered, did not receive ante natal care
- Women receiving no ante natal care, more likely to die than women who received

Skilled attendance at delivery

- It is the single most effective measure required to reduce maternal mortality
- Close co-ordination required between ANC and skilled attendance at delivery
- Post partum care
- NFHS- women whose non-institutional deliveries were attended by doctor, nurse, mid-wife more likely to obtain post partum care
- Unlikely to seek care unless morbidity perceived as life threatening

Unsafe abortions practices

- Government facilities are inadequate and skewed towards urban areas

Care of new born

- 30% neo-natal deaths are a result of injuries during deliveries
- 54% of neo-natals require care, but only 3% received

Individual and community level obstacles underlying pregnancy related care

Lack of awareness of good pregnancy related practices

- Women preferred delivery at home without trained attendance despite availability of government run private and NGO run hospitals
- Use of pregnancy related services are considered unnecessary
- Danger signals are poorly understood
- 44% experienced bleeding and also recognized it as a danger signal

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- Women's illness is low on family priorities
- Pregnancy related health care is frequently delayed
- 81% require permission from family members to avail of delivery care
- Enormity of women's powerlessness demonstrated by a finding that women who delivered in parental home were less likely to die than in husbands' home

Role of men in maternity care

- Men traditionally are uninformed about pregnancy related needs yet remain powerful decision makers
- Men are interested and do want to be more involved but have been neglected in pregnancy related matters

8. Reproductive, Sexual Health and Mental Health

This study session was followed by three role plays, to help the group make their own linkages between reproductive health, sexuality and mental health. The role plays were experiential. Debriefing involved intense group work, focussing on the participants' internal states, while role playing.

8.a Role Play 1

Script

For two years after marriage I did not get pregnant. My mother-in-law started talking ill of me. Then my mother took me for a check-up and the doctor said I was too weak. He gave me tonic and all. All the expenses my mother bore, not my husband. After this one male child was born. My mother gave a gold chain, waist rope and ring for the baby, she had to take loans for this. Even after this, there was no smile on my mother-in-law's face.

When this baby was one year old, he had measles and died. Everyone blamed me, said I must have been 'polluted' (sex?). Three months after this I was pregnant again, but miscarried and was very sick, with heavy bleeding and fever and white discharge. My mother had to come and take me to the doctor. Even though my husband was my uncle, he did not care. Again just about three months after this miscarriage I was pregnant again. Home delivery, everything was ok. Boy. When he was 4 ½ years old he developed brain fever and died. I was so heart broken. After this I have had two sons and a daughter.

Never discussed birth control between ourselves (with husband). After second son I told my mother that I'll have operation, she said wait, you have lost 2 children before. So didn't. Now I have a small baby girl, no one to help even hold the baby. I sit and somehow moving on my seat, manage to do the cooking and basic household tasks. I cannot manage another pregnancy, but have not talked about operation with my husband yet. I don't know what to do.

Daughter

I feel like crying and it is difficult to speak, I feel worried. I have lost two children. There is not one to talk to except my mother in law. Then I feel I am giving her also "*takleef*". My husband has never spoken with me. I cannot communicate with him. I feel helpless. I have aches and pains, I feel overworked and tired and no one listens to me, that makes me feel worse. My mother pushes me to my in laws and vice versa. I am confused and *kuch samajh mein nahin aata*. Domestic Violence from my mother in law and husband is common. What is there to say about it – she does a lot of *chid chid*. That is her nature. My husband also has a lot of tension and they are older than me. I have accepted my fate (submission)[1]. Everyone is correct in their own place. There is nothing wrong. I can't understand why I am not happy. Who will I feel angry with, my MIL will kill me if I say anything. (fear of reprimand) I have no hope, I think I will die this way. (thoughts of dying). (No hope, no possibility of change; helplessness). I feel afraid I will become pregnant again (fear of pregnancy).

Mother

I can feel the pain of my daughter, but I can't do anything, she has to negotiate with her husband and MIL. They feel I bhadkao her.

Son

She is doing natak. Her *chid chid* has increased over time. (Anger). I can't help it, I get angry. She should understand that I am over worked but again and again she comes to disturb me.

Mother in law

Its all *natak*. Its nothing new, she has eaten two children already. How will our *khandaan* go forward. It is all because of her (blaming), she should bring love to my son's life instead she is always complaining.

8.b Role Play 2

Script

I am now 48 years old, both my daughters are married.

I have never even been allowed to sit when he (her husband) is anywhere in the house. If he finds me sitting, he would hit me, saying how dare you be sitting on your ass. He often denies me food, I cannot talk to anyone at all, and not step out of the house unless he takes me[1]. Very rarely.

When I had my third baby, he forced sexual intercourse within two days after delivery. I was so weak, I became unconscious even while he was having me. I became unwell, I was literally starving, I could not feed my baby. The baby girl died for lack of anyone to take care of her. I have lived all my life with this man, under these circumstances. I am now going through menopause and have become even more unwanted. Like a worm he treats me. I am not even useful to him for sex. I have also had a lot of bleeding and pain in the lower abdomen.

Husband

She is so stupid, I have to hit her, that is why the house is in my control. I am clear about women's rights, but how I communicate in my house is not anyone's business. I am a vice president of my company and it has a lot of benefits. If she has a medical problem, she should utilise the medical benefit that she is getting through me. This hitting is a normal part of life. Its okay, she never said anything. In fact I think, she enjoys it, just complains sometimes. I get angry and sometimes I raise my hand (anger).

Wife

I am so used to getting beaten up. I am still fearful of him (fear). I am scared of his voice also. Even when he calls me I get afraid. I am always tired and fatigued. He screams so much. I feel lonely. My heartbeat quickens. Once I have fainted also when he forced himself on me two days after delivery. Since then I am even more afraid. I feel angry but, I am very weak. I don't sleep, I don't feel hungry (loss of sleep, appetite). At least earlier he used to come close to me even for forced sex or beating, now that is also not there (isolated, no intimacy).

Friend

She has everything – house, no financial problems. I want to help her but I can't. If she agrees and is willing to do it then she can be helped but she is so afraid. She has to accept to seek help, then something can be done.

[1] *The comments in brackets are mental health issues highlighted from the narration of the actors in the role-play*

8.c Role Play 3

Script

I knew I was different when I was 14 years old. I always was attracted to other men. I could not relate to women at all. My father used to hit me when he found out about this.

Now I am married. They forced me into a marriage. My wife is not a bad person. She has the usual expectations from me. She also wants a baby. Our families put a lot of pressure on us. I am not able to show any interest in having sexual relationship with her. I am not interested in my marriage at all. I have not told her about the fact that I have another intimate relationship with a man, which is more satisfying for me. This has caused a lot of friction at home.

My wife and father take me to many doctors, including psychiatrists. They say I have a "problem". The doctor showed me pictures of nude men and women. They gave me small shocks in my private parts if I was sexually aroused by the men's pictures. I am very unhappy. My partner is very supportive, but he is not able to intervene. My family shuns him.

Gay man

Felt truly alone, misunderstood, guilty about having harmed my wife and not fulfilling my parents expectations, but felt that I must come out and tell the truth (guilt, shame). I did not feel anything for my wife, I only felt guilty when I looked at her and irritable with her. I sympathise with her from the rejection and loss. Initially I felt the shocks would cure me even though they were painful I went for them. I felt something wrong with me and my friend. I felt that going to doctors for treatment would change me and we could have a family and children. I felt humiliated, ill treated by the treatment. It was an invasion of my privacy. I felt angry with my wife for making me undergo all that. When I could see her point and went to the doctors why couldn't she see? I am willing to give her divorce and take the responsibility for it. I am also ok with her getting into a another relationship, ill support her if she wants to leave.

Wife

I was feeling very frustrated, angry, tense about my future. Feeling very sad, because the dreams which I had about my marriage, nothing like that happened. I tried to talk, it always turned into an argument, or fight. I felt he was not a man, namard hai woh!. I felt it was an abnormal thing, I felt he cheated me, him and his parents. I felt pity for him when he told me about him being a homosexual. But I want a normal married life and children. What about my needs?

Friend

I was in a dilemma. Society does not see homosexuality as normal so I did not know if I could convince her that it was natural, I also felt I should pacify her but she was also in great distress.

Discussion and Summary

About the Role Play

Participants felt that the role play brings out the experienced reality and when we realise that people live these lives, it brings us closer to them. Knowledge about issues is present, but putting oneself in another's shoes gives an emotional angle to it. Academically we take broad sweeping positions, but this helps us to see how we will exercise our cherished values. To respond to these situations we have to deal with our sensitivities vis a vis the sensitivities of the people we are with. Sometimes there seems to be no solution to this.

About Learning from the role plays

- Sexuality as a spectrum of identities

- The need to allow for sexual pleasure in women's experiences
- Acceptance, love, intimacy, and consent are integral to mental well being
- Stress on the woman – repeated pregnancies causing psycho, bio, social stress
- Loss of sexual identity after menopause
- Double blame, double loss on the woman – losing a child and the blame for the loss as well
- Experience of violation of the body – someone can use my own body against me, my body becomes my enemy.
- There is very fine line that demarcates sanity and insanity and we have no control over it.

About the experience of sharing

The exercise after the role play made it more real. Participants took a while to get out of their roles and felt heavy and quiet.

9. Reproductive health and mental health: Evidence Base

After this experiential session, Sundari Ravindran presented the evidence base on reproductive health. The entire day's group work was consolidated through this presentation, and the one following, by Bhargavi Davar on the evidence base on reproductive health and mental health.

"Reproductive health is not now, and never has been, simply a matter of preventing disease. This is because the ability to bear children is linked to the continuity of families, clans and social groups, the control of property, the interaction between human communities and the environment, the relationship between men and women, and the expression of sexuality. It is therefore valuable currency in every society and the object of regulation by families, religious institutions and governmental authorities".

The origin of reproductive health problems in the gendered power inequalities of our society was described. The adolescent years of life were closely examined along with the social problems and taboos associated with sexuality. The impact of cultural norms on the understanding, perspectives and behaviours relating to sexuality, and the gendered nature of this impact was described. Data on abortion was presented, which once again highlighted the unequal cultural, technological, economic and other burdens placed on women. Women are caught between men's unwillingness to take responsibility for preventing births, side effects of contraceptives and the risks associated with poor quality of contraceptive services. The presentation also touched upon the abuse of abortion as a contraceptive method and the high reliance on sterilisation.

Poor pregnancy outcomes that do not include induced abortions were examined for their root causes, including the poor health status of women, and scarce attention was paid to women's bereavement. The pressure is on women to get pregnant again, further compromising health, and restrictions on spacing.

Gender based inequalities often underlie the causes of maternal mortality, a serious issue till date: delay in care-seeking, poor health prior to pregnancy, anaemia, lack of rest and care during pregnancy, lack of partner support and partner-violence are some reasons for morbidity and mortality.

Long term morbidities include anaemia, RTI's (of upper and lower reproductive tracts) sometimes leading to secondary infertility, and utero vaginal prolapse.

Reproductive tract infections, sexually transmitted infections and their consequences were also examined with evidence. The presentation ended with a discussion on reproductive pathways. Very few women achieve their reproductive intentions healthily. For the remaining, the pathway has several negative reproductive events, and they move from one crisis to another including double or triple burden of work, gender violence and sexual coercion. To understand the inter-linkages between RH and MH, the cumulative impact of women's life and reproductive experiences have to be considered and the interaction between gender, reproductive pathways, poverty and other structural vulnerabilities, must be closely examined. Mental health cannot be looked at in isolation, but must be linked to the evident compromises on women's reproductive and sexual health.

It is difficult to find large data sets on women, reproductive health and mental health, especially in the Indian context, as there is a great paucity of research. Data can be organised to address mental health from the point of view of the general health status of women and reproductive health. Anaemia, malnutrition and low BMI, common in women, particularly young women, influence their mental health status. Further, 1 / 3 of all female diagnoses in developed countries, Asia and Latin Americas is an endocrine problem, which also has psychological manifestations.

Most available data is focused on maternal mental health, rather than on other aspects of the life cycle. The medical stream of literature on mental health is not integrated with gender, or reproductive health thinking and a syndromal approach to research, rather than a holistic one covering the entire spectrum from wellness to illness, has been adopted. There is a dirth of literature on male RH problems and mental health, especially in the Indian context.

The research on pre-menstrual syndrome (PMS), gynaecological morbidity, maternal health, abortion, violence during pregnancy, infertility, menopause and sexuality within the psychiatric syndromal approach, was examined and found to be restricted. PMS and Post Partum Depression were looked at in detail to substantiate the critique. It was concluded that mental illness consists of a combination of causes and effects that are biological, physiological and social.

For e.g. in PMS, biology and physiology point out that it is a part of normal ovarian function, rather than hormonal imbalance. Another reason substantiated by research could be mineral deficiency (Calcium, Magnesium). We also need to look at endocrine fragility in the face of social stress of different kinds. Treatment however remains syndromal and research has not covered these metabolic, endocrinological and nutritional aspects.

Similarly when we look at gynaecological morbidity, we find that co-morbidity levels are high. The concepts of distress / disability are almost absent in the research literature and the distress is ascertained only when and if it reaches the illness stage. Preventive and promotional research is absent. Post Partum Depression (PPD) and Post Partum Psychosis were then described and data presented.

The responses of service providers and the impact of this on well being were discussed. The mental health environment at the point of service is very relevant, about which there is little mental health research. Effects of maternal depression on the child have been well documented. However, studies are mostly oriented to looking at child well being, and not at the mother's health.

Interventions for depression have been medical and include the prescription of anti depressants and shock treatment. The detrimental effects of these on new mothers were discussed. Psychosocial interventions like psychotherapy are also relevant but these are still in nascent stages of application in India even though they are just as effective as medication. The problem is that evidence for comparative effectiveness of drugs versus psychotherapy in the Indian context is not available.

