# Partnering with Men to Promote Gender Equity and Reproductive Rights

## Experiences of a grass-roots women's organisation

Rural Women's Social Education Centre (RUWSEC)

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## Preface

The years since the International Conference on Population and Development in 1994 have witnessed growing interest in 'male involvement' in reproductive health, and the evolution of numerous programmes aimed at achieving this end. These programmes vary in their content and in their thrust, ranging from those that work exclusively with men to meet men's reproductive health needs and those that have initiated work with men mainly to promote male contraception to those that have initiated work with men on gender and reproductive health and rights as part of their ongoing struggle for a just society free from discrimination on the basis of class, caste or sex. Rural Women's Social Education Centre's (RUWSEC) work with men falls in this last category.

RUWSEC's work with men predates the ICPD, and evolved organically from its work with and for *dalit* women for the promotion of greater control over their lives and their bodies. Women's growing awareness about their reproductive and sexual rights in RUWSEC's project villages appeared to result in a widening schism between women and their male partners. Lack of understanding of the work of RUWSEC's women workers by their husbands and other men in leadership positions in the community became an important barrier to furthering RUWSEC's work with women in the community. This led to requests from RUWSEC's workers, who were then all women, that workshops be organised, at first for their husbands, and subsequently for men who were leaders of youth organisations or community activists. Our 'Men's programme' began in 1992, with ad hoc workshops on gender, reproductive health and partner violence issues.

This document reports on the evolution of this programme over a period of 10 years, the activities carried out and their effectiveness, and lessons learnt. We also discuss the implications of our experiences for programming for men's involvement in reproductive health in other contexts. We believe that the usefulness of this document rests not only in its concrete descriptions of the activities carried out, but also in its reflections and soul-searching in terms of what is useful and important to do and to bear in mind when initiating a 'male involvement' programme in any context.

We sincerely thank the entire 'men's programme' team and participants in this programme from the community for their inputs and challenges at various points through the evolution of this programme, which helped shape it. A special thanks to the various members of the team is due also for their meticulous and graphic documentation of the workshops and meetings and their own reflections and dilemmas, and to an initial write-up pulling together the multitudes of reports, by R. Ramya without which this document would not have been possible.

# I Background and context

## 1.1 Introduction

The International Conference on Population and Development devoted an entire section of its Programme of Action to men's participation in and shared responsibility with women for reproductive health:

*" Men play a key role in bringing about gender equality since, in most societies, they exercise preponderant power in nearly every sphere of life. The objective is to promote gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. Governments should promote equal participation of women and men in all areas of family and household responsibilities, including, among others, responsible parenthood, sexual and reproductive behaviour, prevention of sexually transmitted diseases, and shared control in and contribution to family income and children's welfare. Governments should take steps to ensure that children receive appropriate financial support from their parents and should consider changes in law and policy to ensure men's support for their children and families. Parents and schools should ensure that attitudes that are respectful of women and girls as equals are instilled in boys from the earliest possible age."*

(ICPD Programme of Action: Chapter 4, Section C)

Subsequently, there have been efforts in many parts of the world to translate these into programmatic interventions. Programmes have sought to promote male methods of contraception such as vasectomy and condoms, to provide services to cater to men's specific sexual and reproductive health needs, to have sexuality education with adolescent boys and girls to promote safe sex practices, and perhaps to a more limited extent, address issues around gender equity and gender-based violence with men and boys. Parallel to programmatic efforts have been debates around the best approaches to 'involving' men - whether programmes were justified in using men 'instrumentally' in order to promote women's reproductive health, whether they ought to focus on men as an under-served group when it came to sexual and reproductive health needs, whether programmes seeking to promote male 'responsibility' were starting from a negative premise (of men as irresponsible) and so on.

Against this backdrop, it may be interesting to read about the organic evolution of a "Men's" programme as part of the activities of a grassroots women's organisation working for the promotion of women's well-being through their empowerment, and for upholding women's reproductive and sexual rights. The grassroots organisation, Rural Women's Social Education Centre (RUWSEC) started working with men after more than a decade of work in the community with and by rural women. This document describes when and why we started it, what we did, and the lessons we draw from this experience for programming for men in reproductive and sexual health. The first section describes the context and the organisation, the second and main section gives a detailed account of the

programme, while the third and final section pulls together the lessons learned and reflect on how these may apply to other programmes for male involvement in reproductive health.

### 1.2 The context

The activities of Rural Women's Social Education Centre (RUWSEC) are carried out in the villages of Tirupporur and Tirukazhukundram sub-districts of Kanchipuram district in Tamil Nadu, South India.

The total population of Tamil Nadu was 62.1 million in 2001 (Census figures), and is among the more economically and industrially developed states of India. According to the 2001 census, it had an urban population of 44 per cent as compared to the all-India average of 28 per cent, and a literacy rate (among the population above 7 years) of 73 per cent: 82 per cent for males and 65 per cent for females. Tamil Nadu has during the last decade been the focus of much attention from demographers and policy makers because of its rapidly declining fertility rates: the TFR was 2.19 according to the National Family Health Survey -II (1998-99), the fourth lowest fertility rate in the country, after Goa, Kerala and Himachal Pradesh. The state is also covered well by health facilities. More than 88 per cent of children are immunised with DPT, polio and BCG vaccines, more than 90 per cent of pregnant women received three or more antenatal check-ups, and nearly 80 per cent delivered in a medical institution (NFHS-II). The national averages were 42 per cent for child immunisation, 43.8 per cent for three or more antenatal visits and 33.6 per cent for institutional delivery.

RUWSEC's work covers predominantly the *dalit* hamlets in the Tirupporur and Tirukazhukundram Administrative Blocks of Chengalpattu Taluk in Kanchipuram district, and a few hamlets of impoverished households of 'most backward castes'.
According to a survey conducted by the organisation in 1996-97, the total population in the project area is 27,383, and the number of households is 6273. 97 per cent of the population is Hindu, and Christians form the remaining 3 per cent. 90 per cent of the population belong to the 'Scheduled castes', and 10 per cent to other backward castes.

The vast majority of the population live in poverty. Although dependent principally on income from land, 79 per cent of the households do not own any land at all. A further 14.2 per cent own less than an acre of land, and are dependent on wage labour to supplement their income. Thus, 93 per cent of the households are landless or marginally landed households dependent mainly on agricultural wage labour, and on any casual wage labour.

Housing conditions are poor. Seventy four per cent of the households live in thatched huts with mud walls and mud floors, and 22 per cent of the households had constructed their huts on sites not owned by them, usually on government-owned land. Most of the houses had only one or two rooms, and only 15 per cent of the houses had a separate kitchen. In the other houses, cooking was done in the living area. Almost 90 per cent of households still use firewood as cooking fuel, but smoke outlets were present in only 3.4 per cent of

the households. Although all hamlets have electricity, a third of the houses do not have connection to the electric supply. 94 per cent of the households do not have water supply within the house and are dependent on public facilities: 29 per cent on wells, 7 per cent on ponds and the remaining 64 per cent on the public tap. Only 3 houses have a toilet.

50 per cent of the population above age 5 is illiterate. About 24 per cent have had up to five years of schooling, and an equal proportion have completed between 6 and 10 years. However, few actually graduate from grade 10 or 12: less than 2 per cent (1.4 %). And a very marginal number therefore goes to university or further training: about 4 in a thousand.

The gender gap in educational status is still fairly high: female illiteracy is 59 per cent as compared to 41 per cent male illiteracy. Among those who have had some schooling, an almost equal proportion has had primary education (25 per cent male as compared to 22.4 per cent female). It appears however, that when boys go to school, they are usually educated beyond primary school level, while most girls stop schooling after primary school: only 18 per cent among females have had between 6 and 9 years of schooling, while the comparable figures for males is 31 per cent. Only 7 out of 1000 in the female population above age 5 have graduated from high school or higher secondary school (grades 10 or 12) and only 1 in a 1000 has had any training beyond this level.

Agricultural wage work is the most common occupation among men (60%) while for women, both agricultural and other forms of wage work (38 % and 35 % respectively) are the most important occupations. Only 20 per cent of women do not work outside the home, while about 3 per cent of women work in their own farms or leased farms. About 3 per cent of women are officially unemployed, while among men, less than 1 per cent do so. About 1 per cent of men work as permanent farm servants under bondage to their landowners.

It may be said that even within this very poor population who constitute RUWSEC's target population, there are sizeable gender gaps in access to and control over resources. There are gender gaps not only in education and in employment, but also in ownership of assets such as land and house-sites, with men owning almost all of the meagre assets. Although women in these communities have almost always been engaged in work outside the home alongside their men, this does not give them equal power within the household. Men still control most of the important decisions related to children's education and marriage, related to important investments and expenditures. What women are left with is the responsibility for meeting the survival needs of the household from their earnings. Marriages are still arranged by male elders of the extended family, and dowry, non-existent even in the early 1980s when RUWSEC was founded, has now become common. Domestic violence and alcoholism are cited by married women as major problems in their already difficult existence. However, unlike many other communities in India, it is not impossible for women in this population to annul a difficult marriage, especially if they can support themselves economically.

**1.3 The organisation and its activities**

RUWSEC was founded in 1981 by a team of 13 women, 12 of whom were from the working villages of RUWSEC and had previously worked as literacy teachers with the National Adult Education Program. The formation of the organization was an evolutionary process; a natural development of the growing awareness of women to gain greater control over their bodies and their sexual and reproductive lives, and to make decisions concerning their lives overall.

Consequently, achieving women's well-being through women's empowerment has been the focus of the organization's work since its inception. Interpreting health in its broadest sense as overall 'well-being', the organisation's objectives include helping *dalit* women whose caste status has rendered them economically and socially marginalized to develop critical consciousness and leadership skills so that they are able to collectively and constructively change the circumstances of their lives. The organisation seeks to challenge class, caste as well as gender-based subordination and discrimination which result in a denial of equal opportunities to health and well being.

In pursuit of the above goal, the organization carries out a wide spectrum of activities that include:

- Community-based health education and health promotion
- Community-based reproductive health care for women
- Gender training of women
- Mobilizing women to form women's groups
- Life skills education for adolescent boys and girls
- Gender and reproductive health programme for men
- Campaigns
- Publications of popular education material and training manuals on gender and health issues
- Training support for grassroots NGOs, mainly on working with men, women and with adolescents on gender and reproductive health, and for the prevention of gender-based violence
- Community-based and participatory research on reproductive and sexual health issues from a gender perspective

## II. The Gender and Reproductive Health Programme for Men

### 2.1 Vision and objectives

The vision of the gender and reproductive health programme for men was

"(the creation of ).. *a just society where there is no discrimination on the basis of class, caste or gender, where all individuals have equal opportunities for development and growth; and access to the resources that will enable them to realise their potential"*.

