ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

(ASCCSA 2014)

16th and 17th April 2014

OUR THANKS TO

Bajaj Group

All speakers and panelists for sharing their expertise and time with us

All attendees for being there and making the seminar a success

Authors of the external papers

THE FOUNDATION

ASCCSA

ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

TABLE OF CONTENTS

Introduction 4

Schedule 6

INDIVIDUAL SPEAKER REPORTS

Flavia Agnes, Majlis, Mumbai 9

Dr. Nilima Mehta, Mumbai 11

Dr. Amit Sen, Children's First, Delhi 13

Suchismita Bose, The Foundation, Mumbai 16

Bharati Kotwal, Muskaan, Pune 19

Dr. Shaibya Saldanha, Enfold Proactive Health Trust, Bangalore 22

Dr. Duru Shah, Gynaecologist, Mumbai 24

Rashi Vidyasagar, CEHAT, Mumbai 26

Dr. Jagadeesh Reddy, Bangalore 28

Dr. Shubhada Maitra, TISS, Mumbai 31

Mr. Suhas Chakma, Asian Centre for Human Rights, Delhi 34

Vidya Reddy, TULIR, Chennai 36

Pooja Taparia, ARPAN, Mumbai 38

EXTERNAL PAPERS

Dr. Rani Raote, Mumbai 41

Parul Sheth, Shaishav, Ahmedabad 46

INTRODUCTION

According to a Times of India report in 2014, “Child sexual abuse cases have shot up by an alarming 35% and places once meant for unbridled fun, are now increasingly unsafe. School vans and autorickshaws, a common choice of transport to and from school of many children, now figure among the places where child sexual abuse cases are often reported from.”

ACCORDING TO CRY (CHILD RIGHTS AND YOU):

- 8,945 children go missing in India every year
- 500,000 children are estimated to be forced into the sex trade every year
- Approximately 2 million child commercial sex workers are between the ages of 5 and 15 years
- Approximately 3.3 million child commercial sex workers are between 15 and 18 years
- Children form 40% of the total population of commercial sex workers
- 80% of these children are found in the five metros – Delhi, Mumbai, Kolkata, Chennai and Bangalore
- 71% of them are illiterate.

The sexual abuse of children is a substantial social problem that affects large numbers of children and young people worldwide. It is believed that more girls than boys are sexually abused, although boys are less likely to report their abuse. Though, it will be incorrect to say that there is a “typical” child victim, it is possible for one to make some assumptions about risk factors for being sexually abused. Children who are emotionally needy because of family problems, poor parental supervision, and low self-esteem may be most vulnerable to sexual abuse because offenders deliberately target children who are responsive to their attention. Hence, force is not frequently needed. Al though it has been observed that adolescent abusers usually use more strength or force.

It is thus apparent that numerous deprivations and vulnerabilities – poverty, age, gender, caste, lack of safe spaces, lack of schools, lack of proper institutional care for children without functional families -- create situations where children may be sexually exploited. It is extremely important to identify and engage with the many ways in which children become disempowered in our society to get rid of the malaise called child sexual abuse.

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ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

The Foundation was pleased to organize the first ever national level conference on child sexual abuse in India in April 2014.With over 150 participants, 13 speakers, and 8 panelists from across the country, the seminar was a resounding success. Delegates took advantage of the networking occasion and have forged several formal and informal relationships.

Participants at the conference raised important issues such as the problems with the implementation of POCSO Act, sexual abuse within institutional homes, ethical considerations in research, the importance of working with the government in tackling this problem, and therapeutic challenges in working with survivors.

We hope this compilation of the presentations at the ASCCSA 2014 will facilitate a renewed interest and commitment to our comprehensive fight against child sexual violence. We look forward to playing a sustained role in the exchange of information on the causes and successful interventions in the prevention and treatment on child sexual abuse.

The Foundation Team

Dates: 16th and 17th April 2014

Venue: Godrej Dance Theatre, NCPA, Nariman Point

Seminar Schedule

Day 1 – 16th April 2014

Start time	End time	Program	Speaker
9:00	10:00	Breakfast & registration	
10:00	10:10	Inauguration and welcome	Rahul Bose
10:10	10:15	Introduction and logistical details	Suchismita Bose
10:15	11:00	Panel discussion 1 – Requirement vs. resources: bridging the gap in child sexual abuse	Moderator – Rahul Bose Panelists – Priyanka Bose, Dr. Nishtha Desai, Vidya Reddy, Ingrid Shrinath
11:05	11:50	Assessing the gap between legislation and practice: Reviewing recent sexual exploitation laws	Flavia Agnes, Majlis
11:55	12:40	Creating Safe Spaces for Children: Zero Tolerance to Child Sexual Abuse	Dr. Nilima Mehta
12:40	14:00	Lunch Break	
14:00	14:45	Paving the path to healing: Resolving therapeutic challenges while helping with trauma recovery in children	Dr. Amit Sen
14:50	15:35	Revisiting trauma: Conflicts and complex recovery in the adult survivor	Suchismita Bose, The Foundation
15:40	16:25	Understanding and Helping Children in Conflict with Law for Sexual Offenses	Bharati Kotwal, Muskaan
16:25	17:10	Setting up hospital-based collaborative child response centres (CCRUs): Upholding dignity and securing justice	Dr. Shaibya Saldanha, Enfold
17:10 onwards		Tea	

Day 2 – 17th April 2014

Start time	End time	Program	Speaker
9:00	10:00	Breakfast & registration	
10:00	10:45	Recognizing and responding to child sexual abuse: A medical practitioner's perspective	Dr. Duru Shah
10:45	11:00	Comprehensive Healthcare: Ground-level experiences	Rashi Vidyasagar, CEHAT
11:00	11:35	Medicolegal aspects of Child sexual abuse	Dr. Jagadeesh Reddy
11:45	12:30	From Shame and Secrecy to Disclosures: Methodology and Ethics in Childhood Sexual Abuse Research	Dr. Shubhada Maitra
12:30	13:15	India's Hell Holes – Can the gaps to prevent child sexual abuse in juvenile justice institutions be addressed?	Suhas Chakma
13:15	14:30	Lunch Break	
14:30	15:15	Navigating the labyrinth: Working towards a common denominator	Vidya Reddy/Nancy Thomas, TULIR
15:20	16:05	Empowering the child: An overview of Arpan's personal safety education model for Prevention and Healing of Child Sexual Abuse	Pooja Taparia, Arpan
16:10	16:55	Panel discussion 2: Moving Forward: 365 days from now, realistic targets and gettable goals	Moderator – Rahul Bose Panelists- Priti Patkar, Persis Sidhva, Dr. Shaibya Saldanha, Sumana Rao
16:55	17:05	The role of the government	Mr Ujjwal Narayan Uke, Principal Secretary, Government of Maharastra, Dept of Women and Child Development
17:05	17:10	Closing	Rahul Bose
17:10	onwards	Tea	