The presentation ended with an examination of the preventive measures that could be adopted for PPD

- Screening for health, hormonal and nutritional problems in post partum women
- Screening for mental health problems in primary care / maternal health care
- Psychotherapy as prevention and maintenance
- Other preventive aspects could include a variety of elements of change in social environments and improvement in service provision.
- Prevention of violence
- Prevention of female foeticide
- Involving the fathers in parenting, family support
- Making breast feeding hassle free
- Role of massage in PP
- Using existing cultural ritual practices
- Food and mood, particularly iron / folic acid, calcium, proteins and essential fatty acids
- Better quality gynaecological and obstetric care

Sundari Ravindran

Discussion

Direct ECT – ECT without anaesthesia for pregnant women who manifest severe depression is still practised. Literature clearly states that women cannot be given drugs or modified ECT, which involves the use of anesthesia, and therefore professionals justify the use of direct ECT.

There is a need for research and analysis that will go beyond infant safety and infant health.

Gender sensitivity is missing in the primarily psychiatric research (tools, methodology, design, analysis and conclusions) on PPD.

Fathers are usually missing from the discussion related to the mental well being of mothers and children, and even, overall.

Integration- Need for research and analysis, which will reflect community experiences of motherhood, and emphasise preventive aspects, rather than psychopathology.

Debrief of Role Plays

After reviewing the earlier day's work, further debriefing on the role play was found to be necessary. The anger in the group against the violent man in one of the role plays was expressed as well as explored. The group freely hated the oppressor – man, and some resolution of this emotion was necessary. The participant who played the role of this man was encouraged to share her experiences of being the oppressor. This resulted in a very intense discussion on masculinity, emotions and violence. Those who played the role of oppressors experienced a process of blanking out of emotions and dissociation from the people they were abusing. It was also a fact to be reckoned with for the group, that we all give space to a beastly part within ourselves. The role play was too close to our experienced inner reality, and it did not matter that we were women sensitive to the issue of domestic violence.

It is easy for us to get into the activist, problem solving mode as was clear from the role plays. Those who were doing the 'service' role expressed that after a point, they did not know what to do. The need to negotiate the activist role with that of the healer was explored, as working at this tension was important to politically grounded mental health work.

Mental distress and healing is a longitudinal process. There must be a way in which to experience and express intimacy and empathy. Sometimes just listening or giving the other person a hug may work. When we are trying to pacify someone or offer solutions we participate in the distress in a proxy manner and we only end up addressing our own internal needs. The mental health needs of empowerment professionals were touched upon through this debriefing.

10. Seminar on Post Partum Depression

Objectives:

- Learn the evidence base on post Partum depression
- Learn the evidence base on intervention in primary care and prevention
- Look at evidence from a gender perspective

Readings from the recent mental health literature on PPD had been given to the groups beforehand, and each group made a seminar presentation. The seminar presentations led to a discussion and synthesis by

the facilitators. The available evidence base on Post Partum Depression was consolidated as well as critiqued.

Putting distress into a psychiatric category and making it biology is the usual course taken with respect to women's mental distress. In the case of a physical illness, like malaria for example, this framework is probably applicable. In depression, however, we may not find a single biological marker, but may find twenty, which may not lead to specific psychiatric conclusions. Psychiatry needs to be better integrated with general medicine, to strengthen its medical basis. On the other hand, it also needs to stay clear from medicalizing social or political problems.

The concept of post partum depression (PPD), and whether it was a separate clinical entity was clarified and further discussed. Research literature also does not sufficiently situate the mental health of post partum women against their overall metabolic and hormonal status during pregnancy, delivery and after. Some social factors, such as poverty, son preference and domestic violence, have been significantly associated with PPD.

Western studies have shown that estrogen deficiency is a cause for PPD. For this Hormone Replacement Therapy (HRT) is looked at as a solution. However, it is established now that HRT is associated with cancer. The group discussed the role of medication for depression in women's lives. The reality of *pain* in women's lives, and the limited role medication played in blunting or removing this pain, was described.

Methodological questions concerning the sampling, gender sensitivity of the tools, the capability of the available tools such as the EPDS, to capture women's experienced realities, the sensitivity of the tools to cultural and spiritual aspects of mental distress, were discussed. In the various ashrams dotting the country, the behaviour of people may be seen as bizarre, strange and schizophrenic, but people consider this a spiritual journey and not an abnormality. Interpretation of this context was left to the group. The need for robust assessment procedures and comprehensive treatment plans was emphasised, while also placing the accent on the experienced reality of distress.

This session transited into the next one with the screening of "Nasreen O Nasreen".

11. Violence against women and mental health

Aparna Joshi

Objectives of the Session:

- Clarify definitions and concepts of violence
- Learn the evidence base linking violence and MH

Two papers related to the theme of violence against women and mental health had been included for reading and a summary of these papers were presented as an introduction to the topic

11.1- Violence against women – an integrated, ecological framework by Lori L Heise

The main objectives of the paper were summarised:

- Single factor theories have been suggested in the paper and it attempts an integrated approach. This approach has been used to organise literature on the basis of the complexity of factors which the approaches discuss
- It helps to develop multi pronged interventions for the factors cited by the approaches
- An interesting observation of the paper is the inter-generational cycle of violence

VIOLENCE AGAINST WOMEN – AN INTEGRATED, ECOLOGICAL FRAMEWORK

- Lori L Heise

Analysis of violence

- Primacy of culturally constructed messages
- Roles of & behavior of men & women
- Power disadvantage (lack of access to resources)

Witnessing marital violence as a child

- Significant relationship- witnessing violence against mother & later abusing partners themselves
- Learnt response

Being abused during childhood

- Children witness violence, victims of abuse higher risk of becoming assaultive themselves
- Early victimisation leaves emotional & developmental scars damages sense of self

Marital conflicts

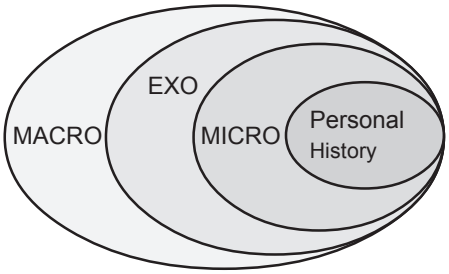
- Frequency of verbal disagreements
- Strongly related to likelihood of physical aggression
- Low family income
- Unemployment among men
- Violence increases as economic situation decreases

Absent/Rejecting fathers

Father-absent cultures: boys are reared by peers from early age, promotes aggressive competition, dominance relationships antagonism towards women

- Causal factor or intervening variable?
- Cold/abusive fathers- personality anger, depression, moods cycles

Ecological Framework



Male Dominance

- Economic and decision making authority
- Societies allow violence on women
- Family approves male dominance

Strongest Predictors

- Male dominance
- Male control of family wealth
- Divorce restrictions on women

Isolation of woman and the family

- Isolation tended to increase as relationship became more violent
- Cultures with high violence families are isolated and husband and wife relation are considered outside of public scrutiny

Use of alcohol

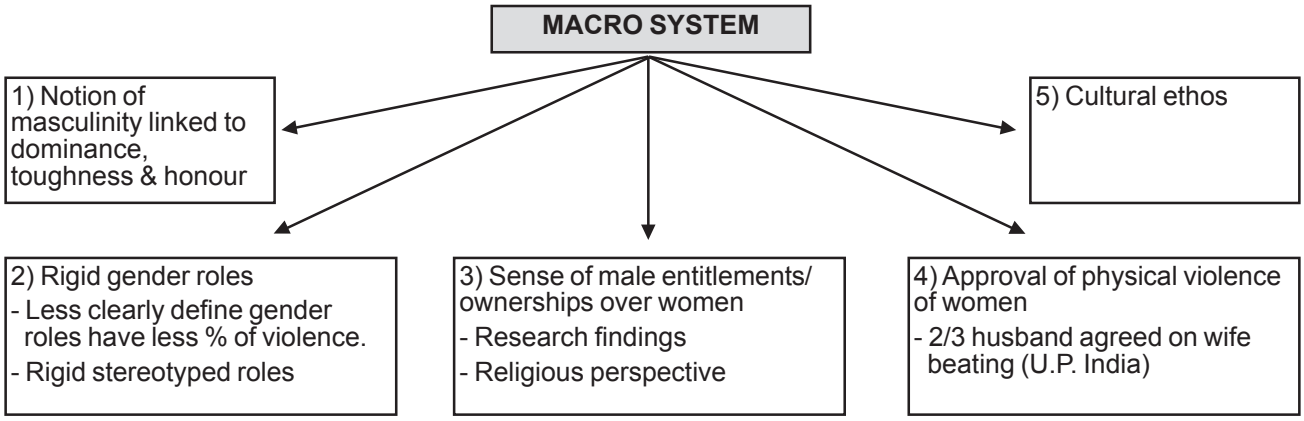
- Alcohol operated as a situational factor, increases likelihood of violence by reducing inhibitions, clouding judgment and impairing an individual's ability to interpret cues
- Abusive men with alcohol problems tend to be more violent

EXOSYSTEM

1) Unemployment/low socio economic status:
- Structural adjustment
- Economic havoc

2) Isolation of the women & the family
- Social status of the family (H.L.) in violent society

3) Delinquent peer association
- Coercion between peer group for expressing violence
- Attachment for men who encourage women abuse



Discussion

The social and political context of domestic violence was discussed. Power and its association with violence were examined. Against this context, the need to establish politically sensitive interventions was emphasised.

The relationship between alcohol intake and violence was discussed. Alcohol helps to reduce the inhibition, but myths about violence being alcohol induced need to be questioned.

The use of violence by women within a patriarchal context was discussed. Whether all of women's rage, particularly against children, was patriarchy induced was examined.

PAPER 2: Violence against women: Consolidating a Public Health Agenda

– *Claudia Garcia-Moreno*

Key findings of the paper and discussion

Gender sensitisation from a young age is a preventive measure against violence.

Community involvement in controlling violence was seen as an important measure in violence prevention.

Women exposed to violence in childhood see themselves as victims of violence, and male children, as assaulters.

In policy, the cost of violence is never taken into account.

When a public health approach is applied, it talks of intervention as preventive and promotive, and not just curative.

In the 1980's, violence against women became the most important issue that the women's movement took up. It was seen from the legal (laws and *adalats*) and police perspective, an issue of community intervention (shaming) and then as a health issue. Today we will see it as an agenda for mental health by recognising the individual distress and the healing that it requires.

Raising the issue of violence against women was seen as a protest against the patriarchal system. Women who deviated from the stereotypes were considered "mad" and therefore there was a resistance to accepting mental health as a reality for some people.

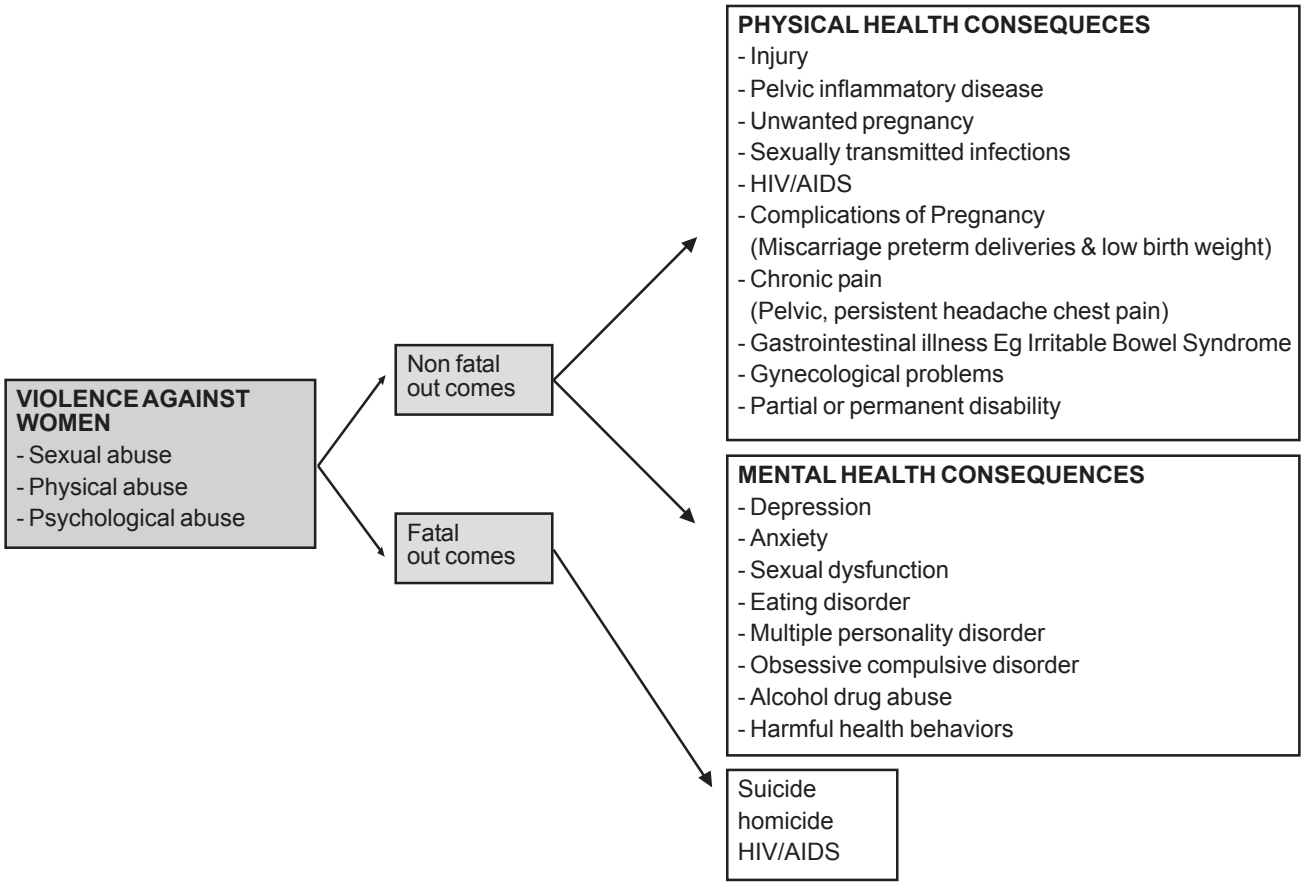
It then becomes critical to address the political inclusion of women's voices that cannot participate in the movement because of the trouble in dealing with their own individual distress.