The specific objectives of the programme, in the final phase of its evolution, included:

- gender sensitisation of men, especially young men to foster values conducive to gender justice in family and marital relationships in future generations, and reducing domestic conflicts and violence in the short-run
- raising awareness among men of women's reproductive health problems, with a view to securing their understanding and support for preventing and dealing with these
- helping men gain more information about their body and its functioning, to be able to better take care of themselves; in particular, to help them gain access to information that will help them deal with anxieties and myths related to male sexuality
- promoting responsible sexuality and the practice of safer sex and prevention of sexually transmitted diseases and HIV/AIDS
- case finding and referral for sexually transmitted diseases; also partner notification
- prevention of substance abuse and counselling and referral for addiction
- prevention of suicides, especially among young men (this group appears to have a high rate of suicides according to data locally collected)

### 2.2 Evolution of the programme

#### *The beginnings*

As already mentioned, RUWSEC's work since its inception has focused on the rights of women: their reproductive rights and right to well-being. Perhaps because we had achieved some measure of success in making women aware of their rights as well as enabling them to stand up for it during the first decade of our work in the community, conflicts between women and men appeared to be on the increase. This was notably so in the case of RUWSEC's staff, who were all women from the local villages. With some rare exceptions, the spouses of our workers were at best indifferent and at worst, antagonistic to the work their wives did. The work done by many of our workers involved acting in ways that did not respect prevailing gender norms about 'appropriate' female behaviour. They visited several villages, organised and spoke in public meetings in the communities they worked in, visited government office located in towns, and had to stay away from

their homes at least some nights of the month - to conduct or participate in monthly training workshops.

The first demands that we work with men, therefore came from our workers. They felt that unless their husbands and other men in leadership positions in their communities understood RUWSEC's (and their) work - and the reasons why it was important to understand and address gender-based discrimination (together with caste and class discrimination), it would not be possible to make any further progress in our work towards equity and social justice. Further, it was important that both women and men worked together for a just society, because gender-inequity was not an exclusively women's issue anyway.

The imperative of working with men became clear to us also because many of the reproductive health problems that women in the community were experiencing were to do with male behaviour - be it unwanted pregnancy resulting from non-consensual sex or prohibition to use contraception; sexually transmitted infections resulting from men having multiple sexual partners; or violence and/or abuse during pregnancy, resulting in morbidity or poor pregnancy outcome. Also in the area of reproductive decision-making, while we had worked at enabling women to take informed decisions, their partners knew very little about these issues, and this again was giving rise to conflicts. We felt that men may behave differently and take more responsibility for their wives' reproductive health if they were better informed, and if we made a serious attempt at involving them as partners in our work.

Thus, it was pragmatic rather than ideological considerations - the realisation that we were reaching an impasse vis-à-vis our attempt at empowering women - which motivated us to initiate a programme for working with men. It was clear that we had to start working with men if we had to get farther. Also, more than a decade of work with women had given us confidence that we could work with men without undermining the cause of women.

This programme may be divided roughly into 3 phases:

***The exploratory phase: (1992-94)***

We began with unsure steps, holding a number of discussions with RUWSEC's workers and with male community workers working for our brother organisation, Rural Development Society, during May-December 1992. Three workshops each were held for two groups: one consisting of husbands of RUWSEC's workers and some male community leaders, and one of activists working with Rural Development Society, during 1993-94. The topics covered included: body awareness and sexuality;
sexually transmitted diseases and AIDS; common reproductive health problems of women; and male violence against women. In each of the workshops, about 60 men participated, and their response was very positive.

We also carried out workshops in the districts of South Arcot and Tiruchy, in collaboration with local NGOs there, for men from their respective project villages. Four such workshops were carried out during November and December 1993 and January 1994, which were attended by more than 250 men.

Encouraged by the tremendous response from men during the exploratory phase of our programme, and the positive effects this had for our work with women in the villages, we decided to implement a 'Gender and reproductive health' programme for men in our project villages.

Just around the same time, two community organisations from the Chengalpattu area showed interest in collaborating with RUWSEC in our work with men. These organisations: Social Development Trust (SDT) and Social Education for Development (SED) were both founded and directed by husbands of RUWSEC's senior co-ordinators who had considerable experience working at the community level. They had attended our workshops for husbands and had received feedback from the community on other workshops for men that we had organised during the previous years.

This offer of collaboration solved our problem of how RUWSEC, as an all-women's organisation up to that point, could go about implementing a programme for men with suitable staff. It was decided that SDT would carry out intensive community-based work with men, and that SED would work with community-organisations in neighbouring districts. This was experimented with for about 9 months in 1994, with SDT working in ten villages and SED running workshops for four community organisations. By the later half of 1994, we were ready to launch a full-fledged men's programme.

***Phase I: (1995-1997)***

During the first phase of the Gender and reproductive health programme for men (1995-97), we continued with the two parallel sets of activities initiated in 1994.

- Social Development Trust (SDT) carried out intensive work in 28 villages, and
- Social Education for Development (SED) conducted workshops for rural men in villages covered by four NGOs in the neighbouring districts.

In our intensive work in the community, we covered young (18-35) as well as older men, married as well as unmarried. Our strategy was to train a group of peer educators from each of the 28 villages in both age groups, and supplement this with community-based meetings in every village, held separately for unmarried/adolescent youth and for married men. The workers of SDT received ongoing in-service training from RUWSEC's senior co-ordinators on a range of topics in gender and reproductive health.

Our work with the four community-organisations underwent some modifications based on feedback received from the respective organisations. A systematic course of training was developed, with several consecutive modules each leading into the other. Men-only workshops were extended to cover couples, in workshops usually conducted back-to-

back, first for an all-male group by a male facilitator, followed by one for the wives of the men facilitated by a woman facilitator. For some topics, there were combined workshops for the couples.

During this period, another development was under way in our work with men, as part of another project initiated by RUWSEC in 1996, with joint funding from the Ford and the Rockefeller Foundations. We started an adolescent life-skills education programme for in-school and out-of-school adolescents, both boys and girls. Out-of-school adolescent boys and young men were reached through two youth centres which provided a wide range of services besides life-skills education workshops. In addition, younger boys in primary schools (10-12 year age group) were being reached as part of the primary school-based Gender and Health training workshops. In effect, this implied that we were reaching out to the future generations of men at an early enough stage of their lives to be able to make a lasting impact on their attitudes to gender and health and influence their behaviour in future in matters related to gender relations and sexual and reproductive behaviour.

By the end of the first phase, the gender and reproductive health programme for men had changed in many ways. We were now working in 32 villages, four more having been added on in response to local demand. Other complementary projects such as the school and youth-centres based life skills education programmes were reaching out to teenagers and young men. We could not continue with workshops for other community organisations after successfully running the first course of seven workshops for couples, because SED was no longer able to undertake this project.

However, the most important change that occurred was in our entire approach to working with men. Starting off as a project to sensitise men on gender issues, to inform them on women's reproductive health problems, and to promote safe and responsible sexuality, we realised the need to address men's own needs in this specific context: understanding their bodies and their health; systematic case finding and treatment for STIs; prevention and management of substance abuse; suicide prevention; and help for mental health problems. These needs were expressed by participants in community meetings as well as in peer-educator workshops.

Because the project personnel believed in responding to the needs of project-participants, they had already begun to address some of these issues as and when the need was expressed, on an ad hoc basis. We needed to make it more systematic.

***Phase II: (1998-2000)***

The second phase of this programme started with an expanded set of objectives that combined gender sensitisation with catering to men's specific reproductive and other health needs. There was also an expansion in terms of number of villages covered. In addition to the 32 villages covered in phase I, an additional work with men started in 28 more villages where RUWSEC had already been working for many years, bringing the total number of villages covered to 60.

In the 32 phase-I villages, a male volunteer was identified from among the peer educators and entrusted with providing a limited range of services on demand. The 28 phase-II villages implemented a comprehensive programme, which included not only training men on gender and reproductive health issues but also providing services for men's specific reproductive and other health needs.

Another change was the inclusion of the 'Youth-centres' project under this programme. This was in order to streamline community-based activities with men and avoid duplication of efforts. Consequently, the 'life-skills' education workshops in youth centres were combined with the peer-educators' workshops being held monthly. However, the youth centres continued to be drop-in centres with a library and reading room and recreational activities for young men and women.

We also decided to focus attention on men aged 35 years and below in our peer and community education activities, while providing services to all age groups of adult men. This was prompted by the not-so encouraging participation of older men in these activities during the previous phase, and the feedback from community workers that the returns to efforts expended with this group was very low. It seemed sensible to focus our work with the younger age groups on whom the interventions clearly made a positive impact.

The two-phased initiative came to an end in December 2000. RUWSEC, as an organisation, is undergoing a transition from a community-based organisation implementing field-based programmes, to an organisation which can provide technical support to other community organisations in a number of areas related to gender and reproductive and sexual health and rights. The organisation is exploring ways in which work with men can be mainstreamed through: existing youth organisations and networks which provide educational and recreational services; and through Primary health centres.

### 2.3 Programme components

There were a wide range of activities based in the community, at RUWSEC's training centre and in youth centres, with different age and social groups of men, as explained in the brief description of the evolution of the programme. These may be classified broadly into the following programme components:

i. Training of community-based peer educators

ii. Community education and awareness building

iii. Health-care and related services

iv. Civic engagement* services, especially for young men

* 'Civic engagement' services include recreation, hobbies, help with seeking educational and work opportunities, and promotion of local groups and networks that engage in civic activities and interlock with state-provided services and facilities.

***i) Training of community-based peer educators***

*Rationale and strategy:*
This strategy was adopted because we felt that for a programme with men to even gain foothold, leave alone succeed, in a traditional rural community, it would be important to have a critical mass of men within each community who would uphold egalitarian gender norms; be well-informed about men's and women's sexual and reproductive health; and serve as community-based resources. Further, such a strategy would be more likely to have a long-term impact than one which relied exclusively on external resources such as a team of field workers of RUWSEC.

Peer educators were expected to share information and encourage others to make informed choices related not only to health and sexual and reproductive behaviour, but also with respect to broader livelihood and life choices. In relation to gender roles and relations, they were expected to serve as a role model for others to follow.

As peer educators, they were encouraged to be sensitive to the problems of others, help them when they could, and refer them to programme staff (these were members of the SDT) for help with finding appropriate health, counselling or other social-support services.

We started out in the first phase with two groups of peer-educator trainees from each village: the younger group aged 18-35 years, and the older group aged above 35 years. However, training for the older age group of peer educators was withdrawn by the end of the first year because of the dwindling number of participants. Thereafter, we had only younger men, most of them between 18 and 30 years of age, being trained as peer educators.