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ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

Individual Speaker Reports

FLAVIA AGNES, MAJLIS, MUMBAI

Topic: 'Assessing the gap between legislation and practice: Reviewing recent sexual exploitation laws'

https://www.youtube.com/watch?v=KVejdhzTT54

Flavia Agnes is a women's rights lawyer. A pioneer of the women's movement, she has worked consistently on issues of gender and law reforms. As co-founder of Majlis, a legal and cultural resource centre, her primary engagement has been to provide quality legal services to women and children. She has played an important role in bringing women and child rights to the forefront within the legal system and in contextualizing issues of gender and identity. Significant among her many publications is her autobiographical book `My Story Our Story ... Of Rebuilding Broken Lives' which has been translated into several languages. Majlis was started in 1991 as a response to a growing need for lawyers with a gender perspective who are dedicated to evolving innovative legal practices to defend women's rights. Their agenda for social change is – quality legal representation for individual women in court, changing mindsets through advocacy and training and evolving gender just ideology through campaigns and interventions.

Flavia begins with describing Majlis' work. Majlis started a program called RAHAT started in 2011 in response to a situation of Child sexual abuse that had risen in a school within their vicinity. Until then Majlis was into matrimonial law/conflict , issues of divorce, child custody, sporadically offering support to rape victims through referrals. This particular case that Ms. Agnes speaks of required criminal legal support and after failing at attempts to find someone who could help from the field, Ms. Agnes and her team decided to take up this challenge which also became a learning process for them. The conviction finally achieved was under Section 377 for 7 years which ought to have been for at least 10 years. This incident brought out various loopholes and flaws within the system at multiple levels. This was a case that everybody including the public prosecutor had given up on and Majlis as a team could win it with comparatively very little professional experience. To make the child comfortable while going through the entire process was of utmost importance to the team rather than the outcome of the case. Yet despite the odds and having to stand against a well known experienced lawyer, MAJLIS won the case. In the middle they also had 2-3 other clients referred to them by different NGOs and all of them ended in conviction.

Ms. Agnes brings up concern with regards to certain issues. According to her, the conviction rate in Mumbai is less than 10%. This brings out the issue of what needs to be done. The team worked extremely hard to get POCSO along with many groups who campaigned. Since specific laws have come about it is up to professionals, NGOs and various bodies to be able to bring about a shift in their work paradigm and work with the laws.

Many women's rights bodies have taken up the issue of abuse but they have articulated them as issues concerning child sexual abuse. They were termed as issues of sexual violation by state

authorities. Ms. Agnes puts up a question where she states she has been a person working against sexual violence for the past 30 years. Does that qualify her as a person working for child rights or sexual violence against women? In this context how does one make the segregation? If a girl is 18 or if she is 17; what are the major changes that take place within the court or the system? For Ms. Agnes it has been a continuum of work pre POCSO as well as post POCSO. Though she has written a lot on sexual violence, she has never worked on victim support till the above case on a daily basis. MAJLIS started RAHAT in 2011, which was aided by POCSO in 2012 followed by Criminal law amendment in 2013.

Looking at the entire criminal legal system, the focus so far has only been on the state and the accused whereas the abused/violated person has been a witness for the state. The state will use the person as per convenience in order to get conviction since for the state the conviction is the most important aspect. But as a support person, what should be the most important aspect has never been articulated or conveyed leaving victim support in the background. This is an issue one really needs to concentrate on. Where is the victim and who is the state agency? Who will provide that kind of support like the state agency? Who has to come into the criminal law system since the Home department is not concerned? Home department is concerned with the conviction; detection of the crime, investigation, prosecution and conviction. To the victim the length of the conviction is not justice. To the child or the woman, the way she has been treated since the crime has been detected is of primary focus.

In conclusion, as helping professionals focus should not be on increasing conviction rates, but on ensuring that in society abuse should not take place. If sexual abuse does happen, handling the situation and taking care of the child or the woman and protecting her from the accused as well as from the system itself should be considered.

DR. NILIMA MEHTA, EX. CHAIRPERSON, CHILD WELFARE COMMITTEE

Topic: 'Creating Safe spaces for Children: Zero tolerance to child sexual abuse'

https://www.youtube.com/watch?v=Qq7eEtjnLmI

Dr. Nilima Mehta is a stalwart in the field of child protection and child rights. She has been in the field of Child Rights, Child Protection, Juvenile Justice, Adoption, Foster Care, Family Counselling and other Community Based Interventions for over thirty years. Dr. Mehta has been an Honorary Consultant with several organisations like UNICEF, CRY, CHILDLINE, ICSW, ICCW, IAPA, FSC, VATSALYA FOUNDATION, as well as with the State and Central Government and the Planning Commission for Policy Development, Research and Review of National Legislations.Dr. Mehta is a visiting faculty member at the TISS and SNDT. She has presented papers at several National and International Conference; has been as an Indian Delegate to Brazil, Korea, Sweden, Denmark and USA; and has also been a Consultant for several Research Studies and Documentations on Child Protection Issues.

Dr. Nilima Mehta talks about her work and her experiences related to CSA based on grass root level work and the convergence of policy development happening in these areas in the context of child sexual abuse (CSA). These experiences can be woven into 3 aspects:

i) Analysis of the situation – in terms of why and how this is happening

ii) Prevention and empowerment of children to NOT be the victims

iii) Interventions that combine socio, legal and medical aspects.

A deep rooted systemic change is required which makes it clear if it is an increase in the occurrence of CSA or increase in the reporting of CSA cases. Analysis is based on case experiences and understanding in the academic world that social construction of childhood, social construction of girlhood is something one looks at in the context of patriarchy and gender violence. The grass root level reality and the academic analysis converge to take the way forward.

Within the rights-based framework, Dr. Mehta looks at it as that the child is entitled to be protected and hence the framework is a finer calibration of various types of abuse and understanding it however small the experiences might be. Today one looks at the mandatory reporting issue where on one hand the individual is bound by the law to report and file an FIR and on the other hand the individual has an agreement of confidentiality of privacy and how to balance these two.

The preventive aspect looks at the personal safety education programs. 'Sex education' is not permitted in schools in that format; it is often referred to as 'family life education', 'personal safety education' or a 'life skills program'. Knowledge of sexuality through this life skills program is one of the most important preventive ways to look at it. Helping them to verbalize using language and verbalizing fear is very important. Awareness about what are personal boundaries as far as your body is concerned resulting in assertive communication. Deconstructing myths regarding within – family abuse as well as institutional child abuse.

Convergence and dovetailing required of relevant legislations to ensure child welfare should

include the 3 current statutory bodies in the context of children - the Child Welfare Committee, The Juvenile Justice Board and the State Commission for Protection of Child Rights along with NGOs, medical fraternities and experts in the field of forensic psychology, sociology, social work as well as counsellors. Initiatives need to be put together so that one does not have to "reinvent the wheel" especially with the multitude of resources available. Collaborations and partnerships between organizations is required so that there are no parallel initiatives but they are all converging or dovetailing into a single focus.