Mental health as a field is gender neutral and blind. The implication of this for mental health interventions for violence was discussed.

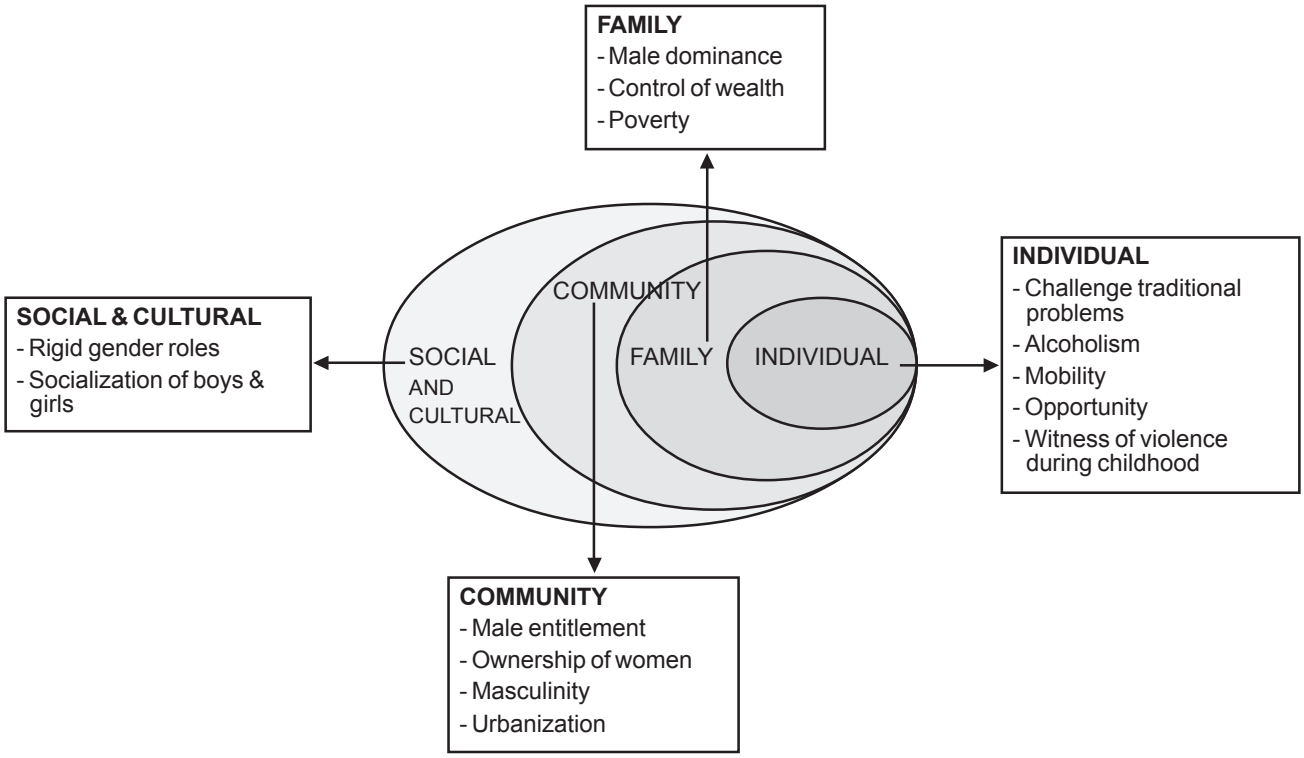
HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN

Violence Against Women: Consolidating a Public Health Agenda

- Claudia Gracia Moreno

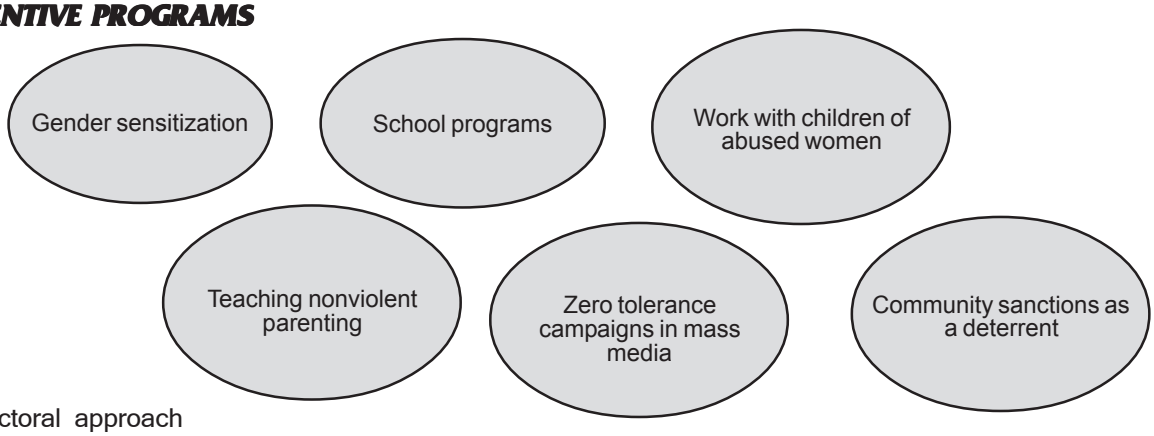


Cause of Violence



PUBLIC HEALTH APPROACH

PREVENTIVE PROGRAMS



Multisectoral approach

TRAINING PROGRAMMES

- Encourage post training follow-ups
- Address experiences, attitudes & values of the providers
- Address structural barriers that prevent providers from doing sensitive work
- Focus should be on 'woman' rather than on service

'Whereas the provider usually focuses on the battering, for the woman, this is often only one aspect of a complex relationship, and her interpretation of the situation is coloured by this.'

After this discussion a presentation on Mental Health and Domestic Violence was made. The presentation elaborated on the definition, types and data on violence against women. It also looked at violence in from the life cycle approach citing the violence faced by women in the pre-partum, infancy, childhood, adolescent, youth, adult and elder stages of life through examples. The common myths about violence were examined and countered.

The emotions and behaviour that manifest as a result of violence were presented. The perpetrator indicators given to survivors, the survivor's interpretation of these and the effect it has on her were tracked. The psychological and social reasons for why women don't leave violent homes were also discussed.

Perpetrator indicators to survivor →	Survivor interpretation →	Effect on survivor
I hit you because I love you	That is what love is	Confusion and re-victimisation
The abuse is your fault	I am bad and to be blamed	Self blame, confusion, helplessness
No one will love you like I do	Without this person I am alone forever	Dependent, fearful of leaving
This is for your own good	Other people know what's good for me	Doubts of judgement
You don't own your body, I do	I have no control over what people do to me	Poor boundaries, re-victimisation
No one will believe you if you tell	I'm alone and no one cares	Silence

In situations of violence women seek help from their families, neighborhood, community spaces, religious groups, NGOs, police, lawyers, health providers and mental health professionals. However it is not certain that she will get help from any of these. Responses to women who have faced violence vary from denial to rationalization, to minimalization to identification and intellectualization.

Responses to cases of Violence Against Women

Denial

- This only happens in other places in the world, to other kinds of people.
- This kind of thing does not happen to our clients
- I don't want to acknowledge it when I see it
- This happened to me, I don't want to admit it.

Rationalization

- It's a private matter
- Its not my job, I don't have time to do this
- If I ask, it could cause me legal problems
- Victims don't want to really talk about it
- She must have done something to provoke it
- There is nothing I can do anyway

Minimalization

- This happened to her in the past and could not be affecting her now
- She does not have a lot of marks, so this could not have been too bad.

Identification

- This could never happen to me, so it could not be happening to a woman like me
- Since I don't do it, no man like me could be doing it
- I could see why her partner would beat her

Intellectualization

- A woman who is being hit should leave.
- People get over these things in a short time
- We only deal with medical problems

Responses of the mental health professionals to cases of VAW are not very different from others. The presentation ended with a brief discussion on how to develop a women centred programme on domestic violence with a healing objective.

12. Workshop on Child Sexual Abuse


Anuja Gupta

Anuja Gupta

Objectives of the Workshop:

- Learn to work with themes of sexuality in mental health
- Build a perspective about CSA and mental health
- Understand the essentials of an intervention plan for CSA

The workshop on CSA, conducted by Anuja Gupta of RAHI, gave a psychological and programmatic view of dealing with violence in the specific context of sexually abused children. The session gave a micro view of developing a psychological intervention program on violence, learnt more theoretically in the earlier session. The session began with a brief introduction about RAHI, New Delhi, and its work. Some important ground rules with regard to confidentiality and disclosure were agreed upon by the group. The participants then discussed what they knew about CSA / incest.

What is CSA, according to the group

- Sexual abuse can happen to a child of either sex by an older person of either sex or both
- Sexual abuse is not limited to the physical act of sex
- It is not an uncommon phenomenon
- It is difficult to identify CSA because of the difficulty in memory and articulation by children
- Perpetrators are usually people the child trusts
- The impact of such abuse is deep rooted and reflects on different areas of the person's early and later life
- Withdrawal and fear among children who are abused
- Guilt and other negative emotions and cognitions
- Loss of a sense of rationality
- Lack of acceptance by older people of the existence of the phenomenon
- Blaming the child for the abuse
- Busy life style of parents, ignorance and no information

The various feelings experienced by the training group were shared and explored. The negative impact of such feelings in children exposed to CSA was emphasised.

Expectations from the sessions were expressed

- Research information in the area
- Education related to prevention
- Programme Intervention
- Concept clarity on consent, coercion etc.
- Coping mechanisms
- Child rights
- Law and legality
- Learning from RAHI's experiences of working with people with CSA
- Clarification on the various shades of sexual experiences during childhood and adolescence ranging from exploration to abuse.

The resource person clarified what the sessions would cover;

- Understanding the dynamics of Incest and sexual abuse
- Impact of sexual abuse on children and adult survivors
- Intervention, treatment, and program development issues

12.1 *Incest / CSA: Definitions*

Various definitions of CSA were explained. The definitions emphasised that the abuser is usually in an ongoing emotional relationship by virtue of his / her powerful position or *like* a parent (an older brother, or a teacher, or a neighbour) with the child. This clearly marks the abuse of power and authority by the abuser and magnifies the betrayal of trust for the child. Discussion revolved around containing the definition to acts and relationships, which were non-consensual. A range of acts were cited as examples and discussed, to show the behavioural scope of sexual abuse. Whether sexual abuse always involved physical abuse, was also discussed.

After explaining that the experiences of CSA often resulted in mild or severe trauma, the concept of Trauma was described and discussed. The syndromal aspects of post traumatic stress disorder, as proposed by the DSM IV, were enlisted, and explained with examples and research evidence. People often experience a

recurrent recollection of events, psychological distress, emotional numbness, outbursts of anger, the inability to concentrate and complete tasks etc. The feeling of complete paralysis and helplessness is what makes the trauma more intense. The implication of a trauma framework for intervention was discussed with examples.

The concept, 'The CSA Accommodation Syndrome' was introduced. This syndrome, accepted by people in the field of CSA as describing the impact of the abuse on the inner life of the child, involved five elements:

- Secrecy – The importance of secrecy in CSA and how this secrecy works itself out in the abusive relationship was discussed.
- Helplessness
- Entrapment / accommodation – This element covered the survival aspects of CSA, where the child uses various routes to safeguard his or her own safety internally
- Delayed / conflicting/ unconvincing disclosure – The psychological aspects of disclosure were discussed: how disclosure is processed or delivered
- Refraction

12.2 Incest / CSA: How it happens

The cycle of violence perpetrated by child sexual abusers on their victims was detailed. The initial phase comprised of giving attention and offering enticements ('grooming'), threats and committing the child to the coercive relationship. The time frame of abuse as well as where it happened had important implications for understanding the traumatized child's psyche and in planning the intervention. How the abuse threatens the child's inner sense of safety and bodily and mental reality was emphasized. The availability of the child, the routinisation of the abuse in the child's life, and the entrapment which ensues in the child's life and mind, results in the long term abuse of the child.

Discussion

Queries from the group were addressed. What makes sexual abuse such a profound childhood experience is the fact that sexual abuse is often only one part of a larger complex relationship. Various other dimensions of the relationship which can lead to enmeshment and love on the one hand, as well as fear, lack of trust, shame and betrayal, on the other, were described. There is a lot of interweaving of the 'good' and 'bad' to a point that there is no specific or clear distinction in the child's mind about the two. The emotional dependence, even love, by the child of the abuser, the template thus formed by the child of intimate relationships in general, was highlighted.

12.3 Incest / CSA: Offenders

The question whether CSA offenders had any distinguishing physical or mental qualities, or personality profile, was debated and myths clarified. It was established that it was a gendered, predominantly heterosexual crime, having little to do with the qualities of the child. The differences between Paedophilia and CSA were discussed. Whether CSA offenders were mentally ill or the 'criminal type' was debated. The intentional nature of abuse was explored in this context. The cloud of trust within which offenders work at in their adult world, friendships and relationships, serving as a cover for the sexual abuse, makes it difficult to mark them as abusers. Their weak profile as 'criminals' was explored.