Depending on the population of the village, three to five peer educator-trainees (initially, from the younger and older age groups) were selected to attend the training workshops. Before the first year ended, the number of trainees had stabilised at 62 young men, usually two and sometimes three from each village, while the others dropped out.

*The Training workshops*:
During the first phase (1995-97) of the project when community based work covered 32 villages, the training workshops were of two days' duration each, usually once a month, and were held during the entire three-year period. During the second phase (1998-2000), a similar pattern was adopted for trainees from the new set of 28 villages.

The peer-educator training workshops were based on a well-thought out curriculum intended to provide an array of information and skills necessary for them to perform their roles and functions effectively. There were five major areas covered by the training: a) Life skills – which included self-development and leadership skills b) Gender analysis c) Social analysis d) Reproductive and sexual health e) Other health issues of major concern

to young men, including substance use and addiction, mental health and suicide prevention. A summary of the topics covered during the first three years is presented in Annex I.

Although topics and issues to be covered were decided and planned for well in advance, it was the policy of the organization to be flexible, and to respond to participants' expressed needs. A scheduled topic would sometimes be moved to the next month to make room for an issue that had been raised and seemed important to address – this is how we came upon topics such as de-addiction, suicide prevention, and male sexual health issues, for example.

Workshops were usually facilitated by the programme staff of SDT (men), with technical support from RUWSEC's co-ordinators who helped with planning the workshop agenda and methodology for training, and developing training tools and materials. The programme staff of SDT were themselves trained by RUWSEC in regular monthly workshops (described in section 2.5 below), on topics they were to address in peer-educator workshops. For some topics (e.g. Addiction, suicide prevention, child sexual abuse) experts from the field were invited to run the workshop.

The peer-educator training workshops were dynamic events with scope for active participation. The methods used were interactive, and included role-plays, case studies, games, stories and group discussion. Rarely did they consist of didactic lectures. Participants were treated with respect, as people who brought their own knowledge and skills as inputs into the workshop process, and not merely passive recipients of information that we chose to fill their heads with. If we wanted peer educators to listen and respond to their friends, to respect them and to not become 'advisors', then it was important that the workshops which trained them followed a similar approach. Annexe II describes two workshop processes, as illustrations.

***ii) Community education and awareness building***

This programme component consisted of three different activities introduced at different points in the evolution of the programme:

a) Community-based 'night meetings' for men in RUWSEC's project villages (32 in the first phase and 28 in the second phase)

b) Street theatre performances in project villages.

c) Workshops for couples: originally organised for those from project villages of four other community organizations in Chengalpattu and neighbouring districts, this later developed into workshops for recently married adolescents and young adults.

The programmes were introduced in the villages through the earnest efforts of the staff of the men's programme as well as any other RUWSEC staff resident in the village, key persons from the community, existing youth centres and leaders of panchayat institutions.

These were usually through one or more community meetings. Since the men's programme was being introduced in villages where RUWSEC had already been working for many years, the process was without significant problems.

*Night meetings*

Night 'meetings' or other 'events' were held once a month within the community in the late evenings after men returned from work. These were complementary to the peer educators' training, and were meant to reach out to a wider audience with messages on issues related to the programme's objectives of promoting gender equity, responsible sexuality and reproductive health of women and men. We wanted to create public debates and discussions within communities on these issues, which we hoped would be the basis of changes in attitudes, values and behaviour.

The meetings were conducted by the programme staff of SDT in villages allotted to each of them. Village men gathered in a central, usually open-air, location in the village for the meetings, and were conducted at the convenience of the villagers with prior intimation to them. The duration was about an hour or so depending on the topic discussed. The topics covered in the night meetings each month were usually the same as those covered in peer educator's training workshops for that month or the previous month. Although the nature of the venue and the possibility for participants to come in and out did not permit adopting the same kinds of participatory exercises in these night meetings, the presentation of an issue was never through a lecture, but through songs, stories and sharing of real-life happenings, followed by a discussion. Even a topic such as sexually transmitted infections, for example, would be introduced through a story of someone who was affected, and then factual information on STIs would be given as part of the discussion that would develop around this story. Sometimes, a video film would be screened and discussion would be based on this: this was the strategy adopted to initially introduce sensitive topics such as domestic violence against women.

In order to help meeting participants retain the messages and factual information imparted in a meeting, pamphlets on various topics would be distributed whenever possible. These pamphlets are published regularly by RUWSEC on a number of topics in public health, reproductive health and gender.

As in the case of peer education training workshops, we started out with having separate meetings for younger men and the older men, believing that each of these groups would have different issues and concerns and would therefore prefer separate meetings. We soon realised that this was not practical, and that when an open-air meeting was organised in a village, anyone who was interested or curious dropped by, and thereafter, only one 'night-meeting' was organised each month for all age groups of men.

*Street theatre performances*

Night' meetings in communities were interspersed with street theatre performances, or 'cultural programme' as this was known in local parlance. Street theatre performances mark the launch as well as the end of a particular phase of work of the 'men's programme' in a village, and are conducted about once in four months. The programme staff of SDT were particularly skilled in street theatre. Their performances would include skits, musicals and dance. They were very popular for their melodious songs touched the hearts of many.

Themes for the performances have included gender equity, consequences of alcoholism, need for men's awareness and responsibility for family planning, reproductive health problems of women, safe sexual behaviour and general health and hygiene and the awareness of the various activities of RUWSEC. One performance for example, depicted how a 'gender-equal' household would be: who would do what, how the husband and wife, brother and sister, sons and daughters would behave and be treated by each other, participate in household decisions and share in household resources. This gave the audience a clear idea of what was being meant when we talked gender equality. Domestic violence and alcoholism were the most popular themes among women who would not tire of having this same theme repeated at least once a year.

As in the case of night meetings, street theatre performances took place in a central location within the village and all the props it needed was a street light or gas lights set up at the centre. Actors in the play would sit around in a large circle, and the enclosed space was the stage area.

Men and women of all ages and children attended these performances. The message conveyed reached the people more easily through this powerful medium. Among all the other activities, street theatre was evaluated by members of the community to be the most effective in touching their hearts and making them think through specific issues.

*Couples' workshops*

As mentioned earlier (Section 2.1), our work with men in 1994 began with two parallel sub-programmes, one, implemented in collaboration with SDT and covering RUWSEC' project villages, and another implemented in collaboration with SED, and covering men from the project area of other community organisations working outside our project area. The latter soon evolved into 'couples' workshops which are described in some detail here.

The couples' workshop was an experimental initiative to assess the feasibility, usefulness and advisability of working with women and men at the same time, rather than giving women a head start, in an area (reproductive and sexual health and rights) that was the basis of patriarchal subordination of women. In RUWSEC itself, we had worked with women for more than a decade before we felt the need to work with men. Was it more advisable to work with women for a considerable period of time before working with men, if gender equity was our aim?

We worked with the following four community organisations:
a) Women's Education and Development Society (WEDS), Uthiramerur
b) Rural Harijan Development Association (RHADA), Nugumbal
c) Village Development Society, Padappai
d) World Vision, Kunrathur.

A series of seven 'couples' workshops were conducted for each of these community organisations during 1995-1997. Each workshop was of 2 x 2 days duration, the first two days for men, and the next two days for their wives. The workshop series started with addressing gender issues and then covered a number of reproductive and sexual health issues, dealing with these from a gender perspective and locating health in the larger context of their lives as rural poor and dalits. The final workshop dealt with self-care and being judicious and well-informed users of health services (See Box for details).

About 45-55 couples participated in the entire series of seven workshops organised for each of the four organisations, the total number covered being about 200 couples.

THE SEVEN-WORKSHOP SERIES FOR COUPLES ON GENDER AND REPRODUCTIVE HEALTH

1. Gender issues: sex and gender; male and female roles; sources of women's subordination in the family and society; role of customs and traditions; women in the media and in education.
2. Growing up male/female: physical and emotional changes during puberty; development of a self-image and identity; development of assertiveness; myths surrounding male and female sexuality and how they influence our behaviour; (brief reference to substance abuse and suicide through role-plays or stories)
3. Relationships: the role of friends and family in shaping our world view and behaviour; conflicts with parents and peers and ways of dealing with these assertively.
Relationships with the opposite sex: platonic and work relationships; passing fancies and falling in love; expectations from marriage and wife/husband; sources of marital conflicts and how to resolve these; the role of sexual relations in conflicts and in domestic violence.
4.Conception, pregnancy and delivery; complications in pregnancy, delivery and postpartum and appropriate care for these.
5. Induced abortions and other fertility regulation measures for women and men – making informed decisions as a couple.
6. Sexuality and sexual health; common gynaecological and sexual health problems, including RTIs, STIs and HIV/AIDS.
7. Seeking medical help: understanding that health is more than a medical issue; India's health care system: the sub-centre, PHC and referral hospitals. Old wine in new bottles: MCH/FP, CSSM and RCH programmes and what they promised/promise; issues in quality of care from the perspective of users; role of NGOs and of the community in enforcing accountability.

At the end of the workshop series, a get-together/seminar was held for as couples completing the series as could attend, which was only about 50 couples. A number of activities were organised in this get-together: a quiz, a poster-exhibition, a slogan-development competition, a skits competition, and song-writing competition. All these were on themes covered during the workshops. The get-together was both fun and an

opportunity to assess the extent to which the workshops had succeeded in imparting information as well as influencing attitudes to gender equity, appropriate conduct towards the opposite sex, on sexual and reproductive decision-making, domestic violence, and so on. The get-together was a fascinating experience, with small but important changes visible: a much higher level of information on reproductive health than before they had attended the workshops; better communication between couples on contraception, pregnancy and delivery-related issues; younger couples at greater ease with each other and able to discuss issues like friends; women refusing to accept control over their everyday movements by their men folk, and their husbands no longer very sure that this ought to be the norm. Overall, we had gone beyond scratching the surface and created serious unease about gender inequalities, as well as contributed significantly to informed decision-making.

Practical difficulties made it no longer possible, after 1997, for RUWSEC to continue with this series of workshops for other community organizations. SED was getting involved in other programmes and did not have the time for this, and we were not able to find another collaborator with comparable skills to play the same role.

However, experiences gained in running these workshops was used within our project area to run couples workshops for those recently married. Marriages are arranged by the extended family in all but a handful of cases, and couples have not had the opportunity to get to know each other before being married. We had learned from the couples' workshops that the first few months following marriage is a crucial period in the relationship, when patterns of behaviour as a husband or a wife, of mutual communication and of decision making are experimented with, before being finally adopted. This is also when information on sexuality and reproduction could help them make informed decisions about these aspects of their lives.