The main focus is then to look at child protection and safe space in greater detail. Child protection can be defined as "Protection from neglect, abuse, violence and exploitation." A safe space is a place where the child feels secure, protected, nurtured, cared for and looked after. It's the right of every child to have this kind of protection. The fundamental principles of child protection looks at the Rights' based framework (as explained earlier), the Rights to survival Developmental protection and Participation. The question here is who interprets the best interest of the child. Is it the interest of the organization, is it the interest of the care giver? The focus is usually on policies and paperwork and in this somewhere the child gets lost. It is the responsibility of the society, family and legal system – a whole allied approach for child protection.

Looking at a systems analysis brings up the question of who should be working with the child and this is where one starts with the family, society, state, the social and cultural taboos, the social and cultural myths, economic, health and religious issues (eg. Devdasi system).

Socio-legal aspects involve 3 aspects of POCSO which are: the best interest and well-being of the child; the privacy and confidentiality and national bilateral/multilateral measures. However, to translate an intent into action is a very big challenge and to date the gap between the two continues being a problem.

The key concerns that emerge through the presentation are interventions and how to take them forward. Social construction of childhood needs to be understood in the Indian context. Childhood construction like 'the child is the property of parents, the child is to be seen not heard' leads to a lot of lack of knowledge and awareness and denial e.g. "this cannot happen in our family". Hence deconstruction of myths at all levels is critical. A lot of intervention is required in terms of child sensitive issues. Helping professionals use appropriate language which is positive and rights-based like "a survivor of CSA" reflects the mind set and the paradigm shift required as far as this issue is concerned. Another area to be looked at is post trauma services in terms of counselling and helping children to break 'the culture of silence'. Recognizing the uniqueness of each case while having systems based approach can avoid a lot of loopholes and confusion within the system.

In conclusion, everybody can do something for a child in this situation. There should be zero tolerance and a non-negotiable approach to any type of abuse; creating a safe environment through affirmation and the empowerment of the child. Ensuring that child – centric processes are sensitive and the support system that is available is in the best interest of the child- is of utmost priority.

DR. AMIT SEN, CHILD PSYCHIATRIST, CHILDREN'S FIRST, DELHI

Topic: 'Paving the path to healing: Resolving therapeutic challenges while helping with trauma recovery in children'

https://www.youtube.com/watch?v=uPLWnEHByp8

Dr. Amit Sen is a child and adolescent psychiatrist based in Delhi. After finishing medicine from AFMC Pune, he went on to do his MD in Psychiatry from NIMHANS Bangalore. Post a longish stint in Newcastle, UK, he added two more qualifications, one of them being in child and adolescent psychiatry. Dr. Sen has been practicing child psychiatry for nearly 20 years now. Over the years he has developed strong empathy and connect to children and their families. Dr. Sen is the founder director of Children First, a multidisciplinary institute that provides clinical & community based services, training and research in child and adolescent mental health. He is the founder of the ever evolving mental health programme in Salaam Baalak Trust, an organization looking after thousands of street children in Delhi. He has also presented in various international and national conferences, written and spoken in popular media, written chapters in books and published scientific papers in peer reviewed journal.

Dr. Sen's talk is from a clinical perspective as well as some of his experiences over the years pertaining to management of children who have gone through some kind of abuse. According to Dr. Sen human development "is a distinctive and dynamic neuro-developmental maze of a child interacting with an equally complex and fluid environment". There are various areas of child development such as medical, psychological etc., including topics like motor development, language, social, cognitive, educational and emotional.

Emotional development is not regarded as a separate topic, though it is central to all areas. It is a "cornerstone" and if one cannot make that stable, it will have a ripple effect on all other areas of a child's life. Various factors influence emotional development:- 'wiring' or 'blueprints children are born with", secure attachments, life experiences, recognition of being unique, stability and security, predictability (having a routine) and stress. Every child as he/she grows up encounters a variety of situation that are stressful ranging from mild to moderate levels which is healthy as it helps the child to become resilient. Extreme stress is what leads to trauma. Causes of trauma include disasters, war, accidents, extreme living conditions, domestic violence and child abuse which can be physical, emotional, sexual, neglect, as well as exploitation.

Trauma from CSA can cause hormonal or structural changes which could be permanent, affective or emotional changes including Post Traumatic Stress Disorder (PTSD) but most concerning is that it causes a decrease in empathy and a lack of control in children. One can draw relationships from all of this in terms of how therapy is going to work.

In terms of relationships- emotional stability in attachment gets deeply affected resulting in disorganization in secure attachments, violence and victimization in romantic relationships and at apersonal level, feelings of shame and guilt arise, there is a reduction of self-esteem and have anexternal locus of control. Behavioural points of view include a high rate of suicidal ideation.

Two most “threatening conditions” that emerge are Borderline Personality Disorder and the risk of the victim turning into an abuser.

One needs to realize how this is transgenerational and affects the future. If a child is in a helpless position of being abused or exploited, that will cause maximum harm and a lot of times even after the abuse stops and the therapeutic process and the management begins, the helplessness does not go away.

Various factors that aid recovery and healing are high level of family functioning and support,counselling therapy, getting rid of the guilt and a sense of justice which is the way the system including the family and the institution deals with it.

The therapeutic process will include no doubt all kinds of resistance or defences that a child will have. The corner stone of how to get into their lives is to build a therapeutic relationship that begins outside the abuse. “Problem-free talk” or “getting to know the child” could start by talking about topics outside the incident for example talking about the family tree, various relationships; people the child is close to etc. The role of fun and play must be brought into the therapeutic process which proves to be very cathartic for the child.

One needs to stay away from the problem saturated narrative and needs to be able to see where the resources and strengths are in a major challenge. Useful techniques could include deep listening and mirroring among others. Due to one’s own anxieties adults are often quick to jump to find solutions.

Containment or containing pain is vital. During the therapeutic process of “fun and play” suddenly one may come across an incident which is very painful. The adult needs to contain it or listen to it without finding solutions.

‘Contracts’ are “do –good behaviours” in case of “high risk behaviours” which are going to harm the child can be made a note of and can be signed off by the child as well as the therapist.

Once the child is opening up and comfortable with the therapist and is in a place where he/she is ready to listen, you can start rebuilding the narrative – i.e. look at the success stories in their lives to look at what worked, when and how. Alternatively, one can look at the strengths and capabilities of the child and what are the forums that one finds where the child can channelize their energies to build a narrative.

Children go back to abusive relationships because they know no better and it is a part of their identity and that is what needs to be replaced by having other narratives in place. One needs to build that narrative through relationships and through a certain lifestyle.