Discussion

Whether elderly men stopped abusing children, was debated. Another question concerned whether offenders exhibited a pattern of abuse or whether they were one time assaulters. The implications of having a relative, family member or friend within one's social unit who was an abuser, the gendered aspects of such abuse, were discussed against this context. The future risks of having been abused once were also discussed. Also discussed was the question, what it means to have the abuser share one's

everyday world and to have the family endorse him or give him legitimacy in various ways. A challenge for intervention is to help women face their abusers without getting traumatized. The intent of obtaining sexual pleasure from the child made this coercive act of power different from other forms of violence. Questions about the prevalence and incidence of CSA in India were addressed.

12.4 Incest / CSA: Unique type of Trauma

Myths relating to CSA were clarified. Features of the CSA trauma were elaborated, discussed and consolidated. The lecture on trauma covered the patterning of CSA with respect to the time of abuse and age of the child, the nature of the relationship, the sexual content of the abuse, the coercive aspects of the abuse, the strategies used to gain compliance, and the impact of repeated negative responses received to disclosure. The trauma inducing factors and the need to anchor interventions against this context, were detailed:

i) Traumatic sexualisation- The impact of CSA on the body, sexuality and sex experiences as an adult

ii) Betrayal- The impact of betrayal of trust on later relationships in adulthood

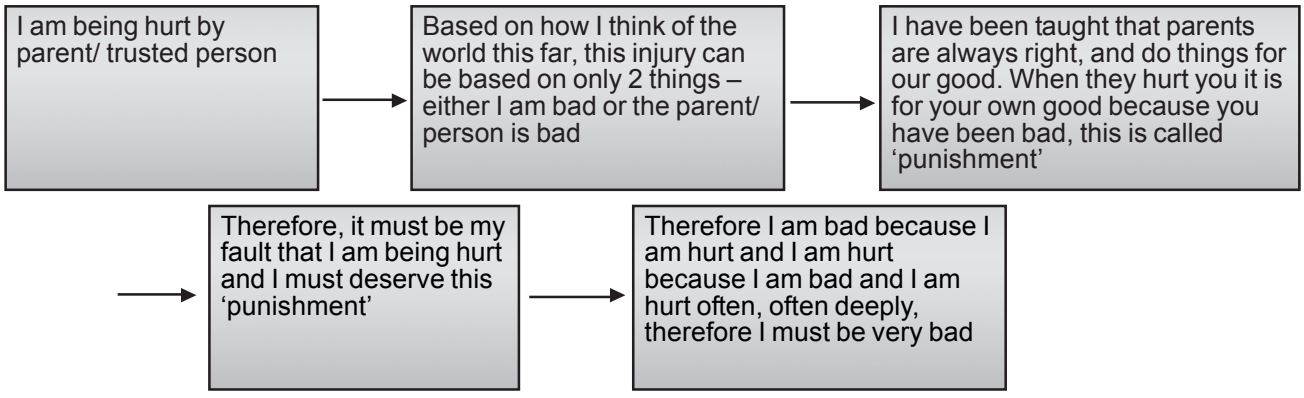
iii) Powerlessness – The loss of control experienced in relationships

iv) Stigmatization - Survivors often feel they are dirty, damaged and different.

The difference of CSA as a unique form of violence was reinforced throughout the workshop. The total impact of this form of violence on the child's sense of self, which continues into adulthood, was highlighted. The notion of an 'adult survivor' of child sexual abuse was explained in detail.

CSA disrupts the survivors' basic assumptions about the world, self and others, or the child's sense of their social world. The negative cognitions and emotions steamrolled into the child's mind through these coercive experiences result in seeing oneself as bad or crazy, and the world as unreal and unsafe. These perceptions carry over well into adulthood, resulting in a range of maladaptive and ambivalent ways of being, called the 'triad of craziness' by one writer in the field, which needs to be addressed in therapy sensitively.

'The abuse dichotomy', a concept found in the literature, to explain the survivor's state:



What the abused child is taught by the CSA experiences

- To think of herself as useless, hopeless, bad and dirty
- To feel guilt and responsibility for the abuse
- To equate affection / attention / love with sexual exploitation
- That she is responsible, did not stop it and therefore, is a bad person
- That she has no right to privacy or to control access to her body
- To service the needs of others even when this is harmful, i.e. she feels she deserves ill treatment and accepts it as her punishment for being bad.

What constitutes 'severity' in the CSA literature was presented. The more severe the abuse, the more difficult it is for children to deal with at any stage in life and more complex is the pattern of resolution for the therapist or for those who intervene. Severity is determined by-

- Duration and frequency
- Type of sexual activity
- Age at onset
- Age, Gender and relationship of the perpetrator
- Passive, submissive or willing participation on the part of the child
- Overt incest with lack of assistance
- The meaning of abuse to the child and what messages were received by her at the time of abuse

Discussion

The importance of memory in recall, and memory repression, of the abuse was discussed. While working with survivors of abuse, it becomes necessary to deal with one's own childhood experiences particularly of abuse. When an experience becomes 'trauma', also was established through the discussion. Ethical and psychological cautions that need to be exercised, in planning research on CSA, were examined.

Instruments that were used for recognising the signs / indicators of CSA in children were detailed from the available literature.

Discussion

- Sexual interaction begins much earlier in women who were abused as children.
- Excessive interest in sex, which goes beyond the exploratory and the curious: For e.g. abused children may draw genitals which are larger than life. They may also play with the genitals of dolls.
- Eating disorders
- Self harm- A more severe form of this is when they attempt suicide or hurt themselves. These are all ways of coping and distractions from the pain within instead to the pain outside. Self harm interventions focus on the gap between the inner pain and the bodily mutilation, which has a neurological basis.
- Dissociation is the most creative way of 'taking off' in children, and a survival strategy. The need to address the usefulness of this strategy in adulthood was discussed.

Significant Mental Health Hazards include

- Emotional reactions and difficulties in forming satisfying relationships
- Alterations in self perception
- Discomfort with body and touch
- Sexual effects (arousal, compulsive interest in avoidance, body image, re-victimization etc.)
- Syndromal mental illness
- Addictions

Intervention with adult survivors would focus on those aspects of resistance and protest made by the child (e.g. hiding or pretending to be asleep) to re-establish a sense of faith in self and control over what happens to one.

Feedback and consolidation

The day ended with the film, 'Colours Black', which was discussed the following morning, along with consolidating the feedback of the previous day from the training group.

- The nature of research in CSA was discussed. Research should not restrict itself to addressing prevalence and magnitude, as it was both sensitive and essentially qualitative in nature. Also while speaking of CSA, more sensitive language should be used in addressing, or sharing research interests. On the other hand, those who have experienced CSA should be open to looking at the issue, also as research material. A balance needed to be struck between research and experience.
- The film elicited heated discussion around the child's anger and rage. Difficulties in the expression of anger, the gendered dimension of anger and how anger needs to be addressed in therapy, was explored. The need to contain the process of anger converting into rage, in order to establish a sense of control in the victim of CSA, was highlighted as a therapeutic goal.
- The blind spot expressed by parents to the sexual abuse of their children, was discussed. Assumptions about children were seen as an important reason for this blind spot.
- When to intervene and when not to intervene was discussed as an important clinical ethical issue. The resource person warned that we have to think and ascertain whether it is our need or the need of the person who has been abused. As activists, our need to act takes over, and we need to be sensitive to this.
- The gendered norms existing in our society blurs the boundaries between protection and abuse. When abuse happens, cultural norms sanctioning protection are brought in, in the interests of the perpetrator, who is usually male. Coercion is treated as normal, causing confusion in women's minds about expectations and acceptance, agency and victimhood. When an abusive relationship sets the frame of reference for relationships in general, the traumatized child / adult survivor finds herself entrapped in repeated patterns of abuse in situations of intimacy.
- Whether early marriage can be termed sexual abuse was debated. How 'consent' must be construed with respect to the age of the child was further discussed.
- The need to provide planners and policy makers with clear evidence was emphasized.

12.5 Recovery and Self Care

The notion of 'recovery' served to anchor the lecture and discussion on psychologically therapeutic interventions for CSA. 'Recovery' counters the disconnection and dissociation of trauma, a core experience in CSA. Recovery is about connecting and reconnecting with one self and others. It involves owning and reclaiming every part of oneself, embracing it and countering the feelings that remove one from oneself. Recovery is centrally anchored to reclaiming self in relationships.

Recovery involves the following:

- Empowerment of survivor
- Creation of new connections
- Recreation of faculties damaged by trauma, which includes trust, intimacy, autonomy
- Restoring power and control
- Reducing isolation and building trust
- Decreasing helplessness

The survivor is the author and arbiter of her own recovery. It is this process of recovery that therapy must facilitate. Clinical aspects of enabling recovery with adult survivors of CSA were detailed, including maintaining therapeutic relationships based on the recognition of the therapist's power in the clinical situation, a point of vital importance to the problem context, i.e. CSA; Transference and counter transference; and expressing solidarity. The therapeutic relationship will be successful if the survivor constructs this relationship positively by breaking some of the patterns she has established with respect to power, authority, coercion and abuse.

12.6 The Recovery Process: *'It gets worse before it gets better'*

The recovery process encompasses the following:

- Self determination of the client: The decision to heal and commitment to treatment has to come from the client. It cannot be forced.
- The emergency stage(s): Life seems to get completely out of control and it is possible that people start to rethink therapy, dropping out of the therapy.
- Memory retrieval: The recovery of painful memories and acknowledging the abuser is intensely difficult.
- Believing it was real: Self doubt has to be conquered for her to believe that it happened to her.
- Recounting the abuse: Though this is a painful process, the survivor must be able to face the fact that she has been abused. Detailing the abuse is important, but therapist sensitivity and ethics is put to the fullest possible test at this juncture.
- Resolving issues of responsibility, self – blame, guilt and complicity
- Recognition, labeling and expression of feeling
- Grieving is an important stage in recovery. The grieving is for a lost childhood and the wrong that happened then.
- Cognitive restructuring of disoriented beliefs
- Disclosure
- Confrontation brings with it further issues of safety and vulnerability

12.7 The CSA Counselor: Doing what we ask our clients to do

Being a CSA counselor has to do with how one conducts oneself in one's own life in relation to the world and of others in it. There is a need to constantly evaluate, assess and re-assess oneself. It is important to realize that being a counselor is about, *'Who you are, not (only) what you know'*. If CSA survivors get into counseling as a career, then dealing with one's own sexual abuse becomes crucial. Counselors have to deal with their own moral and other deep seated prejudices about sexual orientation, promiscuity, etc. Dealing with cultural norms, one's own feelings towards the abuser, and not projecting these onto the client is important. Other counseling issues such as externalization, and secondary traumatization were discussed. The need for self care and supervision for CSA counselors was emphasized.

Discussion

- The notion of forgiveness was discussed. The object of forgiveness was established as the survivor herself, and not the abuser.
- When survivors come for therapy, they don't know why they are there. It takes them some time to realize why.
- In dealing with abuse and violence, sometimes a point is reached when the counselor has nothing else left to offer the woman. Then we must deal with their own feelings of inadequacy and helplessness.
- If clients cannot recollect, create openings for her to do that. The challenge here is to make memories less toxic.
- During intervention, always be alert. Constantly ask yourself what you can do to make people think well of themselves, because feelings of uselessness find their way into almost every part of a survivor's life.
- Nonverbal messages of badness get registered. There is a portion of the mind that stores the experience nonverbally. It is then the challenge of intervention to reach that part of the mind, which is not accessible to language.

- Intervention that involves more bodywork helps. Techniques like psychodrama, theatre and the use of symbols, images etc. must be explored and employed.
- Counselors can help people form symbolic images of loving and caring so they can pull these out and address them when they need to.
- The Doubling technique is another effective technique where the counsellor becomes the inner voice of the client and says things, which she is unable to say.
- The best results are when individual and group therapy is combined.
- Meditation is another powerful medium, which helps as a coping mechanism and to know feelings.

Prevention of CSA was discussed and various strategies enlisted.

If the child does get abused and disclosure is made and dealt with appropriately, she will grow up with not too much damage. Create conditions where she can talk about it. The abuse is only as damaging as the manner in which it is dealt.

13. Research, Education and Policy in Mental Health

Bhargavi Davar

The course, with this module, shifted from micro focus to macro focus, involving a critical study of knowledge generation, mental health education, mental health policies, and the mental health laws. The following sessions broad base mental health work from a 'development' outlook to one of 'human rights'. The learnings from the earlier sessions were applied to understand and examine the macro environment within which mental health work is done.

Objectives of the Module on Research, Education and Policy in Mental health

Participants will:

- Address critical concerns in the production of research materials
- Assess evidence base from a gender perspective
- Address critical concerns in the production of education materials in community mental health
- Learn about some community models and programs in mental health
- Address the mental health needs of their own working groups

Treating Research Data in Mental Health from a Gender Perspective

The participants had been given three papers on mental health to read in groups the previous day. Participants had to garner information from the papers as well as critique the papers.

Papers studied

1. 'Premenstrual symptoms and syndromes in India' by Santosh K. Chaturvedi and Prabha S. Chandra
2. 'Dhat Syndrome – A useful diagnostic entity in Indian Culture' by MS Bhatia and SC Malik
3. 'The socio-emotional development of 5 year old children of postnatally depressed mothers' by Lynne Murray, Dana Sinclair, Peter Cooper, Pierre Ducournau and Patricia Turner

All the papers focussed on the linkages between different aspects of reproductive health and mental health. Information was obtained by the group about the syndromal aspects of mental distress, and medical treatments for the same, in the context of reproductive health.

The group noted that while the medical nature of diagnosis gives a certain perspective, the larger gendered

issues need to be addressed. Another general aspect noted by the group was the risk of medicalization of women's bodies and life experiences. The syndromal approach to psychological distress, its strengths and limitations, was widely discussed. This approach projects women's bodies and minds as sick, as medicine individualises mental health problems.