During 1998 and 1999, three workshops were conducted for married adolescents and young adults from project villages. The format of these workshops differed from the earlier ones in that they were not totally separate workshops for the men and their wives, but consisted of a 3-day format. On the first two days, parallel sessions were run by a female and a male facilitator for the women and men respectively. On the third day, couples came together for joint sessions. The first two days covered topics related to sexuality and reproduction, expectations from the married relationship, decision making related to sexual relations and contraception; sources of marital conflicts and spousal abuse. On the third day, facilitators presented to the combined group what the men said and what the women said (without mentioning any names), so that each group had a better understanding of what the other felt, thought and believed. This was done topic by topic, and was followed by a facilitated discussion in which some general norms of behaviour were agreed upon by consensus.

After the first workshop, a request was made to hold workshops separately for those who had 'love' marriages and those whose marriages had been arranged, because issues for each of these groups were different for the most part. In fact, those who had had 'love'

marriages were younger, often adolescents, many of them had eloped and married without their families' permission, and were more vulnerable and disillusioned with the realities of married life than those whose marriage had been arranged. In 1999, therefore, there were two separate workshops for these two groups. These workshops are described by the couples who attended it as an important landmark in their lives.

Based on this experience, a special project for married adolescents and young adults is currently under development as part of the 'adolescents' programme of RUWSEC, because the concerned department has better expertise to work with age group.

***iii) Health-care and related services***

This programme component covers men of all ages, and consists of

a) Health education, provision of first-level care and referral to RUWSEC's clinic and to specialist care in Chengalpattu District Hospital for reproductive health problems, and especially case-finding for STIs

b) Health education, diagnostic and treatment camps for specific conditions, based on demand from the communities

c) Community-based distribution of condoms for contraception as well as infection-prevention

d) Health education and counselling services provided within selected Primary Health Care Centres (PHCs) as part of an experimental programme on 'NGO-Public Sector collaboration' run by another department of RUWSEC.

*Health education, first-level care and referral*

Programme staff are each allotted 5 villages in which they conduct 'night meetings' and make house visits to every household, covering each household at least once a month, and others, more frequently as needed. Staff members meet the men within each household, explain to the men with health problems the nature of their problems, and suggest home remedies to deal with these or refer them for further treatment when the symptoms warrant this. They regularly follow-up these cases to ensure that they have been able to take the necessary steps and to complete treatment. They also provide them help in seeking appropriate treatment – be it accompanying them to a specialist or finding out where a test can be done, or purchasing drugs for them from a subsidised outlet.

Men who reported symptoms of STIs were followed up as a special category. They were provided with help in seeking treatment – provided at highly subsidised costs in RUWSEC's clinic or at the district hospital, where they received preferential care as a referral from RUWSEC. Men sometimes sought help also in communicating to their wives that they were suffering from STIs and that the wives needed to be screened and treated if infected. This was done with the help of RUWSEC' female health workers. Records were maintained on those infected and all possible steps taken to ensure treatment and recovery, as well as prevention of re-infection.

Pre-marital counselling is regularly provided for young men on sexuality, contraception and reproduction, and behaving in a manner that respects women's rights.

*Health education, diagnostic and treatment camps for specific conditions*

Diagnostic and treatment camps for Sexually transmitted infections have been held, at least one a year, in RUWSEC's field office campus. In these camps, STI specialists from the district hospital carry out physical and clinical examination and also laboratory tests to diagnose and prescribe drugs for treating STIs and other genito-urinary tract infections that men attending the camp are suffering from. These camps have between 60 and a 100 men attending, including those who come for a follow-up check up after an earlier course of treatment from such a camp.

Special camps have also been conducted for those addicted to alcohol and other substance use, followed up with referral for individual counselling. After a series of camps for men, their family members and care-givers were also included in subsequent camps in order to create a supportive environment for the men to quit substance use.

Other camps for information, counselling and treatment have been for men at risk of committing suicide (those who have attempted suicide in the past or are talking about it), and those who report a mental health problem. Specialist advice and treatment has been provided by psychiatrists and trained social workers in these camps.

Another special camp has been for childless couples, in which they were able to ask questions of senior reproductive health specialists, before deciding on an appropriate course of action.

*Community-based distribution of condoms for contraception as well as infection-prevention*

Education and promotion of condom use as an effective method which helps prevent pregnancy as well as infection is backed up by the distribution of condoms to anyone who is interested in using these. Condoms are distributed through programme staff during house visits, in night meetings and in special STI camps described above. In addition, one of the peer educators keeps a supply of condoms to be distributed to any one who approaches him. Making condoms widely available through a number of sources was found to be effective in increasing condom use among young unmarried men as well as by married young men who were interested in postponing the first pregnancy. RUWSEC received its supply of condoms free of cost from the district family planning authorities, and therefore condoms were free of cost to users.

*PHC-based counselling and health education*

This is a relatively new activity which evolved as a result of a request for collaboration from another programme of RUWSEC – the 'NGO-Public sector collaboration' programme which seeks to promote the quality of reproductive health services in primary

health centres. Senior programme staff spend one day a week in the PHCs (the number of PHCs has varied across the programme's time line) offering health education and counselling services to men patients who wish to do so. They also distribute health education pamphlets to the patients. These services are very popular with young men who don't usually have an opportunity to discuss their health concerns and receive relevant information.

***iv. 'Civic engagement' services, especially for young men***

'Civic engagement' services include recreation, hobbies, help with seeking educational and work opportunities, and promotion of local groups and networks that engage in civic activities and interlock with state-provided services and facilities.

Failure in examinations and unemployment were major issues for adolescents and young men in most of RUWSEC's project villages, especially those aged around 16-25 years. We felt that because young men did not have any creative pastimes within the village and/or could not afford investing in equipment for games and sports, they tended to 'hang out' in groups and engage in harassing young women, smoke, use drugs or drink together. This was also borne out by the observation that in villages where young men had formed associations with interesting collective activities for recreation as well as community development, substance use, alcoholism and other undesirable behaviours were relatively less prevalent. Further, we also felt that training young people to make informed choices about their sexual lives cannot be done without addressing larger issues of choices about their lives as a whole, and when we did so, it was important to provide them with some back-up services that would help them in this.

In our discussions with RUWSEC's programme staff, the idea of a 'youth centre' came up as one way of providing civic engagement services to young people. RUWSEC started a youth centre in 1996, as part of its adolescents' programme life skills education programme (different from the men's programme) for adolescents. Support for a second youth centre already being run by a local youth group began in 1998. This second youth centre receives a small amount as annual contribution towards its running costs and ongoing technical assistance to carry out workshops and other activities. This is seen as the most viable route to further upscale our work with young men. The 'youth centre' project became a part of the 'men's programme' in 1998, since there was considerable similarity between the kind of activities being undertaken by the youth centres and what was being attempted as part of the men's programme in other villages. For example, the centres conducted monthly workshops on gender and sexual and reproductive health.

More than 250 young people have been using the youth centres from the villages in the neighbourhood. The youth centres are drop-in centres with support services for young men, including a library, a resource centre providing information on employment, education and vocational training opportunities. Support services such as typing or help with filling applications and preparing CVs; training for appearing in interviews; and tuition and coaching classes for appearing in exams including for those who have failed

in an earlier attempt are provided. The youth centre also provides recreational facilities with equipment for out-door and in-door games.

Over the years since their establishment, the youth centres have provided assistance to a number of young men (information, being accompanied etc, not financial) in finding admissions to training schools, and employment in casual wage work. For example, application forms for admissions to technical courses are collected from various institutions and distributed to prospective candidates. Subsidised tuition fees have been negotiated for some technical courses. Help is provided in applying for labour contracts for local government construction projects. Assistance is provided in finding out about scholarships and fellowships for *dalit* students, for entrepreneurial training and government loans, and so on, and is followed up with help in filling out forms and submitting it to the relevant offices, and following up the outcome.

More recently, tuition classes are being held for students of class 8 – 12 standards through local volunteers throughout the academic year. Donations of text- books and learning aids are sought from individual donors and philanthropic organisations and distributed to students in need. Cash prizes are awarded to students who secure the highest score in the final exams of the high and higher secondary school.

Annual recreational events include a sports meet for youth from the villages surrounding the youth centre, and competitions in drawing, essay writing and public speaking.

A number of active members of the two youth centres also participated regularly in the activities of the men's programme. One clearly observable impact has been the development of their leadership potential. Some of them are now facilitators and volunteers in the men's programme.

## 2.4. Staffing and Implementation of the programme

### *Programme staff and their responsibilities over the two phases*

As already mentioned, the programme was implemented in collaboration with two organisations: Social Education for Development (SED), which was involved only in Phase I of the programme, and Social Development Trust (SDT) which was involved in both Phases I and II.

SED conducted seven couples' workshops for four community organizations, which translated to one workshop a month with each organization, with a few months each year spent on preparation of training material. There were only two main trainers involved in this project: Mr K. Anandan of SED, and Ms A. Bhavani, who was a senior co-ordinator in RUWSEC, well known for her training skills. Anandan is a dalit leader with several years' experience in community based education and mobilisation as part of Rural Development Society before he started SED. Anandan and Bhavani are a husband and wife team, which worked rather well in running couples' workshops. Other senior co-ordinators of RUWSEC served as resource persons for specific topics in reproductive

health. Planning the curriculum and preparing the training materials was carried out under the guidance of TK Sundari Ravindran, then Honorary Executive Director of RUWSEC.

During the first phase, SDT was responsible for all other programme components except the youth centre: training of community-based peer educators, community education and awareness building, and health-care and related services. RUWSEC's collaboration with SDT was on the understanding that it would not interfere with the internal affairs of SDT. SDT would be responsible for recruiting and managing its own staff and for implementing the programme and managing its budget. The budget was mutually agreed upon between RUWSEC and SDT.

SDT's team consisted of a co-ordinator, a senior supervisor and four field workers. The six member team between them worked in 32 villages during the first phase. During the second phase, more field workers were recruited in an attempt to deal with constant turn over of field workers. The co-ordinator and senior supervisor were both dalit men known for their local leadership, and were co-founders of SDT. Both had more than 15 years of experience in community mobilisation before they started SDT. Other members of the team were young men in their twenties with primary and middle school level education. Most of them had experience in community work as part of some local association or a government project.

RUWSEC's collaborating role during the first phase consisted in visualising the programme and planning implementation strategies, planning and implementing an intensive in-service training programme for SDT staff, preparing and providing training materials and inputs to be used in peer educators' training and in community meetings. Ms A. Caries, senior co-ordinator of RUWSEC was responsible for implementing these aspects of the programme and for overseeing SDT's overall performance.