The impact of CSA on families includes guilt, shock, shame, denial, confusion and splitting. There is often so much of anxiety, anger, and blame within the families that they split up when disclosure comes to the forefront. As the families begin experience guilt, shame, remorse, they begin isolating themselves since they believe they cannot face the world. That is one of the most damaging things they are doing to themselves and the child and this is an important issue one

needs to address.

Listening to the child as an adult or therapist the anger goes to the parents as to why could they not do anything. Taking a non-judgmental approach towards the parents can be extremely challenging. Hence the therapist also needs support and supervision because the burnout in situations of CSA is very high.

In terms of therapeutic interventions, there is a model that would even work for barefoot workers going out in the community and not just fully trained professionals in the field. Dr. Sen talks about a form or a philosophy one can approach where the counsellor or the therapist puts down his/ her worries and also the strengths in the system and the resources that he/she finds. The therapist alsodoes that in consultation with the child which empowers the child giving the child a sense of control.

Goals involved would include the child, caregivers and the workers working together as a team. Practice elements involved are understanding the impact and vulnerabilities, looking for clear goals and “scaling” for well-being. Lastly, affirmations and breaking down instances of success in the child’s life will get the child to look at himself/herself in a more positive light. Goal setting should be clear simple and attainable. Focus on the presence rather than the absence.

It is very important to remember that a dynamic process with the child’s interest being central and with everyone’s (family) interest has to be kept in mind.

SUCHISMITA BOSE, THE FOUNDATION, MUMBAI

Topic: 'Revisiting trauma: Conflicts and complex recovery in the adult survivor'

https://www.youtube.com/watch?v=37TGN4OUyMY

Suchismita Bose has completed her Masters in Clinical Psychology from Delhi University. She has already proved her worth as a psychologist in the Delhi Psychiatry Centre in Delhi, the Masina Hospital and New horizons child development centre in Mumbai. Suchismita, director of The Foundation, has been working with the organization since the last six years. She has been instrumental in the development of Project HEAL (Help Eradicate Abuse through Learning) that focuses on child sexual abuse. She conducts workshops and trainings on child sexual abuse, and also does extensive therapy work with CSA survivors. Suchismita has also been invited to give lectures on child rights and child sexual abuse in various colleges like Symbiosis, Pune and St Xavier's, Mumbai.

Ms. Bose has done a lot of work with adult survivors of CSA. During her work she realized that there is no point in doing awareness with children till one has worked with the adults around the children. If the child is sensitized to the issue and goes and reports it to a parent or teacher and they do not know how to deal with it, makes it more traumatic for the child. A lot of cases came up where parents and teachers have had similar experiences in their childhood. Ms. Bose goes on to talking about various experiences that The Foundation has gone through while working with adult survivors of child sexual abuse.

CERTAIN PRECONDITIONS THAT ONE CONSTANTLY NEEDS TO BE REMINDED OF ARE

- It is difficult to disentangle the effects of child sexual abuse from those of other childhood problems: Emotional difficulties are associated with the history of CSA if one gets to know about it.

  But sometimes the cause and effects may not be defined. A lot of the adult emotional disturbances could be a result of other childhood traumas as well.

- People have varying amounts of resilience: to assume that everyone takes the same amount of time to heal or go through the same process is not something counselors should do. Even though people have a lot of emotional baggage from their childhood sexual abuse, they can manage to lead a fairly content life. To assume that everyone crumbles post sexual abuse is not a safe assumption to make.

- Sexual abuse as a child does not automatically condemn a person to a disturbed adulthood.

THERAPISTS NEED TO KEEP IN MIND CERTAIN CONFLICTS THAT MAY EXIST IN ADULT SURVIVORS:

- "A guilty secret": The abuser prepares the child for the abuse and teaches the child to never talk about it. This leads the child to grow up with guilt that continues into adulthood making it uncomfortable for them to talk about the issue. First is the guilt of not being able to stop the abuse and second is the fear of exposure due to the pressure of maintaining a "fairytale family".

▸ Effects of grooming do not wear out: the abuser grooms the child before the abuse but it does not stop there and the effects extend into adulthood. As the child matures and grows into adulthood the grooming becomes more complex. Memories of the abuse and things related to the abuse like consoling oneself post the abuse, stay with the survivor, become one complex memory that the survivor may not even remember in sequence. At times the survivor's self concept of "who I am" is deeply connected with what the survivor is told by the abuser.

▸ The experiences have been kept secret for so many years: as a result of which the consequences are likely to run really deep. Hence it is very important to deal with child sexual abuse when it happens because the layers that accumulate around the abuse are comparatively lesser. As one grows and starts dealing with the abuse subjectively, the layers increase and become more challenging to deal with.

▸ Fear of getting the abuser, loved ones or own self into trouble: this frequently happens when the abuser is known to the child and hence even in adulthood it becomes tougher to acknowledge it. There is a huge burden to have to keep a huge secret within oneself because one in stuck in dichotomy of relationships and does not want to make the abuser or oneself look bad.

▸ Corroded sense of self worth: during the abuse, negative emotions arise like shame, guilt fear, anger etc and have an impact on one's self concept. This lingers into adulthood because the abuser makes the child feel objectified.

▸ The desire to constantly settle for the second best to avoid the spotlight: seen frequently in teenagers. For e.g. purposely putting on weight or procrastinating.

▸ Self punishment: due to the guilt developed during the grooming process. The child starts feeling equally responsible for the abuse and this burden keeps increasing into adulthood. Resulting self punishment may include addiction, self mutilation, suicidal ideation, drop outs etc.

▸ Nightmares and flashbacks: Although they can stay for a prolonged period of time can reduce significantly with therapeutic aid. Techniques include guided imagery and relaxation modules.

▸ Relationship problems: stemming from trust issues. One feels betrayed when a known person is the abuser which then extends to and is generalized to other relationships. These trust issues may even extend to the therapist.

▸ Problems with sexual functioning: sexual abuse being a traumatic experience can have various effects on sexual functioning making the experience of sex very painful. Orgasms cannot be achieved because sometimes in the survivors mind getting pleasure out of sex is incorrect. Sexual identity especially for men can be a confusing aspect.

▸ Anger, despair and depression: effects of child sexual abuse where anger is not necessarily directed towards the abusers and the care takers but instead just intense anger that needs to be let out.

COMPLEX RECOVERY: HOW DOES ONE WORK THROUGH THERAPY?

Most adult survivors come to talk about the abuse just to offload in a safe space. When this happens mostly they do not have a clear goal in mind. One of the main aims of therapy is to establish goals in the beginning of therapy. But while working with survivors, goals of therapy may evolve over a period of time.

After some time in therapy the adult survivors need to be encouraged to talk about their experiences outside the therapy framework to feel that it is not a "guilty secret" they need to protect. This should be done not by coercion but by persuasion with the right kind of skills.