The role of medical science, the nature of its explanations, scientific methodology, and how these do not mirror women's experiences was discussed. Biases found in the literature ranged from poor attitudes about women, omission of any reference to gender and sexual oppression, to active promotion of discriminatory practices against women. Women's mental and reproductive experiences should be looked at in totality and linked to the social determinants or other structural issues which create barriers for achievement of well being. Scant attention was paid to sexuality, and when attention was paid, the concepts needed to be thought through more carefully. A life cycle perspective to understanding women's health, reproductive health and mental health needed to be incorporated into mental health studies. Further, mental health studies should also be linked to overall health status of individuals being studied. Such health indicators were missing from the studies.

Participants felt there were several aspects of menstruation that need to be looked into, to build a context in which research studies on PMS should be placed.

- How is menstruation handled by the parent? How girls are socialised into 'women' and as reproductive beings through the pre-pubertal, pubertal and post-pubertal phase, is an important area for investigation.
- A need for taking menstruation out of the mother-daughter domain and involving the other parent and family members, was expressed.
- The emotional and cognitive processing of menstruation by girls also needs to be studied.
- How the lack of valid information colours the process of menstruation also needs to be addressed. Media portrayals in advertisements only reinforce stereotypes and heighten fears. How these topics are dealt with in the school curriculum was discussed.
- Research also needs to consider the physical health aspects of PMS.
- Linking up research with intervention was discussed. The rationality of using HRT for PMS, suggested by the literature, was discussed.
- Studies also need to explore physical facilities in the households, absence of toilets in schools, sanitary protection used by women, running water, privacy etc.

Methodological issues were discussed, to highlight aspects which needed to be built in for sensitivity to gender and other kinds of structural dimensions. Single cause explanations were favoured in the given literature, whereas choice of other kinds of methodologies may have presented a more complex picture of women's experienced reality. For example, lack of sexual interest could be linked to poor nutritional status or excessive work load. Community based studies also need to be sensitive to the diverse profiles and experiences of peoples within the community. The methodologies must take into account people's experiences.

Ethical aspects of research was discussed, particularly relating to time taken for the interview, time taken for observation of children, quality of observations, and the number of interview schedules used. Disclosures with respect to funding support, and consent was sought from studies.

From the limited data generated, it was felt to be unwise to recommend medications as the solution. Studies have to consider a holistic treatment plan to well being, including the non medical aspects. When non-medical programs, such as counselling, are compared to drugs, the non-medical program has to be a well thought out and a robust one.

It was a point of interest to the group that on a particular topic, the review often comprised of work done by only the same set of researchers, and this being non-inclusive, it led to questions about the limited nature of a 'research tradition' or of originality in research. Some aspects of research were also seen as a 'western agenda' and critically discussed. The inclination to medicalize cultural practices, such as possession, was discussed.

On mother child studies

- The group discussed whether warmth and acceptance, measured in the literature, could actually be measured when these are subjective states and placed non-verbally in relationships.
- The other element that studies needed to define was the 'appropriate' management of children by mothers. Studies need to be mother friendly in the use of concepts.
- Individual factors of the child, including health status, school environment, peer relationships, etc. need to be taken into account in research studies.
- Individual factors of the mother, including health and nutritional status, work load, etc. needed to be taken into account in such studies.
- The role of the other members of the child's family - the other parent / adults etc. should also be taken into account.
- Scales used should be more robust and not be only clinical symptom scales.

On Linkages between Research and Programme Development

- Programmes are usually developed based on studies like these. This comprises the 'evidence base'. There are innumerable programmes on mother – child bonding and for addressing maternal depression, as this is felt to be a priority issue. Whether these programmes are gender sensitive needs to be explored.
- The concept of 'maternal ambivalence' was discussed critically. This notion linked with the risk of violence from the mother. Child protection from the mother is a well-developed programmatic intervention. There is little or no evidence on understanding the social situations of violence among mothers and its causative factors.
- How drug effectiveness studies were funded, conducted was critically discussed. Effects of psychiatric drugs on pregnancy outcomes and maternal / child health were discussed.

14. Preparing materials in mental health

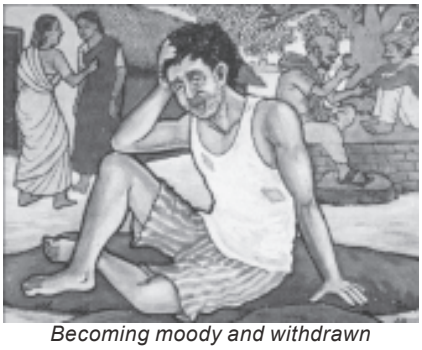
Bhargavi Davar and Sundari Ravindran

A mental health flip chart had been given to the group for study and feedback. This flip chart is widely used in the community especially in the government programs, and was prepared by the NIMHANS, with support from the WHO Country Funds.

Discussions focused on both how society views mentally ill people, as well as, how the topic was treated in the materials. The gender stereotypes pervading this flip chart were discussed. For example, all men are depicted in social and external settings, women are shown to be within homes are isolated and cornered. Males are shown to have functional problems, whereas, women were portrayed with emotional and thought problems. Women are shown as superstitious, and men are shown as the healers.

Socially unaccepted behaviour was portrayed as mental illness in the flip chart. The illustrations were not aesthetic at all, as if people with mental illness were gross to look at. The societal humiliation of a person in distress was evident in the illustrations. Mental disturbance is looked upon as humorous and as spectacular by society. Unexpected, strange behaviour is connected to fear and shame. A person behaving 'strangely' is isolated and judged. How this affects women was discussed. However, this depiction also reinforced the fact that what people see as 'strange' is mental illness. A woman who thinks of suicide is depicted with bizarre appearance, suggesting madness. Only diagnostic aspects were depicted, and even that in a manner that was not precise. Epilepsy and mental retardation were shown as mental disorders. The flip chart used judgemental words such as 'aloof', 'strange', 'abnormal', 'unusual', frequently, in providing diagnostic information. Some words such as 'moody' were vague. Everyday distress was not discussed, and extreme and fear inducing examples were used (e.g. 'plotting to kill'). *'Mental illness itne bhayanak hote hain kya'?* The flip chart did


Behaving in a strange manner


Becoming moody and withdrawn


Seeing and hearing things which others do not see or hear


Abnormally suspicious of others


Unusually cheerful and boastful

not provide any standards to estimate suggested indicators of disorder, such as 'unusually cheerful and boastful', 'crying without reason', etc. which may be open to subjective understanding. All distress was portrayed as being of diagnostic importance, which is misleading. The experiences of personal trauma and psycho-social reasons for distress and grief remain invalidated. The flip chart portrays only chronic mental disability with emphasis on medication and that too, in a totally stigma reinforcing way. Intervention aspects were not touched upon at all. The impact of this 'education' on community workers was discussed. That these materials will lead to more stigma and isolation of people with mental illness was emphasized.

The need to advocate for change with the authorities, who produced these materials, demanding the withdrawal of these materials from circulation, was suggested.

Alternatives to these materials, and what was expected from community mental health educational materials were discussed. A psychosocial perspective needed to be brought into the materials, reflecting the lives of people with disabilities. Other health aspects such as nutrition needed to be highlighted. Mental health needs to be seen holistically on the continuum of well being. Prevention aspects need to be highlighted. The materials must encourage and promote client choice of treatments, rather than pigeonholing all treatments into the medical model. Materials must communicate acceptance of traditional healing methods. Accurate information must be provided, even if the materials are purely medical. The materials should be sensitive to structural divisions in society and its impact on mental health. Materials should encourage community workers to facilitate the self determination of clients.

One group presented a theatre presentation as an alternative stream of mental health materials.


Feeling unusually sad


Having suicidal tendencies


Behaviour attributed to black magic


Suffering from fits


Delayed mental development

15. Community Mental Health – Two examples

- Schizophrenia Awareness Association (SAA) & Eklavya Self Help Support Group
- Dr. Sidhyartha Mukherjee, *Aga Khan Services*

Two examples of community mental health initiatives were described and discussed. The SAA work was in self help, and AKS, an NGO from Gujarat, had a dedicated community mental health program, with focus on common mental disorders (CMD).

15.1 Self help in mental health

SAA presented the Recovery Method developed by Dr Abraham Low and used by Eklavya, their self help group. An introduction to Eklavya, and its roots in the self help movement for persons with mental health problems in Pune, was described. The concept of self help groups and their benefits for people with mental health problems were explained. The concept of 'recovery' was discussed. The presentation emphasised that a self help group for recovery is a 'mental health' group and not a 'mental illness' group. This group did not discuss the illness or diagnosis, as the emphasis is on wellness. The recovery method shifted the focus to group therapy, and away from other existing treatment methods which were costly and time consuming, besides not always being effective. Some simple memory tools were developed, that persons could use to cope with situations.

Steps in the Recovery Method

- Briefly describe the event coped with.
- What mental and physical symptoms and distress did you experience?
- Which 'Recovery' self-help tools did you use to cope?
- Compare the event before and after using the self-help method?

Once a group member followed the steps, the next crucial action is self-endorsement and then feedback by other peer group members, who could suggest some other relevant tools for the situation. The process of using these tools and the benefits derived therefrom were described. One of the salient features of the proceedings of a self help group meeting is that it is very structured and encourages routine. The tools were simple memory tools for cognitive retraining ('will training'), and did not go into the depths of the person's emotional lives. This essentially involves developing a habit of making a shift from 'negative' thoughts and actions to 'positive' ones. So it was fairly easy to use the tools. The facilitator sees to it that not much deviation from these steps takes place. Examples of some of the tools used during recovery were listed and explained. A demonstration of the recovery method was presented to show the use of tools in the recovery process.

The session demonstrated that recovery is a proven method of self-help for the purpose of preventing relapses in former patients and chronicity in nervous symptoms. It serves to reintroduce an individual into the working and social world and helps make him / her self-sustaining and self-sufficient. A cognitive behavioural approach was at the core of the method.

The presentation ended with discussing who could use recovery in self help groups. It included people with all types of anxiety disorders, depression, psycho-physical disorders, and the stress of psychological problems. Those suffering from schizophrenia or manic depression could also benefit, though people with brain damage or dementia may not be able to use this.

Discussion and Feedback

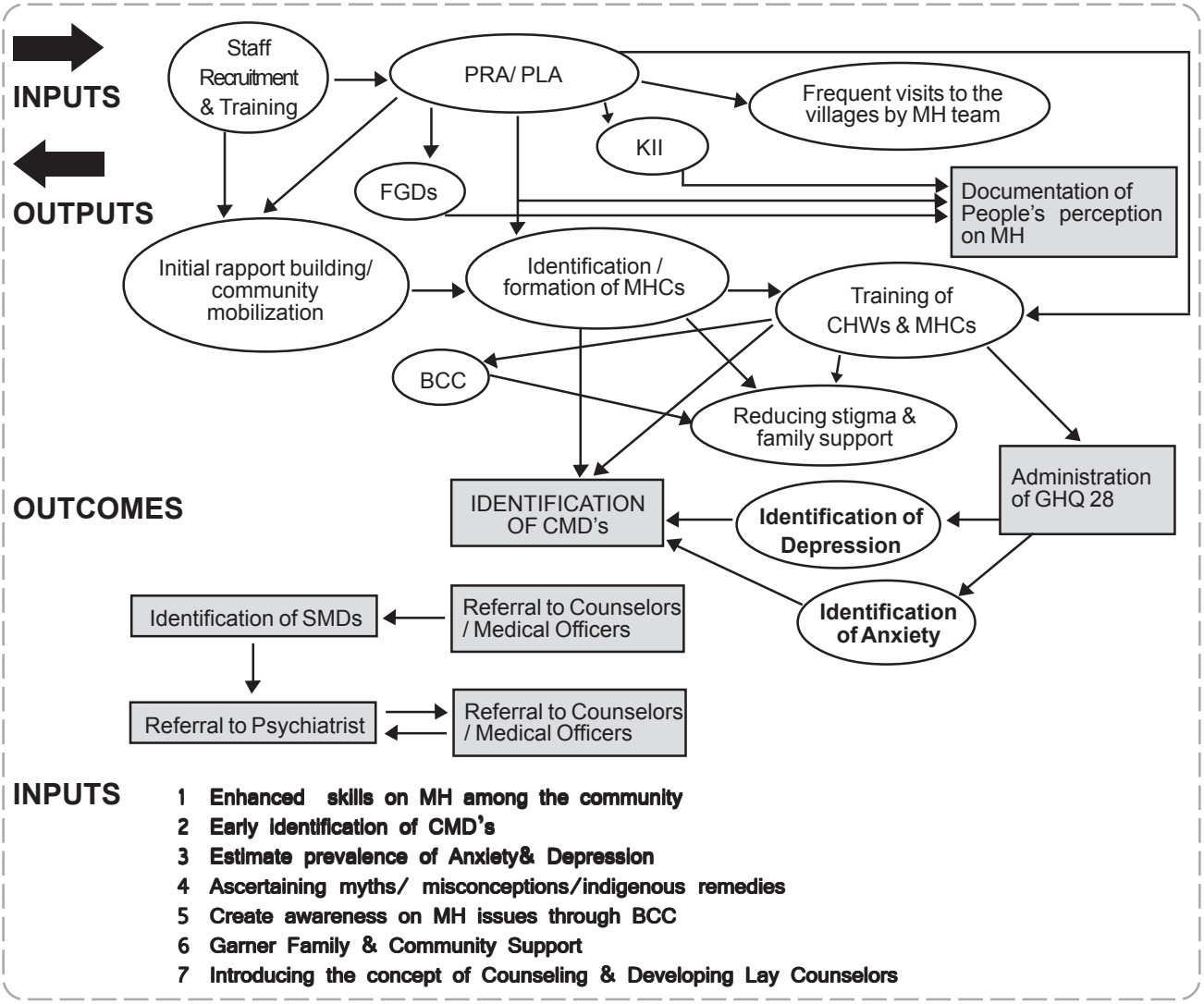
After the presentation a brief discussion with the Resource Person and the Eklavya group followed. Loss of self esteem and confidence and inability to take on the pressures of daily living were other results of illness, which the recovery method aided to address. The Recovery method could be used with families, carers of mentally ill people as well as patients themselves, though in separate groups. The diversity in the kind of illness or the contextual range that people come from was not a hindrance because the method was so simple. Queries relating to the use of the tools were addressed.