In the second phase, the SDT team moved into 28 new villages to start work on the three programme components mentioned above. As before, RUWSEC continued its overseeing and support role to SDT. In addition, it undertook the responsibility for follow-up work in the 32 villages where SDT had worked during 1995-97. Ms A. Caries was responsible for co-ordinating and providing technical support to both the work of the SDT team, as well as follow-up activities in the 32 villages.

Staff in the second phase included besides the SDT team and Ms Caries, a team of volunteers to undertake follow-up activities in the 32 villages. These activities, as mentioned earlier, related mainly to only one programme component, namely the provision of health-care and related services. There were occasional 'cultural' programmes as well, but not the regular 'night' meetings or other community awareness activities. We started originally with a team of 32 volunteers, one each from each of the villages. But this pattern soon ran into trouble. Each volunteer had only a few days of work a month and was paid accordingly. However, this did not suit the volunteers who were all unemployed young men looking for full time work with a regular monthly salary. Eventually, this pattern was replaced with a smaller number of full time workers who were paid a monthly salary, each worker responsible for 5-7 villages depending on the population of the villages.

Much of the time of staff members – 15 days a month - was spent in field work within the villages, either in house visits or in conducting meetings and cultural programmes. One day a month was spent on planning meetings in the office, and about four days in various workshops – two for their own monthly in service training by the RUWSEC team (usually Caries) and two in workshops for community-based peer educators. Supervisory staff including co-ordinators spent 5-10 days in community-based activities, 1-2 days in local primary health centres as counsellors and health educators, and the remaining days in preparing for the training workshops, compiling reports and attending to other managerial and administrative tasks, including managing the finances.

***Staff training***

RUWSEC believes in building effective and sustainable capacity and local leadership in order to bring about social change and to sustain it. Training played a crucial role in capacity building, and demystifying technical knowledge and information. All staff members – both those in SDT and in RUWSEC – belonged to the local villages and were drawn from the same community and class backgrounds as the groups they worked with. For programme staff - all local men – the training on gender and reproductive and sexual health and rights was a challenge, demanding attitudinal changes as well as acquisition of a considerable extent of new knowledge and skills. It is through the knowledge and skills gained in the training workshops that they were able to present and challenge prevailing notions on gender, and double standards regarding sexual and reproductive decision-making within their communities.

The training of staff was a major social experiment for yet another reason. The trainers were usually women from RUWSEC, also drawn from the local communities. The main trainer – Caries – was married to the co-ordinator of SDT. Participation in the training demanded that the male programme staff accept the leadership of women and be open to learning from them. It is to the men's great credit that they were open to this experiment and did not being 'taught' by women. By doing so, they were setting an example to other young men from the local area – that women and men could each learn from the other.

In addition to the in-service training workshops, staff also came together every month for a 'planning' meeting. The meetings served several purposes such as

- planning the month's activities
- reviewing feedback of the villages
- discussing problems encountered as well as positive responses and to make suitable modifications to what was visualised in the annual plan
- providing staff with a space to exchange news and views and learn from each other, and
- submitting monthly reports.

According to programme staff of the men's programme, working in this programme has created tremendous changes in their perception over the years and has developed a positive attitude towards gender equity and equality. Staff feel proud to be a part of this unique programme.

"*I as a men's team staff can see many changes in me. I am happy that I got this exposure at a very early stage it is very useful for my life. Now I am able to counsel the youth in to right path. (*Kumar)

**2.5. Programme effects**

At the time of writing this report, we had not yet carried out an 'impact assessment' of this programme in terms of collecting hard data on behavioural change except for specific programme inputs such as use of condoms, treatment seeking for STIs, and reduction in prevalence of substance use. During the first four years of the programme, 4990 packets of condoms (three in each packet) were distributed to about 500 men. Of these, 429 men used it for infection prevention and 71 for spacing the next child. Thirty-seven men were referred to RUWSEC's clinic for symptoms of STIs, and in 20 cases, their wives were also referred. However, the recurrence rates have been very high, especially among those where we have been treating the men alone.

Forty-eight men have received counselling for alcoholism and 56 for addiction to 'ganja'. Apart from creating a general awareness on substance abuse, this aspect of the project has not made much headway. We need more expert guidance and perhaps also employ counsellors on a regular basis. At present, we have engaged them from time to time, whenever they were available.

According to Vinoth who was among the peer educators trained by the programme and later became a staff member,

*"I have noticed that the use of condoms has increased after the men's team programme. And the men approach me without any hesitations for condoms, which was rare before the commencement of this program. Previously I was an ordinary young man but now I am identified as a health worker and many people approach me with their health problems and other social issues".*

The task of evolving reliable indicators for attitudinal as well as sustained behavioural change has been a challenging one, and we hope to successfully tackle it and carry out an impact assessment study in the near future. What we have is more 'soft' evidence, if we may call it that. We have regularly documented feedback from participants in peer education workshops, and in health services and education interventions. We also carried out an interim 'evaluation' of the programme through an external consultant – a young dalit leader working in another organisation – who interviewed programme participants, community leaders, and most importantly - women from the community, to find out their assessment of the usefulness of the programme.

The peer educators' workshops, for example, have not only imparted new information and skills to the young men who attended it so that they can use it to work with others, but have been a source of support to the peer educators who are themselves in need of support. For example, one young peer educator had this to say after the workshop on how to help young men with suicidal ideation:

'*My father regularly picks quarrels with my mother for no reason at all. He is always suspicious of her morality. Unable to bear this, my mother attempted suicide twice. I felt helpless, I hated my quarrelling parents, and ran away from home on two occasions. After this workshop I feel more empowered, I think I know how to deal with the issue and help my mother.'*

Following a workshop on barriers to access and utilisation of public health services by the rural poor and dalit in their communities, participants observed:

*' I feel the need to revamp the health services and to ensure better services for the rural poor'*

*'I think the marginalisation of indigenous medicine further disempowers the poor'*

What is important to note is that this has translated into action for change, because RUWSEC as an organisation builds on such feedback. Thus, groups of young men have been included in initiatives to monitor the quality of services in primary health centres, and others who were interested have been provided training in providing first line herbal or 'Siddha' treatment at the community level for common health problems.

The workshops for couples have also been much appreciated by the four community organizations. However, for young married couples from RUWSEC's project villages who participated in these, it was literally a turning point that altered the course of their married lives. The young husbands had this to say after the workshops:

*'It is very helpful for us at this stage (soon after the marriage) to know the importance of understanding the partner and her expectations from marriage'*

*'I feel for a successful married life, respecting the wife's values and feelings and sharing in household chores is important'*

*'Giving up some of our 'habits' (usually habitual drinking and/or smoking) may bring about better understanding (between the couple) – there is nothing wrong (non-masculine) to make such adjustments.'*

An indicator of more sustained behavioural change is that the peer education workshops have created a core group of gender-sensitive young men in at least 50 villages, who are better informed, act more gender equally within their marriages, and actively participate in various initiatives of RUWSEC aimed at redressing gender discrimination.

The participation of young men in RUWSEC's community-based initiative for the prevention of domestic violence is a matter of great pride to the organisation and one of the most tangible indicators of the usefulness of the peer educator workshops. RUWSEC has constituted a 'prevention of domestic violence' committee in 30 villages in its project

area. The committee of eight in each village consists of women and men who actively intervene through conflict resolution between couples and where necessary, providing the women with immediate succour and shelter in their homes.

Ezhumalai from Acharavakkam village, one of the participants in the first batch of peer educator workshops in 1995 recalls his experiences:

*"In those days we were unaware of the fact that we should treat our women with respect and we as men has the responsibilities to share the house hold chores, and their legitimate role in decision making. These monthly workshops have changed our views on women and now we participate and share our household chores. Moreover in our village, domestic violence was considered as a private affair but now we the participants of the men's team intervene if any such incidents occur. Now most of the men do not indulge in domestic violence as most of them have fair understanding.*

Adding to this, Arumugam and Ekambaram, also participants in the workshop from the same village, say that alcohol consumption and addiction to other substances (usually *pan parag*) has declined considerably. They feel that the awareness created in men on reproductive and sexual health has had a tremendous impact on the village as a whole. Now, the three young men have taken the initiative to launch along with other youngsters, a social action group to mobilise around local issues.

Such stories are heard from many villages.

Health education services –especially special camps for education, diagnosis and treatment – had greater visibility and evoked greater appreciation than routine case finding, referral and follow-up.

The STI camps that were held at least once a year, with the collaboration of the District Hospital's STI department was a popular one, often attended by 70-80 young men at a time. Many of them were referred to attend the camp by programme staff who had been approached during house visits in the community. These camps were held in different venues. In the early years, it was held in the premises of RUWSEC's clinic, and later, in the campus. This was to provide confidentiality and privacy for those who chose to have a medical check-up and laboratory test after the initial health education session for all. In later years, camps were held also in some villages where there was a demand for it.

According to Sivaraji who worked in this programme in the initial years,
*"After these workshops many young men have contacted the volunteers and us for the treatment of STD related and other health problems and as a follow-up they were referred to government hospitals. The classes conducted by Dr. Usman on reproductive health has helped in safer sex and prevented the spread of venereal diseases to family members, and there is a reduction of STD cases in these villages due to the awareness."*

Special camps on substance use and de-addiction which were held in collaboration with specialists – the TT Ranganathan Trust in the first few years, and later, from the relevant department from the District Hospital – also drew a large number of participants. There

were some who were persuaded by these camps to not get addicted to alcohol or cigarettes:

*'I used to smoke and drink regularly. During the workshop I understood how much money I was wasting on these, and now I am completely out of these habits.'*

According to Vinoth, who works in the men's programme,

*"In our village Karumarapakkam I can give the example of Chandran and Soundrarajan who had stopped drinking because of the counselling and I am happy to see them leading a peaceful life".*

The special camp for childless couples, although attended by a very small number - five couples and three women – was very helpful for those who did. The participants who had consulted several doctors and other healers for their childlessness, had an opportunity for the first time to ask questions and clarify doubts from doctors about the possible reasons for their childlessness. There was both a general lecture and time for one-on-one consultations, for no cost. Some couples were referred for further treatment to the district hospital.

Another noteworthy health education and advocacy workshop for couples was on vasectomy. The intention was to address the many myths surrounding vasectomy, and to encourage men to consider this as a contraceptive option. For this, we brought together a panel of vasectomy users from within the local community, as well as a medical doctor. The panellists talked about their personal experiences, and this was followed by a question and answer session from the floor. For any medical issue that needed clarification, the doctor gave responses.