Developing trust and maintaining it even when the client tries to test the therapist is a very important concept. Sometimes, the therapist may have to tell certain people about the issue to get the right kind of help. At such times this needs to be discussed with the client. Making sure the client is safe and no suicidal tendencies are involved, or no physiological harm is done and the client has support back home requires crisis intervention.

The therapist needs to set boundaries so that the client is not completely dependent on the therapist and learns to maintain appropriate boundaries which may be blurred due to the abuse and keeps the "inner child" in check.

Confronting the abuser will depend on the survivor's emotional stability over a period of time. It can be done directly or can be done via role plays within the safety of the therapeutic environment. The survivor needs to be made aware that disclosing the issue of the abuse, may not get the survivor the exact response he/she would expect. The survivor needs to also be prepared for adverse consequences due to this disclosure.

In conclusion some learnings as a therapist would include distributing literature about child sexualabuse helps. Group therapy can be tried only after significant amount of individual therapy. One must be aware of discrepancies between the therapist's and the survivor's perception of the abuser and not to impose one's view as a therapist on the client. Most importantly, learning to take care of oneself as a therapist especially with issues related to burnout.

BHARATI KOTWAL, MUSKAAN – AALOCHANA, PUNE

Topic: 'Understanding and Helping Children in Conflict with Law for Sexual Offenses'

https://www.youtube.com/watch?v=BpZZQUfr_yc

Bharati Kotwal is an MBA from Delhi University with a Certificate in Feminism from Women's Studies Centre, Pune University. She is a core group member of 'Muskaan', an Aalochana program against child sexual abuse, since its inception in 2000. She has conducted many awareness sessions on child sexual abuse for parents, teachers, social work and law students and community members. She has also co-authored a paper on 'Imperative to include child sexual abuse in the curricula of social work' for an international conference on 'Social Work Education in the Contemporary World' organized by Karve Institute of Social Sciences in 2012.

Ms. Kotwal represents Muskaan, a campaign against child sexual abuse. Reasons for taking up this issue are because it is so rampant and insidious, and is hardly ever spoken about, a lot of stigma and denial is associated with this issue and also there is no satisfactory closure to these cases. The criminal justice system is inadequate while dealing with child sexual abuse due to delays in convictions and prosecutions causing further trauma to the child. Therefore for all these reasons, prevention is of utmost importance. Muskaan's emphasis is on prevention through awareness with a broad spectrum of population.

Over the last 13 years, there has been an increase in the demand for awareness coming from schools, community based organizations, NGOs, police personnel and so on along with case referrals. The organization's main activities involve awareness with children and adults, using puppets as a mode with very young children to teach them about safe and unsafe touch. With adolescents, apart from talking to them about who can be the abusers and abused, comprehensive sexuality education is imparted and changes happening at puberty, gender, power and so on. With adults talking includes debunking various myths and misconceptions about abuse, symptoms related to detection of the abuse, medico-legal information and information about short and long term consequences of abuse. Also since POCSO has come about in 2012, Muskaan has been creating awareness among police personnel, probation officers, NGO workers and staff of children's homes. Their work also includes counseling, case work, psychosocial interventions, etc.

One of the challenges faced is when children talk to Muskaan personnel about the abuse and ask them not to tell their parents about it. At times the personnel has to talk to the parents but they sensitize them on how it needs to be reported in the interest of the child and in the interest of other children who may be abused by the abuser if no action is taken. Psycho-social interventions are done at school levels, talking to teachers, classmates and others to sensitize them to what the abused child can go through as a result of it and how they should handle it.

Working with children in conflict with the law is a new area for Muskaan. Discussion forums and capacity building workshops have been conducted from time to time to increase their own knowledge and skills on the subject.

It has been seen that a lot of children come from abusive backgrounds or have seen abuse in their homes, neighbourhood, community and other places. Quite often children who are brought by the police to the JJB and then sent to homes are labelled as criminals and receive contemptuous

treatment from everybody. Another reason why Muskaan thinks it is important to reach out to these children is because they get incorrect information about sex and sexuality. Information they receive is from their own peers and pornographic material which may be violent and unscientific. Such children have greater exposure to sexual activities and have fewer avenues to discuss such personal issues with adults.

LEVELS THAT MUSKAAN WORKS ON INCLUDE:

▸ Sexuality education: with boys in the observation homes. They started off with weekly sessions on sexuality and other related topics. A male resource person has been engaged to do so. Topics covered include anatomy, health and hygiene, sexuality including values and attitudes, responsibility, patriarchy and gender, masculinity, power structures and so on.

▸ Individual counseling: within the home and those children who are out on bail, come to Muskaan. A holistic view about the well-being of the child is taken. Focus is not just on sexuality but also on the child's rehabilitation and reintegration into society. Personnel avoid being judgemental and condescending with the children. Their primary approach is to have a dialogue with the child to ring up any questions and concerns.

▸ Parent counselling (primarily focused on education): Parents also go through a lot of trauma and emotions like anger, disbelief, guilt and shame which need to be considered. When there is a long gap between the abuse taking place and the case coming up, denial is common on the part of he parents. Parents need to be made aware that the child needs their emotional support and that they need to empower the child to take care of himself in an age appropriate manner but not to over protect him.

▸ Sensitization: of staff of the observation homes and police. Focus here lies on child rights because it has been observed that they have a 'different way' of looking at the children like they are beyond hope. Authorities need to be reminded that they are children after all and with counseling and guidance they can be rehabilitated and can live a more productive life. An important concept taught here is sensitivity to individual circumstances because every child comes from a different situation. Thorough knowledge of the POCSO sections is also imparted to the staff which is a requirement under the law.

MUSKAAN'S OBSERVATIONS:

Every child is in a different situation. Children are confused about the difference between friendship, physical attraction, and love. There is natural emergence of sexual feelings and physical attraction among adolescents once they reach puberty. They need to be educated that they do not have to commit sexual abuse neither do they have to be victimized by the abuser to deal with these sexual feelings.

Also it is preferable to have many friends at this stage rather than only one. Commitment to one partner should be made only when they are mature enough to handle it. The feedback received from a girl's observation home which received the workshops was that had they known the difference between friendship, physical attraction, love and commitment; they would not be in the kind of situation they were currently in.

There is lack of awareness about the outcomes of sexual activity resulting in irresponsible behaviour. Most of the children do not know what a criminal offense is and what qualifies as abusive behaviour. Sexual activity takes place without prior knowledge of consequences whereas it should be the other way round.

Children try and separate the physical/sexual act from the emotional aspect thinking the two can be kept apart. For a lot of them, the sexual aspect is of paramount importance. The girl is looked upon as an object to be used rather than someone who has feelings and opinions.

There are gender roles that equate power and violence with masculinity which are imbibed in boys since childhood. Sex, power, control and aggression are attributes of masculinity in a patriarchal society. Boys and men are quick to feel that they can have a sense of entitlement to have their needs and urges fulfilled while expecting the woman to be submissive and satisfy these needs and urges.