15.2 A CMH Pilot program in Gujarat

As another example of Community Mental Health, learnings from a Pilot Programme established by AKS in Gujarat was presented to the group and discussed.

The presentation began with an introduction to the world mental disability burden. This was juxtaposed with the mental health budget to show the gap between the need and the resource allocation. A historical review of the services of mental health was presented, linking mental health to the consumer movement, human rights, development, community mental health and public health. Though the community health services were expanded, they continued to remain separate from primary health care services.

Focussing on the Pilot project in Gujarat, the presentation expanded on the vision, mission, essential services, location, goals and objectives of the project. The possible structure to achieve the goals was



then shared. The geographic coverage in which intervention has been introduced was presented. The programme cycle was explained.

Activities that were carried out to achieve the objectives of the programme were listed and described, including Participatory Rural Appraisals, Focus Group Discussions (FGDs), Key Informant Interviews (KIIs), formation of Mental Health Committees (MHCs), Information Education and Communication (IEC) Campaigns, Administration of GHQ-28, Training to Counsellors, Medical officers, MHC Members on Mental Health Counselling, Case Identification & referral by MHCs, CHWs & AWWs. The process of these activities was then explained in detail and the presentation concluded.

Some interesting findings of the PRA exercise

- People immediately sense MH problems, but mostly Psychoses. Neuroses generally go unnoticed.
- Most villagers resort to faith healing, 'Dora dhagas' and visit the Bhuva initially for treatment of any kind of mental health problems.
- Myths prevailed about who is mentally ill.
- Symptoms like headache, irritability, lack of sleep /interest for food/ enjoyment/ socializing /work, BP, constant worry, suicidal thoughts etc. were attributed to mental illness

Findings of FGDs with different groups

Adolescent's boys & girls (10-19yrs).

- They were aware about anxiety and depression, and related this to exam phobia and negative behavior of the teachers
- Broken love affairs or unfulfilled sexual desires
- Desire for and guilt feeling after masturbation
- Pressure from parents to excel in studies and career
- Very low knowledge about treatment of mental illness problem

With 20 to 54 men of reproductive age:

- Every one knew about causes and symptoms of anxiety.
- Causes reported included marital Conflicts, family conflicts, financial problems, uncertainty about the future etc.
- They believe in Bhuva's and 'Dora Dhaga' to solve their problems.

15-49 Female reproductive age:

- They are all aware about anxiety and depression and accept that anxiety affects an individual's life.
- Causes of depression in these groups are: financial problems, divorce, children's education, adjustment to husband's family.
- This group also approached to 'Bhuvas' and 'Dora Dhaga' in order to solve their problems.

60 and above Female and Male Group:

- They are aware about causes of Anxiety and Depression.
- The main causes are: loneliness, adjustment with family, physical illness, financial problems
- They also believe in 'Bhuvas' and 'Dora Dhaga'

Findings from the Key Informant Interviews (KIIs)

- No mental Health Programme has yet been implemented in the villages.
- In every village approx 20% of the population is alcohol addicted.
- 80% of population is tobacco addicted.
- Bhuva has social acceptance in the society.
- Village did not have any recourses to rehabilitate mentally ill persons. Villagers did not behave properly towards mentally ill person, so that patient became more difficult to handle.

Discussion

Discussion ensued on faith healing. The resource person shared that people received results and good outcomes from traditional healers. In CMD, medicines don't have a very large role to play. Counselling and psychotherapy are better. Whatever method used by the traditional healers, their acceptance in the community is very high and people believe in them. We need to understand the methods they use, may not always be scientifically acceptable to the western world but people have tremendous faith and that goes a long way for them in the healing and recovery process. Psychiatrists are not the only people privileged to treat people. Psychologists, Counsellors etc. should also be included and when faith healers (Bhuvas) occupy such a large part of this sector, there must be something they are offering people. We cannot challenge traditional healers without any knowledge about their methods and without ways of measuring them.

It was discussed that in rural areas it took almost a year for people to accept the centre and use its services. The system has to percolate still further. Village areas need services and an occupational therapist at the village level is a very essential need.

With regard to service providers, the need for more psychologists was stressed.

16. Mental health in organizations and working teams

Bhargavi Davar

Based on the feedback received from the previous day, a session on mental health in working teams was included, aiming at exploring the mental health needs within teams and organizations through self-reflection. Participants were asked to make a drawing of their respective working environments. Debriefing was done about how these environments were experienced by each participant and the learnings were summed up. The session deconstructed many myths the group had about NGOs, individual power, organisational power and tried to connect people to individual initiative and creativity, within a chaotic work environment.

There were positive and negative portrayals as well as physical and emotional depictions of working environments. The workspace was perceived as a safe space where learning and sharing took place and where there was growth and feelings of accomplishment. Some participants saw it as a space where they felt rejection, burden, accusation and confusion, along with positive feelings of motivation, achievement etc. A member shared that her workspace constantly reminded her of her responsibility towards people. Discomfort resulted due to comments or ideas of male colleagues about women, or the behaviour, beliefs and attitudes of male members in office. One of participants had depicted her experience of the work environment at the course. The process of adapting to the environment included feeling hesitant, to finding company, then joy, then freedom and construction.

A discussion ensued on why mental health in working environments was important. The following were the responses:

- The environment affects the quality and output of work
- The long time spent at the work place causes a spill over from the personal to the professional and vice versa
- One of the main elements in a working space is competitiveness and dealing with this, becomes important to be productive at work
- The environment affects the relationship with peers and other people in the hierarchy
- While we work with people and believe in values like equity it does not always translate into our work space or relationships at work, and this causes confusion especially for subordinates
- Issues of survival: competition heightens this situation and if people feel that their job is threatened, then they respond without much sensitivity
- Conflicts are always a part of environment and dealing with it has an effect on people
- When we work in healthy environments, we become more confident and learn from positive examples and critiques

Even though we are in the care giving professions, mental health in work environments is never spoken of. There was willingness in the group to attribute all mental health problems to the leadership. This led to a discussion on power, hierarchy, and mental health. Whether power is really centralised was deconstructed. The different ways in which power plays itself out within organisations and working teams was deconstructed (e.g. who speaks in meetings and who doesn't). The sense of being wronged and being victims within NGOs was discussed. The paradox of working in the empowerment sector with core feelings of powerlessness and victimhood and the need to address these was emphasised. The discomfort with power was deconstructed: How do we relate to power and powerlessness, how does this translate into our work, with others in our work space, and in the community with those, who we work for; What kind of agency do we have in the power equation, what do we do to amass it or distribute it, was discussed. The fact that each of us in working environments had a responsibility in the creation, enjoyment and sharing of power was emphasised. Issues of inclusion and exclusion were discussed.

In affecting mental health, notions related to the 'external' environment were weaned out from those related to the individual and to the interpersonal. The personal agendas and interpersonal dynamics contributing to mental health in the work space were discussed. The agency of the individual vis a vis her contribution to the work, the team and the organisation, and the placement of these within the broad organizational goal, were discussed.

Personal situation	Interpersonal situation
• Need for self endorsement • Emotional dependence • Personal emotional content which comes from our own individualised contexts and our relation to the larger world • We bring in our patterns of individual behaviour and habits into our work lives • Identifying our working peers with important figures in our lives • Need for approval, rewards, conformism, acceptance • Sense of ownership – to feel at the centre of work • Sense of rejection, low self esteem	• Alienation • Feeling of superiority/ inferiority • Others laughing at you • Images we carry in our heads about groups • Stereotyping

The need for posting self growth as an objective within professional work was discussed in terms of response to power and authority issues, decision making, aggression, anger, rage and blaming, conflict, self complacency, and ideological rigidity. The possibility of creativity and the advantages of professionalism in providing structure to interpersonal relationships and to emotions were discussed. The impersonal usage of performance measures in organisations was debated, along with the challenge of how to humanise this process.

In the social development sector, there is a lot of space to explore different patterns of working and interacting with work, peers and people. The utilisation of this space to exercise the values we subscribe to, leads to an enrichment of emotional spaces and directly affects output. It is only when the values we believe in, become intrinsic to our person, and are exhibited in all the situations we are in, that there is a harmony between the internal and outside world. It was felt that there was a need to sufficiently personalise our politics, while in the women's movement, we have politicised the personal. When we bring rage from our own lives into our workspaces without resolving it, we do more harm than good to the space and ourselves. The need to bring peace and harmony into our own selves and our working worlds was emphasised as the first responsible step towards creating a caring world.

17. Public Health and Policy

Sundari Ravindran

Sundari Ravindran

The objective of this and the next session was to introduce participants to what policy meant in the health sector and to construct a conceptual framework for carrying out a policy analysis in the mental health sector. To explore the policy making process and the changes in perspective required, was also an objective.

Discussion – What is Policy?

- A set of plans and guidelines that a group of people make that govern the development of strategies

- They are goal-oriented documents to achieve something, an implicitly felt need for changing the current situation, or adding something that is not present.
- Collective decisions by those in power, to be implemented for large populations
- A process of negotiation between various constituencies – political and representative of different groups. This usually results in developing policies, which have a little bit of everything, but don't do justice to any. The power balance between different groups influence policy making.
- A discussion ensued on whether political groups really present the interests of groups they say they represent and whether decisions made about policies are necessarily collective. The debate between consensus versus the collective was examined.
- Policies could be formulated or / and implemented, at various macro levels, for example, organisational policies in schools, dress codes and uniforms, recruitment policies, national / state policies, population policy, etc.
- Policies could be for the larger good or for the promotion of one group, which is marginalised.
- Policies are broad guidelines and strategies are context specific for implementation.
- Policies are evidence based. However, the nature and quality of 'research evidence' had to be kept in mind. The fact that research gaps are political was discussed.

The challenge in developing policies is to give it a human face and to ensure its sustainability. In order for it to address a large number of people and maximize benefits to them, policies have to be made inclusive by basing them on the concept of social justice. This can be done by making policy development processes more inclusive.

Policies are not always written. For example, household level policies are seldom documented – 'No using abusive language in the house' or, 'Everyone will do their own work'. In case of conflicting interest, resolution or decisions are made by those in power and in all likelihood will tilt in favour of those having more power in the house. The prevalent customs, conventions, societal and familial norms will prevail.

At a macro level, if policies are not written, they have greater ramifications. Clarity and flexibility of a policy is also a matter of policy. Most policies tend to be vague, allowing broad interpretation, depending primarily on the benevolence of those in power, leading to marginalization. There is usually resistance to changing policies or bringing in new policies.

The difference between policies and other normative instruments was discussed. The Gujarat Mental Health policy making process was discussed as an example.

Following this, an exercise on analysis - how different policies identify and address gender inequalities - was carried out. Participants had to classify policies as gender blind, gender just, gender redistributive and gender unequal based on the policy statements. These approaches were defined and explained to the group and they had to analyse and classify various existing policies into these approaches.

Approaches to Gender

- A 'Gender unequal' policy privileges men's well-being over women's. These are policies which directly deny women's rights or give men rights and opportunities that women do not have.
- A 'Gender blind' policy is blind to gender differences in the allocation of roles and resources.
- A 'Gender specific' policy is aware of the practical gender needs of women and men, and tries to address them.
- A 'Gender redistributive' policy tries to change the allocation of roles, resources, and power between men and women in society.

These were described and discussed with handouts and examples.

Gender unequal	Gender Blind	Gender-specific	Gender redistributive
A water supply policy establishes a mechanism to provide taps close to villages so that women will not have to walk as far to fetch water.	The government introduces a new social insurance schemes for all workers employed in the formal sector.	Maternal health policy trains women midwives to improve their clinical skills to prevent maternal morbidity and mortality.	A land policy which removes restrictions on women's right to inherit land.
Only women have to carry water as the policy assumes that this is the woman's role. How to make the policy redistributive was discussed.	90% women are in the informal sector. This policy leaves out women, who are really few in the formal sector. The policy fails to look at existing structural inequalities which continue to uphold those structures.	This could also be called unequal because it should be trained birth attendants (male and female).	In order to make it more redistributive the policy should state that anyone can inherit land.
Tokens are issued for claiming relief after a disaster to the male heads of households.	Senior management recruitment policy in a department of health requires all managers to have a PhD.		Information, Education and Communication policy establishes messages and methods to advocate to women and men about mutual respect and equal rights in sexual decision-making as a means of promoting safer sex practices.
In the case of the tsunami disaster this gender unequal measure was adopted.	More men have a PHD than women. Class bias. If we don't accept PHD as an indicator of competence then there should be some other ways of ascertaining competence. If PHD is necessary, then the opportunity of acquiring it while in service should be given.		
	Community-based AIDS care programme says that the health care system cannot take responsibility for caring for people with AIDS, and that home-based care must be instituted		A human resource policy includes provision for child care facility at the workplace.
	The burden of care taking usually falls on women as they are the ones who are responsible for these functions in the home.		The policy should openly state that men are also encouraged to bring their children.