Some of the initial comments on vasectomy from participants were as follows:

*'This operation (vasectomy) drains our energy therefore let the women undergo operation (tubectomy)'.*

*'If a man undergoes vasectomy he will loose his maleness and will be weak in sexual relationship.'*

Experiences of vasectomy users helped counter many of these fears. The doctor's responses were also quite convincing, and at the end of the camp, a small number - eight men came forward to undergo vasectomy. Ironically, however, only a fraction of them were able to obtain vasectomy services. The government's family planning programme had not offered vasectomy for close to 20 years following the backlash after the Emergency during 1975-77, that there were few doctors who were trained to perform this simple operation. The two men who did undergo vasectomy obtained these services after a couple of years, when there were a few 'special camps' held by the government owing to the 'male involvement' push following the ICPD.

What has been the overall effect of the programme in achieving the larger objectives of the programme, namely, promoting egalitarian gender relations?

The internal evaluation carried out mid-course showed that health related messages, and in particular, information on reproductive health issues have reached the target group. It was especially heartening to hear mothers and wives talk of the positive impact of the male involvement programme on the behaviour and attitudes of their sons and husbands. The men, as described by the women, showed a greater concern for their mothers'/wives' health, were more willing to be conciliatory in case of conflicting interests, and a few even participated in 'women's work' in the household: e.g. fetching water, minding children, cutting vegetables and minding the stove.

*"In the villages of Reddyarkupam, Perunthaavakkam it was reported by the women in the families that about the men sharing household chores with an understanding which is still continuing. I have also come across the youths and few elders who have given up alcohol and smoking"*

There was also greater support in the community for women's participation in training workshops and night meetings organised by RUWSEC. Another observable difference, according to the women workers of RUWSEC, was that they had gained respect and support from the men in the community as a result of the men's programme, and could always find a few young men who would support and actively help them with the implementation of various interventions.

## III Integrating gender concerns in work with men on reproductive health: some reflections

### 3.1 Lessons learned in RUWSEC's men's programme

What have we learned about the opportunities for and challenges in working with men on gender and reproductive health through RUWSEC's experience?

#### *a) Gender sensitisation of men may be difficult, but by no means impossible*

It will soon be a decade since RUWSEC started its first few interventions for the husbands of our workers. As years go by, it appears progressively less controversial to raise gender equity issues in the community and also receive greater support for it from at least a core group of young men. However, as can well be imagined, attitudes change slowly and behaviour is even slower to change. It seems important to sustain programme efforts for many more years to come.

***b) Men are more open to gender issues when these are integrated into programmes addressing men's sexual and reproductive health needs***

In terms of programme content, while we started out with running gender workshops for men, the programme began to make sense to them only because we responded to their expressed needs in terms of education and services related to men's (and not just women's) sexual and reproductive health, and other specific concerns such as substance use and suicide prevention. Addressing gender issues became easier when integrated into these topics – for example, men were willing to discuss even domestic violence, when this came up in the context of sex within marriage.

***c) Multiple programme components are needed to meet varying needs and diverse target groups***

A programme for male involvement in sexual and reproductive health needs to have multiple components such as education, counselling, health services and civic engagement services. Each component needs to be packaged differently for different groups and made available at diverse locations. For example, RUWSEC carried out health education activities in 'night meetings', in peer education workshops, in youth centres, house visits, and in special camps, and more recently, in Primary Health Centres. This enables reaching out to a much wider audience with the messages and influencing a critical mass in a relatively shorter period of time.

***d) Behavioural changes related to sexual and reproductive health and in substance use require long term and sustained programme efforts***

It may be easy to achieve programme objectives such as distributing a certain number of condoms, ensuring that a certain number of STI cases are treated, or that men are better informed about aspects of their and their partners' sexual and reproductive health. However, to ensure that condoms are used with all sexual partners in all sexual encounters, that men do not get infected with STIs in the first place, and change behaviour that has negative impact on their own and their partners' health is a long-term goal that may take decades of sustained and systematic work.

Prevention of alcoholism and use of addictive substances such as *ganja* and *pan parag* are especially challenging tasks and we have made little headway in these except in making them issues for discussion. The absence of any public programmes or policies addressing substance use in young people as well as in the prevention and treatment of alcoholism makes our task that much harder. We believe that our immediate priority is concerted efforts at public education reaching out especially to young people, but also to families of alcoholics so that there is a better understanding in the community of the nature of addiction and the considerable efforts needed to address it. We also have to focus much more on policy advocacy, and liase with public health authorities dealing with mental health and addiction.

***e) Programme staff need to be chosen with care and provided with intensive and ongoing training inputs***

Men are best suited for working with men in the community.
The programme needs to be constituted predominantly of men, and as far as possible, men from the local communities. However, we have learned that it is better that the field staff are not assigned to work in the communities to which they belong, especially when it comes to matters related to reproductive and sexual health. Men in the community are reluctant to seek help from field staff if the latter are from the same community, for reasons of protection of confidentiality. This is in direct contrast to RUWSEC's experience in working with women – where the field staff consist of women from the same villages.

This does not mean that the programme team should be all male. It may be useful to include women as a part of the programme team, especially for providing support services such as training and development of teaching and learning materials. They also play an important role when an issue needs dealing with a couple, as well as in running workshops for couples.

Staff need to be gender-sensitive and role models in terms of gender-equal behaviour
This is of course, true of any 'social engineering' effort where we are attempting to alter entrenched values and attitudes. It was fortuitous that RUWSEC was able to identify collaborating organisations headed and staffed by men open to gender issues, for implementing the men's programme. Further, a great deal was invested in ongoing training for staff through monthly workshops throughout the six years of the programme.

The willingness of senior staff from SDT to undergo training run by women co-ordinators of RUWSEC, and their ongoing effort to be role models who behaved in a relatively more gender-equal manner with their wives and other women in their communities made all the difference to the acceptance of the programme in the communities. What is more, it has made the lives of the staff members themselves more rewarding, as expressed elsewhere in this report.

We do not think it will be possible to achieve the objectives of the programme with staff who are not gender sensitive, and go beyond saying the right things to attempt to put it into practice. Even in RUWSEC's case, we can only say that conscious and sustained efforts were made to ensure that the programme staff practiced what they preached.

The team should consist of a mix of young and mature men
While younger staff members have a good rapport with youth in the community, and peer educators are an important source of information within the villages, mature men have an important role to play in the programme team.

Young people still look up to older men for cross-verifying the information they receive from peer educators, and to seek counsel and guidance when faced with difficult

problems. Furthermore, married men – young as well as older – feel uncomfortable discussing their sexual health problems with programme staff who are 'unmarried youth', and this discomfort is shared by the young unmarried field staff themselves.

Staff turnover is an important challenge

Staff turn over was an important challenge for us. While the senior coordinators of SDT were the constants throughout the programme, field staff came and went, making retraining a major challenge. The reason for the turn over was that for many men, work in a community organisation was only a stop-gap before they found a 'real' job. This may be a reality that we would have to live with. However, the problem of retraining has been mitigated to some extent by the availability for recruitment of peer-educators trained by the programme, so that despite the turnover, we continue to find suitable staff for replacing those who leave. However, these are all young men. Older men are more difficult to recruit and retain.

***e) Building local capacity is important for ensuring that programme efforts are sustained long term***

We have learned the importance of working with a cohort of men from the community and investing intensively in changing their attitudes and building their capacity to influence others. This critical mass will serve as the engine ushering in attitudinal and behavioural change in the many decades to come.

***f) Investing in the future and young may be the way to advance gender equity***

Our observations through the several years of programme implementation has led us to the conclusion that our educational and civic engagement efforts are better focused on adolescents and young men. This group is open and eager to learn and also willing and daring enough to adopt behavioural change. Investing in this group appears to be a better investment of our time in achieving our goal of gender justice.

On the other hand, sexual and reproductive health services as well as education in these aspects is needed for all sexually active men. Providing these services has another strategic advantage. It wins friends from among older men for the continuation of our work with women in the community, and with young men.

### 3.2 Implications for programmes for male involvement in reproductive health: some reflections

RUWSEC's work with men began more than a decade after it had started working with women, and as a result of women's felt need for working with men. We have often wondered whether it would be advisable to 'involve' men from the very start of a community-based reproductive health programme. Would this not result in the erosion of women's autonomy and the translation of locus of control from women to men?

It appears to us that the best starting point for 'male involvement' is to work with community based women's organisations which have successfully mobilised women and developed women's leadership, so that they are able to work alongside men from a relatively less disadvantaged position than otherwise. Of course, if women as a constituency – and not as individuals - do have a history of public participation, then it may be possible to involve men from the outset of a programme.

Where reproductive health issues have not been addressed by a women's organisation seeking to work on 'male involvement', involving the men and women simultaneously – through the kind of couples' workshops we have run, for example, would be a good way on ensuring that men do not have a head start, thus widening further the gender gap in women's access to information.

Working with young couples seems to be a promising entry point to bridging the gender gap in generations to come. There is a readiness and enthusiasm to experiment with a different way of being in the new relationship. Patterns of sexual and reproductive behaviour have not been firmly established at this stage, offering greater opportunities for adopting safer sex practices and in more gender-equal decision-making in matters related to sexuality and reproduction.

Gender concerns inform RUWSEC's work with men. We believe that male involvement programmes working without a 'gendered' approach may succeed in treating the symptoms of reproductive and sexual health problems, but not in preventing them. Integrating gender concerns is not just a matter of ideology, but a requirement of good public health practice. Many reproductive and sexual health problems (for men as well as women) arise from the way masculinity and femininity is constructed in our social milieus, and cannot be prevented without addressing gender.

Gender concerns have been woven into every warp of RUWSEC's programme. Programmes cannot have a separate 'gender' component that does the 'sensitisation' part, and a separate reproductive and sexual health programme which is gender blind. Unfortunately, the RCH programme approach in India appears to have taken this route – leaving the 'gender' to NGOs, and taking on only the 'technical' work of dealing with the health problems. Such an approach will probably make a headway in neither aspect.

If in the telling of this story of RUWSEC's modest experiment we succeed in inspiring more such initiatives, we would have taken another big step towards our larger vision of a jut society free of discrimination by gender and social position.

**ANNEXURE I**

**Curriculum for peer-educator training workshops**

*A topic may be addressed more than once, at increasing levels of complexity*

Module I: Life Skills
1.Self-awareness and self-image: defining the kind of person I am, my likes and dislikes, and my strengths and weaknesses
2. Assertiveness: learning to express opinions and to take stands; learning to say 'no' to peer pressure; to take decisions, and to take responsibility for one's actions
3. Skills for functioning within and leading groups: Effective participation in group discussions, conducting meetings, facilitating group discussions
4. Public speaking
5. Making informed choices
5. Planning and organising events
6. Active listening and non-judgemental support to peers
7. Negotiation and resolving conflicts within the family and in other relationships;

Module II: Gender
1. Understanding where our notions of gender roles come from: home, school, peers, movies, stories, other cultural forms; from proverbs; religious teachings.