Boys will behave in ways they want to while girls have to protect not only themselves but their reputation and virginity as well. In case they are unable to do so, the victim is held responsible for the abuse. No focus is set on the boys who should be changing their behaviours and attitudes. Boys rationalize coercive behaviour for example "how can sex be forced if she is my girlfriend".

CHALLENGES FACED BY MUSKAAN ARE:

- Boys have a short and indefinite stay in the group home make accessibility to the same set of boys difficult for the helping professionals.
- Some have to sit through repeated lectures while other boys are new. Hence both their requirements and these gaps have to be looked into.
- Due to the shifting population, the staff does not get sufficient counseling sessions with the children considering the average stay may be just a few months for each boy depending on them getting bail and the case outcome.
- Many a times parents and children do not realize the importance of counseling. Counseling sessions and community service are mandatory for children who have received bail. Such children are asked to come into office for counseling but the children along with lawyers and parents do not take it seriously and hence the lack in counseling regularity

In conclusion, as mentioned earlier helping children in conflict with the law for sexual offenses is a fairly new area for the organization. They believe that there has been very little work done on sexual abuse by minors and with this new assignment Muskaan hopes to develop some understanding of their environment, thought processes, perspectives, motivations, so that they can be better helped to be reintegrated in society.

DR. SHAIBYA SALDANHA, ENFOLD PROACTIVE HEALTH TRUST, BANGALORE

Topic: 'Setting up hospital-based collaborative child response centres (CCRUs): Upholding dignity and securing justice'

https://www.youtube.com/watch?v=P-T-uif9nf8

Dr. Shaibya Saldanha started as an obstetrician- gynaecologist but is steadily metamorphosing into a sexuality activist with a strong affinity for child rights. While continuing her clinical practice, she works as a trainer in setting up child protection systems at the state level. Along with Dr. Sangeeta Saxena she started Enfold Proactive Health Trust in 2001 in Bangalore to impart life skills and sexuality education to children, parents and teachers. With the increase in reporting of sexual abuse among children, Dr. Saldanha underwent training on setting up child protection service through UNICEF /ISPCAN/ CPU-Net Philippines/Tulir in 2010.

Through her past experiences, Dr. Saldanha talks about a lot of people coming into hospitals with fertility issues stemming from child sexual abuse. A lot of cases involved non-consummation of marriage, difficulty in having sex, dislike of having sex, etc. Hence Dr. Saldanha and her colleague started sexuality and life skills trainings to prevent the problem rather than treating it after occurrence. Targeting children from grades 5-7 they realized that these children already had their ideas clear for example "boys need to have sex to prove something" or "girls have to be compliant". The reason why children have sex at ages 14-16 is because the child comes from a household where nobody talks about sex and they tend to build up their own ideas and images about this issue. Sometimes girls give in to having sex just to prove that "she is a woman who can be wanted". Hence talking to people about the life skills approach to sexuality was of utmost importance. That led to children disclosing episodes of being sexually abused. On talking to various professionals like CWC, child psychologists, child psychiatrists it was established that there was no system and that is how the CCRU came up.

When a child discloses or has been detected with sexual abuse, "you get a mess" and the "child gets slaughtered in the middle of it." Dr. Saldanha talks about a case that occurred in 1994 before the JJ Act to point out loopholes in the system which planted the seed for the CCRU. A 14 year old girl developed herpes after being sexually abused by her classmate's father. The girl's parents fought to drag him to court and were very supportive of their daughter. They refused to take any bribe from the man's wife who admitted that this was not the first time her husband had abused a child. But due to the embarrassing accusatory questions by the defence lawyer like "what has that man done to you that you want to harm him" made the girl not want to come to court. Therefore, with the primary witness not being there, the man was acquitted.

There is complete lack of awareness in the system about child sexual abuse including confusing reporting mechanisms. 95% of individuals are unaware of the fact that a child who has been sexually abused should never go to a police station. The JJ Act clearly states that a child who has been abused is not a criminal. The police officer on being given the report has to go to where the child is most comfortable. The police also are not all bad, but they are helpless against the system. The child gets bounced around from person to person in police stations and hospitals and probably finally gets seen by a person who cannot push the case onto any other authority. There is an absolute delay in procedures and deliberate harassment to reduce reporting.

There are no proper medico legal protocols that are being followed. Medical staff does not get trained in terms of response, sensitivity, documentation protocols, examination findings, etc.

22 Documentations of history and findings are completely inadequate. In medical certificates though most doctors know that the two finger test has been abolished, yet statements such as "habituated to sexual intercourse" or "hymen is open" are used and this creates a problem. Looking at psycho-social support, the best interest of the child is not kept in mind. Within the family itself there is no rapport with the child. They are treated as unwanted baggage "new headache" for all authorities involved. No procedures are explained and absolutely no support with statements like "how could you have allowed this to happen." No mental issues are addressed and there is a lack of counseling services offered. This sums up systemic failures. Once the child comes in, there are a series of interviews that follow that can be traumatic for the child. The fact that the child is never to see the perpetrator is lost in the process. The child is taken to the same hospital as the perpetrator in the same van!

Dr. Saldanha concludes with how the CCRU started from this process. It's a multidisciplinary team approach. The idea behind it being hospital based is that it is a child facility based program and having it in a hospital makes it less scary and more natural for people to enter a hospital. The police come to the hospital and Dr. Saldanha herself conducts the interview using the forensic interview methodology asking the child about the entire process without 'leading questions'. The police officer will take down the statement of the child and hence the interview is taken only once. The child is then taken in for a medical examination along with the person the child is most comfortable with.

The consent of the child is of utmost importance. The CCRU is hospital based, adequately equipped and conducts 24 – 48 hour trainings for all the hospital staff. For the doctors and nurses training involves – reporting abuse, how to interview the child, documentation, engaging others, how to testify in court, among other things. Once this training is completed, the convergence training includes the involvement of police from that area. The idea is to develop familiarity between police and doctors. Chain of custody and proper documentation is followed.

Therefore, the results that they are looking for is first better care of the child, better support from the family, reduced recurrence of abuse and last but not least punishment for the perpetrators.

DR. DURU SHAH, GYNAECOLOGIST, MUMBAI

Topic: 'Recognizing and responding to child sexual abuse: A medical practitioner's perspective'

https://www.youtube.com/watch?v=gX4ikkOCKyM

Dr. Duru Shah is the Scientific Director of Gynaecworld, Mumbai and is a Consultant to the Breach Candy Hospital, Jaslok Hospital and Sir Hurkisondas Hospital in Mumbai. Over the years, Dr Shah has been engaged in several social awareness initiatives such as "Growing up" - the Urban Adolescent Empowerment project, "Kishori"- the Urban Slum-based Adolescent Empowerment program in Dharavi, and a Rural Maternal Health, program "Save the Mothers". Currently, she is focusing her attention on combating Sexual Abuse, especially in young girls. Towards that end, more recently, she was part of a ground breaking campaign on gender violence issues, "Breaking the Silence on Violence" by the NGO SNEHA. She is a recipient of many National and International Awards, the most prominent being, the "Distinguished Merit Award" for service towards women's health awarded to her by FIGO at the World Congress in Rome, Italy in October 2012. She is the first Indian to have ever received this prestigious award.