A presentation consolidated the discussion, introduced policy approaches to gender and gave a framework for policy analysis, along with examples. The contexts within which policy was made included

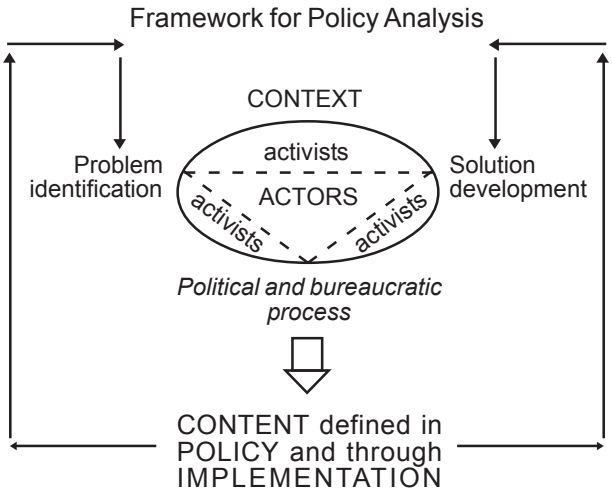
- the socio-economic and political context
- immediate historical context
- international factors
- cultural factors

The actors in policy making could include a variety of stakeholders. Some of them are politicians and political parties, government officials, NGOs, community groupings, specific constituencies, media, research institutions etc. Dialogue, persuasion and building a consensus from the opposition are areas we often ignore, but are important as the acceptance or rejection of a policy is based on this.

The process of policy making was described and discussed with examples. Gender is a variable at every

step of this process. The session ended by looking at the rationale for the way policies are developed and also identifying spaces, where a gender and rights perspective could be included. The need to develop gender redistributive policies was emphasised. How to make the policy making processes more participatory was discussed at length. The need to advocate gender equality throughout the policy making process was emphasized. Strategies for doing so were also discussed.

The work of the policy makers and other stakeholders does not end with merely its drafting. Its implementation is what will determine its robustness and effectiveness. Here the elements of management, administration and monitoring will play a critical role. Examples of policies in other countries were shared and debated in this context.



18. Mental Health Policy – A Review

❀ Bhargavi Davar

The participants were given the National Mental Health Program document to analyse. An analysis framework was given to the group. The learnings from all the previous sessions were brought to bear on this session.

Critique of the NMHP

- Gaps between objectives, strategies and plan of action were identified.
- The document was silent on the social determinants, traditional healing, domestic violence or social violence. The document was fully based on a bio-medical perspective.
- The gendered aspects of service provision were not addressed.
- Vulnerable groups are mentioned as an objective, but this does not carry over in the action plan.
- In monitoring, all targets are in terms of process indicators, human resource and infrastructure development, instead of outcomes on client life. The targets have nothing to do with the objectives.
- With regard to service provision, rehabilitation centres are few in urban areas, hardly present in rural areas. Further, there is only 1 part-time community worker per 1000 population. Rehabilitation aspects were not emphasised in the document.
- An interesting point noted was that the committee meeting on the drafting of the policy comprised only of doctors. There was a complete absence of psychiatric social workers, or any other civil society agents working in the sector.
- It is a *mental illness* program and not a *mental health* program.
- There is only a spattering of outdated data sometimes even without the year of the data being mentioned. This data is not segregated by gender, age groups, social deprivation etc.
- In the 10th Five Year Plan, the government released 190 crores of which over 75 percent was spent on infrastructure and strengthening psychiatry departments. The DMHP, an unevaluated program, was proposed to be replicated.
- While it mentions minimum health care for all and objectives in addressing the whole spectrum from distress to chronicity, in setting priorities, only illness and chronicity are addressed.
- The program has effected a shift of institutional facilities to a community setting, without any change in perspective or inclusion of a variety of community based services. Medicine was the only treatment being provided.

Participants were asked to reflect on what kind of solutions could be proposed to make the policy better. If a community mental health model that is holistic and addresses the issues of gender, class etc. is to be implemented, what are the alternatives, what needs to be added, strengthened or removed from the policy.

19. Ethics, law and mental health

Objectives of the module:

Participants will be able to:

- get a stakeholder perspective in mental health and the diverse value systems
- appreciate the legal subtext of mental health decisions and choices
- be informed about legal aspects driving the mental health sector
- develop their concerns about the right to health care in mental health sector

The morning was spent in viewing the film, 'One Flew Over the Cuckoo's Nest' and discussing it. The film gave a general experiential introduction to law and its role in the mental health sector, particularly in the context of institutions. The acute differences in the influence of the law between the health sector and the mental health sector were presented. It is assumed in the law that mental health patients have no personhood, unlike health patients. Law in the mental health sector is tuned to protect the health and safety of others, even if it means denying the rights of persons with mental illness. The presentation also highlighted facts in the field of gender, law and mental health.

The Mental Health law is custodial. The constitutionality of the Act has been contested by scholars. The scope of law in mental health encompasses the aspects of care and treatment, civil status and capacity decisions (marriage, property, custody, public office, contract, etc.), criminal responsibility as well as human rights, equal opportunities and non-discrimination. Laws pertaining to each of these areas and the consequences of these laws to women's lives, were described. In most of the laws dealing with mental illness, highly objectionable language is used.

Why law needed to intervene in the mental health sector was discussed. The various sections of the law relevant to client life were addressed, including admission and discharge procedures, forced treatment, medical opinion and certification and legal capacity. As people working in the community, we do not realise the legal burden placed on a person with illness and we take the infringement of their rights for granted.

The mental health act has been used as an instrument to oppress those who are already vulnerable due to a disability condition, even though it has some good provisions which are unutilised. Examples of such unutilised aspects of the law, which are meant to empower the client, were cited, such as magisterial powers, procedure for giving medical opinion, etc. The gendered aspects of the mental health act were highlighted. For example, discharge procedures go against women as men are usually allowed to leave institutions once they are considered fit but a woman has to wait for someone to get her discharged. Within the institutions itself, differential treatment is given and the 'Good woman patient' syndrome works against women.

The presentation also touched upon the European standards for commitment and the recommendations of the Draft UN Convention 2005, with regard to mental health and its legal aspects. The effects and outcomes of the enforcement of the mental health act, on people were also touched upon. The issue of clients' rights, care givers' roles and the role of institutions, were discussed.

After this presentation, the group was given three case studies to analyse and propose human rights sensitive social interventions.

Case Study 1

Sapna, a young graduate, with some medical history of manic - depression, residing in the city of Jamshedpur, started moving around with one of her colleagues from a different community. Her brothers did not approve of her friendship and asked her to stop her relationship. Sapna however asserted her freedom of choice and continued to move around with the young man. Annoyed by Sapna's disobedience, her brothers first thrashed Sapna and the young man, and later, filed a complaint against the young man in the local police station. On being summoned for questioning,

at the local police station, Sapna lost her temper and shouted and screamed at the Station House officer and even slapped one of the constables. The brothers on being informed of Sapna's conduct contended that she had never been mentally stable and this conduct was also a result of her mental instability. As a result of the report of her brothers and due to her conduct at the police station, the SHO reported Sapna's case to the magistrate and obtained an order to send her to the nearest mental hospital. After treatment of a couple of weeks, the hospital authorities came to a decision that Sapna required no further hospitalization. They declared her fit to be discharged. Consequently, they write to her brothers to take her back. The brothers fail to turn up on the appointed day. Sapna insists that she is educated. The authorities should discharge her at her own risk. She also expresses reservations at going back to her brothers. There is a proposal to transfer Sapna to a protective home for women.

Discussion

The limitations of the institutional set up were discussed. The social reasons why Sapna's brothers were bringing her illness into the picture need to be looked at. They have attributed a poor mental condition, to break up the relationship. Sapna's anger was pathologised, when she had valid reasons to be angry. It is apparent that the family does not want her or they would have come to take her. It is important to differentiate between mental distress, disability, illness and chronicity. Sapna is capable of taking care of herself. The fact that there is 'no one for her' should not result in life long institutionalisation. Her brothers should be bound to give her residence / property. The mental health system should create sensitive psychosocial pathways for her healing from the violence she has faced. This process of seeking self care should be voluntary. But the opportunity for exercising that choice should be created. This is the responsibility of the institution. The process of shifting a person from one institution to another is degrading to the free human spirit.

In response to the suggestion that the woman should sign a discharge document, it was stated that when men are allowed to leave freely then why should this procedure be required of women. Such administrative procedures are used only to protect and safeguard the institution. When there is a clear provision of voluntary discharge, introduction of more administrative procedures becomes irrelevant. This will only further reduce the rights of individuals and give more power to the organisation, which is already powerful and protected.

Case Study 2

Aparajita, a young married woman with two children, is extremely unhappy with her husband's infidelities. To seek peace, she starts visiting a religious guru. Her husband intercepts a number of letters written by her to the guru whose tone seems amorous to him. He is convinced that the Guru is sexually exploiting his wife. He shows the letters to his in-laws to obtain their support in preventing his wife from visiting the Guru. Aparajita however alleges that the husband has launched this counter offensive to hide his own infidelities. Both the husband and the parents suspect Aparajita's mental stability. After narrating her conduct to a psychiatrist friend, they get her to meet the concerned doctor in the lobby of a hotel for about 15 minutes. The doctor is convinced that Aparajita is suffering from paranoia and needs institutional care. He sends a copy of the letters and his own opinion to a colleague psychiatrist, asking if he could provide the second certificate necessary to institutionalise Aparajita. Subsequent to obtaining the two certificates, the parents of Aparajita file an application in the court of the local magistrate seeking her institutionalisation on the ground of insanity. They expressed inability to produce Aparajita before the magistrate on the ground that she could not be safely produced in court. In view of the fact that the application came from the parents of Aparajita, and was accompanied by two medical certificates, the magistrate passed the order of institutionalisation without examining Aparajita. Armed with the magistrates order, the admitting psychiatrist and the local police, the parents and husband of Aparajita move to institutionalise her in a private psychiatric home. However, before they could execute the order Aparajita fled from her house and challenged the order in the State High Court.

In the High Court Aparajita contended that

i) she was not mentally ill and she was being so labelled for ulterior reasons;

ii) the doctors who had issued certificates had never examined her even though the law requires them to examine her independent of each other and issue a certificate clearly demarcating symptoms reported and symptoms observed by them;

iii) the magistrate had also issued an order without seeing her on the assumption that she was violent by reason of her mental illness even though she had not been guilty of any violent conduct.

In their reply the parents sought the help of the court to save their daughter from the clutches of the guru who was sexually exploiting her. They further contended that there was no truth in the infidelity allegations of Aparajita and it was only her paranoia which was causing her to so speak. Further because of the nature of her illness they could obtain no cooperation from Aparajita in relation to her treatment and were doing the best that could be done in the circumstances. In their anxiety to seek help for their daughter they may have not fulfilled the requirements of the law in its full technical rigour but their genuineness should not be doubted and they should be assisted in seeking help for their daughter.

The psychiatrists in their reply also informed of the difficulties of providing treatment to a person suffering from paranoia and how some relaxation in the technical requirements of the law becomes necessary to provide help to one who needs it.

The poor role played by the medical professionals in processing legal aspects within the mental health sector was condemned. The negative role played by the husband and her parents was discussed. It was felt that the medical officers should be penalised. Procedural faults should not be overlooked and the license of the psychiatrist should be taken away. It was also felt that no comments were made by the Supreme Court on the psychiatrists, or on the lapses by the High Court. An independent evaluation of the person should have been made and her case should have been seen based on research and with an unbiased angle.

Case Study 3

A pharmacological company needs to test the effectiveness of a new drug for the treatment of schizophrenia. It approaches the Superintendents of several mental hospitals with the offer that it would pay the food bill of the institution for the next six months and also provide the drug free for a period of two years after testing provided they could test the drug on the inmates of the institutions. The Superintendent of XXX Mental Hospital accepted the offer and the Company carried out its testing on the inmates with his consent.

Six months after the tests were completed, some of the inmates who were given the tests experienced renal complications causing kidney failure. Once the drug was tested and marketed, the Company, despite its promise, did not provide the drug free of cost to the hospital, causing deterioration in the condition of those patients who were benefiting from the drug.

A patient advocacy group is planning to take up the cause of the patients and wishes to move against the hospital and the pharmaceutical company.

Section 81 (2) of the Mental Health Act 1987 lays down that 'no mentally ill person under treatment shall be used for purposes of research unless such research is of direct benefit for purposes of diagnosis or treatment' or 'such person being a voluntary patient has given his consent in writing or where such person (whether or not a voluntary patient) is incompetent by reason of minority or otherwise to give valid consent the guardian or other person competent to give consent on his behalf, has given his consent in writing for such research.'

There was a discussion about the current reality and ethics of drug testing. The issue of compensation

was discussed. The nature of 'consent' in such cases was discussed. Full medical support and care should have been granted and knowledge of probable side effects should have been shared with the participants in the trial. Any side effect that surfaced during the trial should be the responsibility of those administering the trial. With regard to permitting the trial on patients without consent, it was felt that it was a case of gross violation of patients' rights. As medical consent involved technical matters, the need to provide robust information was discussed. The question of proxy consent was discussed with examples.

20. Integration of Mental Health in Women's Health

Objectives of the session:

Participants will learn to

- develop strategies for inclusion of psychosocial concepts of mental health into programs and into their own work
- develop at least one plan for integration of mental health

As a concluding exercise, the participants were asked to plan mental health interventions in a community. The intervention had to have clearly defined goals, objectives, values, target groups, strategies, time lines and plans of action. They also had to build in components of monitoring and evaluation into their programmes. Participants worked in groups and made presentations on the same. Interventions touched on different aspects of mental health for different stakeholder groups. Some plans focussed on awareness and prevention, others on training and capacity building, counselling and outreach. Interventions were designed for women, tribal communities, marginal groups (LGBT) and entire village communities.