2. Understanding the sources of women's subordination in society: gender based division of labour, access to and control over resources and decision-making power; control over women's sexuality and reproduction; examining our values and behaviour as men in reinforcing discrimination against women.

3.Relationship with the opposite sex: platonic and work relationships;
relationships with members of the extended family; romantic relationships.

4. Gender relations within marriage Expectations from marriage and life-partner, sources of marital conflict. Visualising an egalitarian marital relationship and a democratic family.

5. Gender and sexuality: What shapes our sexual behaviour; our expectations from sexual relations, marital conflicts arising from differences (as currently perceived by the men) in sexual needs of the husband and the wife; extra-marital sexual relationships: causes and consequences; and working towards a healthy sexual relationship within marriage.

6. Violence against women with a focus on spousal abuse, violence and battering

7. Sexual abuse: harassment, rape and incest, child sexual abuse.

8. Men's role in fighting against women's exploitation: an introduction to the life stories of some role models (historical figures as well as those brought in by participants)

Module III: Social Analysis

1. Caste and class based inequalities within our communities: who owns what, who does what, who gets what, and who decided what.

2. The status of *dalits* in India and Tamil Nadu: Economic, social, educational and political.

3. A critique of the education system and how it keeps out the poor and the socially marginalized.

4. India's economic development model since independence and its impact on narrowing social and economic inequalities: focus on green revolution (Chengalpattu is a green revolution area), industrial development strategies in the locality, energy policy and the coming up of an atomic power station in the vicinity; lack of basic amenities such as housing, water supply and sanitation, etc.

5. Legal and policy initiatives to address caste and gender inequalities: how successful have they been? What are the barriers to their effectiveness?

6. Health as a development issue: poverty, mal-development, environmental degradation, net transfer of food to cities through the market mechanism, the depletion of natural resources, pollution etc. and consequences for the health and well-being of the rural poor. The elitist nature of the health care system; *dalit* women and health care system: discriminated as poor, low caste and as women.

7. Discussion of current issues as and when they arise: communal tensions, environmental concerns, new economic policies and so on.

Module IV: Sexual and reproductive health

1. How our body works: male and female reproductive systems

2. Common reproductive health problems for women: menstrual problems, uterine prolapse, menopause related problems, urinary tract infections

3. Pregnancy and birth; care during pregnancy, and danger signals and risk factors; preparation for home delivery; danger signals which call for medical attention/emergencies; maternal mortality and morbidities due to complications in delivery; and post-partum care as well as likely complications and when to seek medical attention.

4. Miscarriages and induced abortion

5. Birth control measures and devices, with a focus on condom use, vasectomy, oral contraceptives and the rhythm method, and information on basic standards for carrying out sterilisations, and inserting IUDs.

6. RTIs and STDs in women and men; HIV/AIDS. Safe sexual behaviour and prevention of STIs. Cervical cancers

7. Sexual health issues for men: masturbation; virility; sexual satisfaction; sex within and outside marriage; assumptions about female sexuality, men having sex with men, impotence and sterility.

Module V: General Health

1. Understanding basic human physiology; our body and its functions

2. Taking care of ourselves: nutrition, personal and environmental hygiene, health practices to prevent many illnesses

3. First aid; self care and home remedies and herbal treatment for many common illnesses : colds, fevers, diarrhoeal diseases, acidity, skin problems, eye infections, sinusitis, anaemia etc.

4. Understanding common laboratory tests

5. Commonly prescribed drugs: their rational use, contra-indications and adverse side effects

6. Substance abuse: the role of peer pressure; learning about different stages in addiction and health consequences of addiction; counselling and helping addicts and knowing when to refer for professional help

7. Understanding causes underlying suicides (sharing of personal experiences); common myths about suicides; how to help those expressing their intention to commit suicide (including referral).

8. Mental health: recognising mental illness and learning how to help those with a mental health problem

## Annexure II

### Training on Gender & Sexuality for Community Peer Educators

Venue: RUWSEC Training Center

Dates: 14th May 2000

Participants: Community peer educators [Sixty]

Facilitators were the staff of the programme who were youth volunteers from the community– Mr.Kanniyappan, Mr. Kumar and Mr. Shanmugam.

Mr. Kanniyappan began with the sharing of the objectives of the workshop.

Objectives of the workshop:

- To understand how our body works: male and female reproductive systems
- Gender relations within marriage: Expectations from marriage and life-partner, sources of marital conflict. Visualising an egalitarian marital relationship
- Gender and sexuality: What shapes our sexual behaviour; our expectations from sexual relations, marital conflicts arising from differences (as currently perceived by the men) in sexual needs of the husband and the wife; extra-marital sexual relationships: causes and consequences

### Participants' Introduction

Each of the participants was given a piece of paper with a word. For each such word there was a matching word amongst the participants. The participants had to 'find their match', their partner in this game. Once they identified their partners, they introduced themselves and then each other to the entire group.

***Reflections of participants***

- *It was difficult to find our match in the group.*
- *Introductions helped us know each other better.*
- *This exercise also made us think about to choosing the correct person as our life partner.*

### How our body works: male and female reproductive systems

This session looked at the male and female reproductive health systems with a focus on changes during puberty.

According to local culture/practice, when a woman attains puberty it is celebrated publicly. However the same practice is not followed for men. Then what are the signs in a man who has attained puberty?

- *Change in his voice, growth of moustache, facial hair.*
- *Appearance of pimples on his face.*
- *He is able to produce semen and ejaculate.*
- *When men watch movies or are exposed to any kind of sexual or phonographic pictures they are sexually aroused.*
- *They may also masturbate.*

*The participants had some doubts and feelings about masturbation which were shared:*

- *Masturbation is a wrong practice.*
- *There is loss of sexual power, which may lead to impotency.*
- *There is a fear of being caught while indulging in masturbation.*

*Some of the participants felt that:*

- *There is nothing to worry, even if someone masturbates often.*
- *It is not a wrong practice we should have self-control.*

What are the reasons for irregular menstrual cycle?
What is ovulation?
What are the health consequences of frequent childbirth?
Is it advisable to have sexual intercourse in the first night itself? What are the preparations for sexual intercourse?
How to understand whether the women is satisfied after the intercourse?
Is there is any problem if we indulge in frequent intercourse?
What is masturbation and ejaculation?
Does sexual urge decrease

The doubts raised by the participants were discussed and clarified.

A picture-series about male and female reproductive organs was displayed, and discussions about their functioning and puberty and menstruation in women were conducted.

The participants sought clarifications and information based on this session [See Box] which were clarified by the facilitators.

**Marriage**

This session proposed to look at gender relations within marriage. What are the expectations from marriage and life-partner, sources of marital conflict? What is an egalitarian marital relationship? Reasons for Marital conflicts arising from differences

(as currently perceived by the men) in sexual needs of the husband and the wife;
extra- marital sexual relationships: causes and consequences

The participants were divided into four groups and had to respond to the following questions:

What is marriage? Is it necessary in life?

Your expectations of your wife.

What is the difference between love and arranged marriage? What kind of marriage do you propose to have?

What are the reasons for conflict between husband and wife? Your suggestions to avoid or prevent such problems between the partners/spouses

The responses of the participants was as follows:

<u>What is marriage? Is it necessary in life?</u>

- *There is a need for a life partner for both the sexes.*
- *Marriage is necessary to lead a meaningful life.*
- *Marriage is essential for bringing up future generations.*
- *Human beings need marriage for physical and psychological health.*
- *It is a natural way of life.*
- *It is essential to safeguard the assets.*

<u>Your expectations of your wife?</u>

- *The wife should understand the husband and his parents and be accommodative of all relatives of the husband.*
- *She should always have a smiling face.*
- *She should be educated.*
- *She should be obedient to the husband and respect him*
- *She should understand and be tolerant of the ups and downs in life.*
- *She should be a knowledgeable person.*
- She should be beautiful.
- She should take care of family responsibilities and should be able to handle issues in the family.

- *She should be in the marriageable age and should be a chaste woman.*
- *She should have the maturity to have children.*
- *She should be able to fulfill the sexual needs of the husband.*

While consolidating the expectations of men about their wives, disccussions were held about a woman's or wife's expectations of her partner/husband.

A woman may expect her spouse to be:

- *Handsome with a good physique*
- *Teetotaler*
- *Rich and without any a bad habits*
- *Non suspicious*
- *Tolerant*
- *Educated*
- *Loving*
- *Monogamous*
- *Efficient*
- *Earns money*
- *Fulfils the expectations of the wife*

As men have expectations so do women. Women's expectations are rarely heeded and decisions regarding the man she wants to marry are usually not made by her. Women's expectations must be considered and respected. Further such expectations are usually based on social constructions of 'male' and 'female'.

What is the difference between the love marriage and an arranged marriage? What kind of marriage do you propose to have?

The differences between love and arranged marriages:

LOVE Marriage:

- Love marriage means living with a person of our choice.
- It is irrespective of caste and religion.
- Husbands parents are less tolerant of the wife's mistakes.
- Better understanding of each other.
- There will not be any problems.

- Less care and nurturing for children.

ARRANGED MARRIAGE:

- Wife will be accommodative.
- Parents intervene and settle issues if any.
- Less possibility in understanding each other.
- Lesser tolerance towards each other.
- The partner can be chosen from a suitable background in keeping with expectations.

What are the reasons for conflict between husband and wife?

Participants' responses:

- The wife does not consent when the husband wants to have sex.
- Disrespects the husband.
- Insufficient money in the family/poverty.
- Large number of children- inability to fulfill their needs.
- Alcoholism, gambling, extravagant spending.
- Extramarital relationship of the husbands.
- Suspicion.
- Sickness of either of the spouses.
- Dowry and suppression of wife by the husband.

Suggestion for avoiding such conflicts:

- Adjustment.
- Understanding each other and constant exchange of views among the spouses.
- The husband should be a sensitive person, responsible and should respect the wife.
- They can seek help / support of elders and other family members when the need arises.

In the ensuing discussion these points / issues were highlighted by the facilitator:

- Marital relationship should be based on partnership
- It is essential to communicate and respect each others' views

- Understanding and acceptance of each other is another factor essential in a marriage.

A relationship based on this could prove to be more meaningful.

**Gender & Sexuality**

This session explores - what shapes our sexual behaviour; our expectations from sexual relations, causes and consequences of extra marital affairs.

This session began with a discussion on what we understand as 'masculinity'.