Dr. Duru Shah talks about sexual violence in children from her perspective as a practising gynaecologist. When one looks at the health consequences of sexual violence, one automatically comes to reproductive health because it is the reproductive system that gets affected. There is a lot of gynaecological trauma to the extent that there has been forced penetration which could be causing a lot of injury to the perennial, vaginal and anal area. Later on in life the girl may even have difficulty in having normal sex or cause unintended pregnancy.

Besides, every girl does not complain to the police or go to the hospital. Staying at home and not realizing they are pregnant can lead to unsafe abortions. Health consequences also involve sexual dysfunctions which make it difficult for the woman to have sex for years. Sexually transmitted infections such as HIV or hepatitis B could be picked up from the abuser and are for life due to lack of treatment. Lastly, constant leaking of urine or stools post forced penetration which requires surgical intervention.

Mental health issues involve depression, post traumatic stress disorder, anxiety, sleep disorders, somatic complaints, suicidal ideation and panic disorder. Behavioural issues involve high risk behaviour due to the unprotected sexual intercourse, early consensual sexual habits initiation, multiple partners and alcohol and drug abuse. Fatal consequences could stem from suicidal attempts, risky pregnancy, unsafe abortions, HIV leading to AIDS, honour killing and infanticide of a child born of rape.

Statistically speaking, more than 95% of sex offenders are neighbours, relatives and friends and therefore, majority of the cases go unreported and amongst the ones that do get reported, 90% do not get justice due to lack of evidence. Looking at the number of cases lingering around in courts, which have not yet received justice are more than 25,000 cases.

One can say that the lack of evidence is due to failure of the medical profession. 95% of the victims do not get justice because the doctors fail in both evidence collection as well as documentation.

There is a continued use of the two finger test which is banned by the Supreme Court and the private sector of the medical profession does not even want to get involved.

About the two finger test- it is stated on the forms that if the two fingers go in easily, the victim "is habituated to sex" and this is exactly what is written on the medical forms. But does that mean that a only a woman who's a virgin always has to be raped? Could it not be a woman who's already married or already sexually active who gets raped? When this sort of documentation is put in, the lawyers start thinking "this person has no moral values" hence this unscientific and invasive method has been looked down upon by most of the countries and therefore it's been scrapped.

According to Dr. Shah, it is not the hymen that one needs to focus upon. One must remember that the hymen can be torn even because of excessive rigorous physical activity, such as cycling, riding and swimming. One does not need to document old tears and examination of those is unnecessary.

Current doctors who have not been trained in this are over emphasizing presence of injuries in medical examinations. There's poor history taking, there's a mandatory police requisition which has been asked for and hence doctors neglect medical treatment.

FIGO is an international body which calls upon all gynaecologists all over the world and has national standards for the respect of these rights for women. It calls upon all members of the profession to respect and protect women's rights. Two important guidelines that FIGO is working on are

- Health care professionals responses to violence against women
- Conducting medical forensic examination in a case of sexual assault

FIGO recommends direct training programs with continuing medical professional education or university based or comparable courses on management of sexual abuse. The second recommendation is preventing sexual abuse through education of young people. Trainings have been provided and more than 1000 gynaecologists have gone to schools all over the country within 10 years talking to over 5 million girls about their reproductive and sexual health. They also ran a slum program called the 'Kishori' program in the slums of Dharavi empowering girls between ages 15 – 19 in the same way as they did in schools. Vocations were also provided to make them independent and stand up for their own rights.

Clinical care should be woman centred. One must not treat the woman only as a piece of evidence and there needs to be a first line support that includes consultation in a private confidential place, being non-judgemental, careful, and respectful. Care for victims must be integrated into existing services rather than stand alone as separate services. FIGO also recommends that women presenting shortly after sexual assault should be offered protection against sexually transmitted infections and emergency contraception to avoid pregnancy within 120 hours. Victims must be offered appropriate care and every gynaecologist who is responsible for conducting medical forensic examination, should be trained, equipped and willing to present evidence in court.

National protocols and checklists for examination for survivors of sexual abuse are being developed and these will be soon available to all professionals. The way forward is sensitizing, updating doctors, creating awareness about the current law, uniform protocols needs to be taken up. It needs to be understood that if a doctor is approached by a survivor it is mandatory for them to collect evidence and if they do not- it will be a criminal offence.

Dr. Shah ends with a quote from the United Nations General Assembly, New York -“Violence towards women is probably the most shameful of all human rights. It knows no boundaries of geography, culture or wealth. As long as it continues, we cannot claim to be making real progress towards equality, development and peace.”

RASHI VIDYASAGAR, CEHAT, MUMBAI

Topic: 'Medical evidence collection & case impact: Protocols for complete & sensitive medical examination in CSA cases'

https://www.youtube.com/watch?v=ePQNxdvwQ-k

Rashi Vidyasagar is a Research Assistant at CEHAT focusing on Violence against women- Sexual Assault and Domestic Violence. The idea of CEHAT was conceived 20 years ago when a group of researchers and healthcare professionals decided to create an alternative health research institution which is at the interface of activism and academics. CEHAT comprises of a multi-disciplinary team such as doctors, lawyers, social workers, public health experts and counsellors. CEHAT through its research, intervention, education and advocacy, has been addressing issues of right to health care for all; investigating and combating violence; and caring for survivors. CEHAT has pioneered a comprehensive healthcare model in 3 public hospitals in Mumbai, based on standards set by the World Health Organization for sexual assault survivors. Since 2008, the services have extended to over 250 women and children.

Rashi talks about CEHAT's experiences since 2008 in the Comprehensive Healthcare Response to Sexual Assault centres. She also gives an overview of existing practices in medical examination. Current practices involve no particular standard protocol on how to examine a patient or a survivor of sexual violence. There have been gender insensitive practices and observations like the two finger test, the elasticity of the vagina and anus habituated to sex etc. There is overemphasis on the presence of injuries in medical examinations. For example during medical examinations most often it will be stated, "The girl did not resist. There is no injury. There was no rape." There is no recognition of non penile penetration. Therefore unless it's a peno-vaginal intercourse with semen emission it is not considered as rape.