Discussion and Feedback

Perspectives in the groups were diverse and it was difficult to adopt one point of view or reconcile different points of view.

It was felt that till the intervention itself was not articulated, it was difficult to determine what values were flowing from it. This led to a discussion of which comes first, intervention or value.

Developing monitoring indicators for interventions was a challenge.

Developing constructive language that people could relate to and still have it based on the values of empathy and emotion, was another challenge. The questions, '*What am I going to do*, *how am I to put it into words?*' lingered throughout the process.

It was felt that a consolidation of learning of the previous days had happened while planning interventions. A process of applying different modules and assimilating them into the intervention took place.

'*It was an empowering experience to think of what can be done, a transformation from critique to action, moving from outsiders to actors.*'

Reflections of Resource Persons

The facilitators felt that presentations showed concept clarity with regard to gender and mental health. The methodology had taken this into account and was specific in addressing gender issues. The guiding principles of the interventions were also well defined.

The definition of mental health was still unclear. However defining this is important because, the largely prevalent view about mental illness is of chronicity requiring medical interventions.

It was also felt that the term 'awareness' about mental health was a very large concept and should have been further broken down. The profile of people and social determinants in communities is diverse and programs have to reflect fulfilling the needs of this diversity.

Caution about going through panchayats was expressed. Power distribution in communities and structures becomes relevant – who is at the receiving end is a question that we need to keep asking.

A discussion about overlooking mentally ill people ensued. Communities hide patients because of the stigma and a lack of positive relationships with service providers.

Integration of traditional healing was discussed. How we look to traditional healers was discussed – are they only agents for detection and identification of mentally ill persons or do we also look at them as holders of knowledge or just quacks used for referral into the mainstream system?

It is always useful to have indicators that tell us if we have reached where we wanted to go. It helps in evaluation and also for guiding as to where did we go wrong. These could be process indicators or baseline, and they have to be specific to the programme designed.

Drum Circle

Zubin Balsara, of the World Center for Creative Learning, Pune, conducting a Healing Circle with Drums at the GMH program. WCCL conducts some art based therapy sessions at GMH for sensitisation, including meditation, drums or theatre.

Evaluation and Feedback of Participants

Expectations from the course:

New topic, came to explore and could relate the learnings in future work.
Build personal capacities, and to enhance knowledge in the area of Mental Health
Understand the linkages between gender and Mental Health
Develop research ideas in the area of GMH
Pursue socio-psychological research related to gender

Whether the expectations were met in the course?

10 participants said that they were met fully and 1 said that it was met partly.

Comments:

Learnt more than expected
Wanted to learn more on research methodologies
Got better picture of Mental Health as a topic for research purpose
The therapy sessions like meditation, drum gave insights that could help to cope

Satisfied with the overall balance of topics and materials in the course?

8 participants were fully satisfied and the remaining 3 were only partly satisfied

Comments:

Reading materials were useful
More time should be given to the topic of sexuality, sexual orientation & gender
Very comprehensive course
The topic on community models was not so interesting
Reading were good, but presentations were too basic
More time should be given for violence and CSA

Did you read the material ?

8 participants read partly and remaining 3 read it mostly

Comments:

Papers related to presentation were read in detail
Very tiring at the end of the day to read
Lack of time for reading
The articles were interesting
Were the reading materials suitable?
10 participants felt that the reading materials were mostly suitable. One felt that it was only partly suitable.

Comments:

Reading materials provided database for understanding issues
Informative reading, very interesting
Homework should be more about reading than making presentation

About the Daily Schedule:

Two of the participants felt that the schedule was too long.
The other 9 participants felt that it was just right.

Comments:

Did not get enough time to talk about general issues or share experiences
The pressure of making presentation became heavy
Group work should be less
There must be more space for short films
Meditation, music etc. therapy exercises should be planned after heavy session to get rid of burn out
Some sessions were to slow
The initial days were little hectic. Introducing role plays or other activities may help to make them less hectic.

Most valuable sessions: *(No. in the bracket is the no. of participant's response)*

Violence and Mental Health (5)
Child Sexual Abuse (9)
Reproductive health and Mental Health (4)
Gender and Mental Health (4)
Schizophrenia (2)
Value Clarification (2)
Gender Analysis Tool (2)
Policy (6)
MH in organisation (1)
Laws & Mental Health (4)
Developing community M.H. Programme (1)
Session on PND (2)
Research (3)
Community Material (1)
SAA (3)
Drum Session (1)

Comments:

Session on Workplace and mental health needs to be given more time

Least Valuable sessions:

(No. in the bracket is the no. of participant's response)
Violence (3)
Reasons:
Very Basic, already knew
Community M.H. (3)
Law (1)
Reason: Couldn't relate it much to research.
Schizophrenia (2)
Reason: Too bio-medical
The remaining 3 participants felt that there was no session that was least valuable

Anything to be cut from the course:

Part of CSA and law (1)

Comment: ***Should design separate course on these topics.***

Domestic Violence (1)
Community Mental Health (1)
The remaining 7 participants felt that there nothing to be cut out of the course
Other suggestions :
Reduce the session on schizophrenia
Add more about sexuality
More emphasis on disseminating findings of literature reviews and experiences

Level of course:

All 11 participants felt that the level of the course was just right

Added comments:

Except for few terminologies of the medical field
At times felt it's a longer course looking at the topics and sessions covered, few shortcut strategies can save the time
It was great, introduces a lot of new understanding
The homework & presentation pressures made it little difficult

Future Actions based on inputs:

While designing the project interweave the M.H. component to it.
Gained sensitivity to the topic
Enhanced skills
Will do more research
Will provide social support to individuals
Try to do more micro-level research
Like to carry out research related to missing gaps (2)

Personal impact of the course:

All 11 felt that the course left a personal impact.
Sensitivity about mental illness
Feel more equipped to deal with issues of M.H
Made stronger, firmer and feeling fully in control
Helped to unravel the complexities of life
Learn skills of review of literature, analysing research material
Feel confident about alternatives to psychiatric interventions

Logistical arrangements:

All 11 participants were satisfied with the arrangements.

Additional Comments:

Exposure to more meditation, drum sessions
Distressing issues can be made lighter by developing a more comfortable environment
The method was participatory
Course was very well arranged
The course period should be extended by 4-5 days, never get chance to participate in such extensive courses
More time required for readings
Alternative should be given between individual work and group work
More free time to relax in order to concentrate better on sessions

Annexure I

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Annexure II

Gender and Mental Health - A 10 day Residential Academic Program [26th January – 5th February, 2006]

Session Outline

Session	Topic and facilitation	Learning Objectives	Time	Process
26/01/06 Thursday	INTRODUCTIONS	6 p.m. Objectives and expectations		
Module – I 27/01/06 Friday	CONCEPTS ON GENDER AND MENTAL HEALTH – Bhargavi Davar and Sundari Ravindran	Participants will be able to 1. See the conceptual linkages between physical health and mental health 2. Seeing mental illness from the disability perspective 3. Understand how gender and other social determinants influence mental health 4. be able to process evidence base on gender and other social determinants in mental health 5. be informed about the special problems of women with chronic mental disability		
Session 1 27/01/06 Friday	Sundari Ravindran	GENDER IN HEALTH	Morning (10 A.M. – 1 P.M.)	**Lecture method** **Working groups** Guided discussion
Session 2 27/01/06 Friday	Bhargavi Davar	Clarifying concepts: Orientation to Mental Health / psychosocial disability	Afternoon (2 P.M.– 5 P.M.)	**Lecture method** **Working groups** Summary presentation
		DAY 1- EVALUATION	**5-5.30 P.M.**	
Session 3 28/01/06 Saturday	Dr Shantha Kamath	"Gender and Schizophrenia"	Morning 10 A.M. – 1 P.M.	Lecture seminar and discussion by the Resource Person (SCARF)
Session 4 28/01/06 Saturday	Bhargavi Davar	Identify social determinants to mental health, including gender	Afternoon (2 P.M. – 5 P.M.)	**Study groups** Readings and group presentation Summary presentation on evidence base
28/01/06		**DAY 2- EVALUATION**	5-5.30 P.M.	
		Optional	Evening	Movie

Session	Topic and facilitation	Learning Objectives	Time	Process
Module II 29/01/06 30/01/06 31/01/06	Reproductive health, sexual health and mental health: Sundari, Bhargavi, Aparna, Anuja	Participants will be able to: 1. Understand the ways in which gender influences RSH 2. Identify the mental health aspects of RSH and learn the evidence base on RSH / MH linkages 3. Understand the mental health impact of violence 4. Be able to work with gender concepts in the area of sexual health and mental health 5. Understand the process of developing a program in the area of violence and mental health		
29/01/06 Session 1 Sunday	"Why is RH a gender issue?" Sundari Ravindran	Clarify concepts: RSH	Morning10 A.M. – 1 PM	**A lecture presentation** Case study and bubble Exercise
29/01/06 Session 2 Sunday	Sundari Ravindran Bhargavi Davar	Make RSH / MH Linkages Identify points for intervention Learn an evidence base	Afternoon (2 P.M. – 5 P.M.)	**Workshop** Role-plays and Discussion Summary presentation
		DAY 3- EVALUATION	**5-5.30 P.M.**	
30/01/06 Monday	Asha Pillai, Pune	Meditation	Early Morning (6.30 – 8 AM)	**Healing Experience** Meditation
30-01-06 Session 3 Monday	Seminar on Post Natal Depression	Learn the evidence base on post natal depression Learn the evidence base on intervention in primary care and prevention PP on RH / MH Linkages	Morning 10 AM – 1 P.M.	Interactive session with papers by the participants
30/01/06		**DAY 4- EVALUATION**	5-5.30 P.M.	
31-01-06 Sessions 5, 6, 7 Tuesday	"Child Sexual Abuse" Anuja Gupta	Learn to work with themes of sexuality in mental health Build a perspective about CSA and mental health Understand the essentials of an intervention plan for CSA	10 AM – 5 PM	**Workshop on child sexual abuse**
1-02-06 Wednesday	CSA		10 AM – 1 PM	Workshop on child sexual abuse
1-02-06		**DAY 5 & 6 - EVALUATION**	1 PM – 1.30 PM	Break for afternoon and dinner

Session	Topic and facilitation	Learning Objectives	Time	Process
Module 3 - 2/02/06 3/02/06	Research, Education and Policy in Mental Health	Participants will: -Address critical concerns in the production of research materials -Address critical concerns in the production of education materials in community mental health - learn about some community models and programs in mental health - address the mental health needs of their own working groups		
Session 1 2/02/06 Thursday	"Treating research data in mental health from a gender perspective" Bhargavi Davar	Participants will learn to : Assess research evidence from a gender perspective	Morning 10 AM – 11 30 AM	Study groups Group presentations
Session 2 2/02/06 Thursday	"Preparing materials in mental health" Bhargavi Davar	Participants will learn to critically look at community materials in mental health.	Morning 11 30 A.M. – 1 PM	Working groups, and interactive session
2/02/06 Session 3 Thursday	Community Mental Health – An example	Participants will be introduced to a community model in mental health	Afternoon 2 PM – 3.30 PM	Lecture demonstration by SAA
2/02/06 Session 3 Thursday	Community Mental Health – An example	Participants will be introduced to a community model in mental health	3.30 PM – 5 PM	Seminar Presentation by ex-GMH trainee
2/02/06		**DAY 7- EVALUATION**	**5-5.30 P.M.**	
3/02/06 Session 4 Friday	Mental health in organizations Bhargavi Davar	Participants will be self reflexive about mental health needs within their own organizations and working teams	Morning 10 AM- 11 AM	Open discussion Creative activity
3/02/06 Session 5 Friday	Public Health & Policy Sundari Ravindran	Participants will be Introduced to Policy in the health sector Have a framework for Policy Analysis	Afternoon 11 AM - 1 PM	
3/02/06 Session 6 Friday	Mental Health Policy Bhargavi Davar and Sundari Ravindran	Participants will be able to respond critically to policy drafts in mental health Identify policy issues in various mental health contexts	Afternoon 2PM – 5 PM	Study group presentations
		DAY 8 EVALUATION	**5-5.30 P.M.**	
(Optional)			6-7.00 PM	**On Healing –** On Nutrition & MH

Session	Topic and facilitation	Learning Objectives	Time	Process
4/02/06 Module 4 Saturday	Ethics, law and mental health	Participants will be able to : - get a stakeholder perspective in mental health and the diverse value systems - appreciate the legal subtext of mental health decisions and choices - be informed about legal aspects driving the mental health sector develop their concerns about the right to health care in mental health sector		
4/02/06 Session 1 Saturday	Value Clarifications in Mental Health Bhargavi Davar	Participants will learn to: Articulate value related issues in mental health Negotiate values between different stakeholders in the MH sector Articulate ethical issues in the Mental Health sector	10 AM – 1 PM	Role Plays Negotiation exercise Group resolution
4/02/06 Session 2 Saturday	**Law in mental health** Bhargavi Davar	Participants will Learn aspects of the law pertaining to mental disorder Learn legal implications of decisions on mental disorder	Afternoon 2 PM – 5 PM	Case work using lay jury Group presentations
		DAY 9- EVALUATION	**5-5.30 P.M.**	
4/02/06 Saturday	Drums Circle **A CMH activity**	Exposure to healing strategies in the use of arts in mental health work	Evening 6 pm – 7.30 p.m.	**Healing experience** Drum Circle - Zubin Balsara
5/02/06 Session 4 Sunday	Mental health in women's health- strategies for integration Bhargavi, Sundari	Participants will learn to 1. develop strategies for inclusion of psychosocial concepts of mental health into programs and into their own work 2. develop at least one plan for integration of mental health	Morning 10 A.M. – 3 P.M.	Program development Group work
		CLOSURE	3-4 PM	Certificates and saying good byes

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