The participants felt that 'masculine' implies:

- *Having a good physique.*
- *Sexual feelings.*
- *Capable of producing sperm- be fertile.*
- *Capable of producing children.*
- *Should be able to sexually satisfy partner/perform well sexually.*
- *Should have a high sperm count.*

Reasons for impotence were also briefly discussed.

**Expectations from sexual relations**

The facilitator placed before the participants a very common occurrence in the villages in this regard. In a village the couple are expected to have a child soon after marriage, expectations of bearing a male child may also lead to frequent pregnancies... The first delivery is supported by the families of the couple and for consecutive deliveries this support diminishes. Though Frequent pregnancies cause health problems for the woman.

Bigamy and extra marital relationships are quite common in the villages. The reasons are usually cited as the woman/wife becoming less attractive due to frequent childbirth. In such a situation the husband feels that he does not get sexual satisfaction and may have extramarital relationships. Such relationships may increase the probability of getting sexually transmitted infections. Though such practices for men have social sanction, men have to think about the consequences of such practices. This could affect not only the physical health but also the relationship between the spouses and the children.

*How do we perceive relationship between a man and a woman?*

A picture of a man and a woman standing was shown to the participants. They participants had to describe what they perceived-what was happening in that picture? The responses of the participants were:

- They are lovers.
- They are discussing something.
- They are watching something.
- They are waiting for a bus.
- He is threatening her.
- She is pleading with him.
- They are seeking help.
- They are friends.
- The man is expressing sexual interest in her and proposing a relationship.
- The man is teasing her.
- He is complimenting her.
- The man is praising the woman's beauty.
- They man is calling her in exchange for money
- The man is enjoying looking at her body.
- They are wanting to have sex.

This exercise explored our perceptions about a relationship between a man and a woman. These descriptions of the participants reflected that perceptions are based on gender stereotypes and understanding of how a man and a woman would behave. Barring a few exceptions the perception of the relationship was sexual. The session strived to challenge these perceptions.

This was the last session before lunch. The next session began with a song expressing love.

*Expectations*

Mr. Shanmugam distributed pieces of paper to the participants. They had to write their names on it and an action that they wanted one of the other participants to do. Most of the participants wrote that the other person should dance, mimic, someone or something, sing etc. Then the participants themselves were asked to complete the actions that were intended for others. They found it difficult to do what they have written for others.

- Our expectations from others could very well be their expectations of us.
- We should not have a different set of rules/expectations from others.
- Similarly with our spouses too.

**Visualizing an egalitarian marital relationship**

Mr. Kumar facilitated this session on attitude towards women as subordinates in a marriage. This can create problems and strain the relationship. This could cause psychological stress and sexual problems in a marriage. A women enters into a marital relationships with lots of dreams. After the marriage due to the suppressive attitudes towards them the couples have a lot of conflict and may even end in a divorce.

Such an attitude is because the couples do not understand each other and do not have mutual respect. It is important in a marriage to maintain respect, adjust and understand each other and share all responsibilities.

The facilitator talked about socialisation into male and female roles which governs what we expect men and women to do and how we expect them to behave. He sought to distinguish between roles and attributes that are the result of biological differences between males and females, and those that arose from socialisation. Socialization also prevents or discourages relationships between the sexes outside marriage. Understanding of the opposite sex is usually limited to marriage and this influences how we perceive men and women and our attitudes and behavior towards them.

In our villages the woman has to leave her natal home and go to a new place, family. The men should be sensitive and understand the problems of women, who have to cope with new surroundings, people and practices. So the husband should help her to cope with the new surroundings, which can definitely avoid problems.

The participants felt that a large number of love marriages are failures because these marriages have taken place with false promises while the couple were in love. Either of the spouses may indulge in practices or activities unknown to the other or dislikes by the other. There is no support from parents in such marriages. Marital relationship should be based on respect, trust, open communication, sharing and equality.

Before the feedback session doubts of the participants were clarified and information/inputs given as required by them.

**Feedback from participants**

The participants expressed satisfaction with the one-day workshop.

- I got to know about the kind of expectations in marriage.
- I learnt a lot about menstrual cycle, how semen is produced, ovulation. The discussions about love and arranged marriages was also interesting.
- It was useful for me learn about being understanding and respect the expectations of my wife
- I understood how difficult it is to get acquainted with new surroundings and therefore men should be supportive of their wives
- I now know how to win the affection of my wife and keep my wife happy

The facilitators informed the participants that they could access the counselling services provided by volunteers in the villages through RUWSEC.

Such workshops were very useful for future marital relationships and also understanding issues relating to sexuality and gender. Young men and women have very little or no access to such information and inputs.

Such workshops promote better relationships between men and women reducing marital conflicts and creating more egalitarian relationships.

***Model of Training II***

**Child Sexual Abuse**

Facilitator : The Co-ordinator of the Programme –Ms. Caries

Venue : RUWSEC Training Centre

Discussion

What is child sexual abuse?
The participants shared their understanding and knowledge about the topic.This was followed by a discussion about the meaning of abuse; and sexual abuse, why does abuse take place, conditions under which it occurs and perpetrators and victims of such abuse were discussed.

**Role play**

*The following situations were given to the participants. Volunteers from the participants – one as an adult and the other as a 7 year old played the following situations:*

- *Feeling hungry but there is no food*
- *Someone stamps on the foot in a bus*
- *Somebody picks your purse and runs away*

*In the first situation the child*

- *waits for mother to return*
- *drinks water to quell hunger*
- *cries for food*
- *goes to the neighbour for food*

*The adult cooks and eats food.*

It is seen that there is a difference of reaction between a child and an adult. The reasons are age, physical ability and maturity.

This role-play highlighted the differing reactions of a child and an adult in similar situations. It was clear that an adult is able to manage by himself/herself well and satisfy

his/her needs in any situation. Whereas, a child is weak and dependent and seeks external support in order to fulfil her / his needs.

**Story**

*Ramu, a 35 year old man calls his neighbour Mala, a 6 year- old girl for an outing. Mala knows that she is likely to face a problem.*

Questions for discussion

a) Why is Mala hesitant to go out with Ramu?

b) What problem might Mala face if she goes out with Ramu?

c) Does Ramu have the right to force Mala to come with her?

d) What can be done in such a situation?

It is assumed that Mala does not have a good opinion about Ramu.

Why is Mala hesitant to go with Ramu

*a. She might have had a negative experience with him*

She may still go because:

*b. Ramu may be related to her*

*c. Parents forced her to go*

*d. Because he is older and has called her*

*e. He may have threatened her*

*f. Nobody else to accompany her*

*g. She expects something from him*

What problem might Mala face if she goes out with Ramu?

- *If she goes out with Ramu, she will face danger of sexual abuse.*

Does Ramu have the right to force Mala to come with her?

*Ramu does not have any right to take Mala out forcibly.*

What can be done in such a situation?

*Mala should avoid the company of Ramu and must never let any opportunity to be alone with him. She could as well talk about her feelings to the elders at home. She can talk about it with her mother, sister, friend.*

Why does Mala not tell anyone?

- *Because of age difference.*
- *Unable to understand what has happened.*
- *Does not know to say it /articulate.*
- *She thinks no one will believe her.*
- *She is afraid that Ramu will harm her.*

How does it affect her?

- *She may not show interest in school*
- *Feels guilty*
- *Does not mingle with others/peers*
- *She may be preoccupies as memories recur in her mind*
- *She cannot study and does badly in school*
- *Restless*

This session highlighted how child sexual abuse occurs, why it is so difficult to talk about it, what are the consequences of child sexual abuse, the power relationship between an adult and a child.

**Case studies -discussion**

Is this child sexual abuse?

The facilitator presenteded some case studies.

A 7 year old girl is very attached to her grandparents. She spends a lot of time with them. Her grandfather makes her sit on his lap and rub his penis covered by a cloth.

A 10 year old boy is shown pictures of naked men and women by his uncle. He then make this boy rub his penis. He does not touch him.

Are these cases of abuse?

The participants discussed similar cases that they had heard of in their areas. This exercise helped them understand the range of abuse that a child could undergo. The participants also spent some time reflecting upon the torture because of the abuse and urgent need for its prevention.

**Questionnaire -conclusions**

A questionnaire calling for opinion on different aspects of child abuse was given to the trainees.

The outcome of the decision arrived at, by way of the majority was:

- Child abuse occurs frequently.
- Child abuse takes places irrespective of education and economic status.
- The child should not be let out for long hours at unknown places.
- Abusers are not 'sick' in majority of the cases.
- In most cases the mother of the child abused is not aware of it.
- Whether child abuse should be reported was discussed at length as many were of the opinion that such reporting would ruin his/her life and affect the child's future. For prevention and punishment reporting is necessary.
- The accused of the child abuse need not necessarily be a stranger. In fact in most cases, the accused is a close relative / friend and sometimes even the father.

**Suggestions**

Finally the trainees were made to give their suggestions on the ways of preventing child abuse.

- The parents must be made aware about child abuse and hence be cautious.
- When a child shows her / his disapproval to any particular person, it must be taken seriously.
- The victims must be made to speak out and the accused punished.
- The children should not be encouraged to watch any sexually arousing movies, pictures or acts.
- The parents while upbringing their children should teach them to protect themselves from any abuse and thus show disapproval when unnecessarily touched.
- The society should be made to realize the evil effects of child abuse and also empathise the victims of such abuse.

This workshop was a very informative one. The participants understood what child sexual abuse was and how important it was to communicate such issues to parents, take children seriously and create conditions to reduce the risks of such incidences taking place.

**ANNEXURE III**

Topics covered in the inter-village workshops in the second phase during:

| | | |
|---|---|---|
| 1998 | : | Our Body and its functions<br>Aiming towards good health<br>Health Consequences of substance abuse |
| 1999 | : | Awareness on venereal diseases<br>Group Counselling for alcoholics<br>Marital / Sexual Counselling for the newly married couples |
| 2000 | : | Status of Dalits |

**Annexure-1V**

COSTS

| **Annual cost for the program** | **Rs.** |
|---|---|
| Camps | 6,400* |
| (3 camps in a year) | |
| Cultural programs | 18,810* |
| Training programs | 5,400* |
| Village visits (includes Night meetings) | 14,400 |
| Youth Centre (Includes cost for maintenance, books, cultural events, camp, etc.) | 33,560 |
| Salary for the staffs | 8250 |
| **Total cost per year** | **86,820** |

* Includes TA and Food allowance

*References :*


1. Reports on Men's Team Programmes, SDT and SED
2. Survey Details of Men's Team October–November 1999, by Research Department – RUWSEC
3. Census of India 2001
4. Rural Women take Reproductive Health Matters Into Their Own Hands: (Sangeeta Subramanian Sokhi)