There is an absence of reasoned medical opinion and interpretation of medical findings. Very often the opinion is missing – the doctors have not interpreted what they have found. Samples sent to the forensic sciences laboratory do not receive reports due to which doctors are unable to give final opinions. When patients are examined a 'provisional opinion' is obtained based on immediate findings. Samples are sent to the FSL and one gets back a report with doctors' 'final opinion'. However, because reports are delayed, there is a lack of that final opinion.

WHAT DOES 'COMPREHENSIVE HEALTH CARE' MEAN?

In any set up; in a public or a private practice, doctors have two roles when it comes to sexual violence.

- Therapeutic role is providing medical treatment not just limited to the patient's injuries but also providing treatment so that there are no infections, pregnancy and manifestations of the violence further on her health. Providing psychological care is also considered under this umbrella. Both the physical, mental as well as emotional signs of violence need to be treated. This could be done just by referring the patient to a counselor or by providing some element of psychological first aid. Services will include referrals to legal aid and shelter services.

- Forensic role involves an appropriate documentation of the assault, conducting a thorough examination, collecting crucial forensic evidence, maintaining a chain of evidence and providing a reasoned medical opinion.

A proper chain of custody has to be maintained. CEHAT works in three BMC hospitals in Mumbai and over 500-600 doctors have been trained to go through this comprehensive health care module. First, a gender sensitive performa is used. It does not matter if the survivor is a child, male, female, transgender, etc. A manual has been created which is provided with every safe kit and is given to doctors. This manual is self explanatory and extremely practical to use.

An orientation program is conducted for every doctor that does not only talk of sexual violence, but also talks about the reasons for it. Sensitizing them to the fact that sexual violence happens due to power and not due to lust is an issue that is discussed. Standard operating procedures have also been provided. Each person for example the Assistant Medical officer, the Casual Medical officer, the staff nurse, physician and others has a role to play and is sanctioned by the highest authority of the hospital.

Ms. Rashi concludes by talking about some of the major challenges faced by CEHAT. There are certain challenges that are faced while implementing this module with the CWC for example will a survivor be better off in a shelter home than her own home. Issues with courts are a concern - For example a 4yr old survivor currently is 6yrs old and her cross examination has yet to be done. Hence, synchronizing with the system to overcome these challenges is what CEHAT hopes to achieve soon.

Dr. Jagadeesh Reddy, Consultant – CEHAT, Bangalore

Topic: 'Medicolegal aspects of child sexual abuse'

https://www.youtube.com/watch?v=ePQNxdvwQ-k

Dr. Reddy received his medical degree from Mysore University and an MD in Forensic medicine. He is a consultant to NGOs CEHAT, PEHEL and CSER of Mumbai as well as ENFOLD of Bangalore. Dr. Reddy is also the member of the National Committee which formed the Uniform Guidelines for medical examination of Sexual Violence Victims. He has also been part of the Guideline development group, , World Health Organisation, Geneva, Switzerland, 2013 which formed the Policy and clinical practice guidelines for responding to violence against women. He is also the International and National Promoter of the SAFE kit (Sexual Assault Forensic Exam Kit) for examination of Sexual Assault Victims prepared by CEHAT, Mumbai and working for establishing One Stop Crisis Centers for examination of Sexual Assault Victims.

Dr. Reddy seeks to bring to the fore the contradictions that exist in the medico-legal system in India that impact medical experts and their treatment of CSA.

According to Dr. Reddy if there are so many contradicting issues within the laws that are passed and the system, how does one expect doctors to do justice? For example can an examination take place without a police requisition? Currently, all medical colleges are teaching the 1997 graduate medical education curriculum while the graduate medical education of 2012 is still pending in the Central Health Ministry.

Another important issue is that whether it is mandatory to report to the police? The child cannot report and hence the responsibility falls on the surrounding adult. Unfortunately every adult shrugs off their responsibilities but doctors cannot escape. Section 357 CRPC also brings up this issue.

Section 164A CRPC, talks about how to medically examine a rape victim where in it is specified that nothing should be done without the consent of the victim. But contradictory to this Section 19 states that irrespective of the consent, the police need to be informed. Doctors face a dilemma because the concerned person does not want to inform the police but the doctors have to do so. One of the solutions would be whether it would be possible to document informed refusal. This may work with adults but when it comes to a child of POCSO of less than 18 years, rule 4 states an automatic FIR needs to be registered.

Though Dr. Reddy believes that treatment should be given top priority, a lot of doctors believe that evidence must be collected first. By making informing the police a compulsory issue while treating the victim reduces chances of the victim coming in for treatment. Another issue arises when it comes to pregnancy termination as a result of rape. Today, one cannot terminate a pregnancy without informing the police both in the case of adults as well as children. The confidentiality and trust that is promised under the MTP Act is diminished due to the mandatory reporting law. The MTP Act states that all the rules need to be followed whereas POCSO and the Criminal

Law amendment Act states otherwise leaving the doctor in a fix.

The next issue is where should the sexual assault examination be done? The law states that any hospital public or private should provide treatment for these people. Rule 5 of POCSO talks about the nearest hospital. But 164 A states that only in the case of the absence of a government hospital, can one go to any hospital. This is another example of laws contradicting each other.

The next problem is the presence of a female doctor as mandatory. However, this impacted the trust on male doctors and there was an issue when the courts liberally interpreted Section 53 of the CRPC: when female is the accused she should be examined by a female doctor. According to the courts if this is the case when the female is an accused why cannot the same rule apply when the female is a victim. Not restricted to metropolitan and bigger cites but sexual assault cases take place even in smaller cities or villages. Sometimes there are none or a shortage of doctors in such places, how can one get a female doctor? Unfortunately people had to wait to get examined and in this process evidence was getting lost and treatment was getting delayed. Health and family welfare guidelines of 2014 partly addressed this issue where every possible effort should be made to search for a female doctor and if that fails a male doctor can conduct the examination in the presence of other female attendants. But it is still only a guideline.

Section 41 under POCSO talks about section the non-application of 3-13 whenever medical examination or treatment is done with the consent of parents and guardian. The doctor is in a dilemma if the child wants an examination and needs treatment but the parents are against it. 18years was about consent for sexual intercourse, the question is why does the 18years have to apply as consent for medical examination? Both are two different entities. But unfortunately both issues are getting linked resulting in doctors not conducting the examination.

Who can be present when the doctor conducts the examination? Parents or guardians should be present but most importantly those the survivor trusts must also be present. In case of incest situation the parent must not be there. The irony here is that according to section 27 POCSO if the above are not present it is mandatory for the hospital to provide it.

Is it relevant to document when the examination was done? This information unfortunately lacks in most medical opinions. Just because the medical opinion is negative, it does not mean that the incident or the crime did not occur. It only means that the medical examination did not pick it up. Not being able to 'pick it up' can happen due to delay in medical examinations, post assault activities like washing and bathing, each passing of urine and defecation loses evidence. These need to be documented upfront.

Is it necessary for the presence of injuries in all forced sexual assaults? Unfortunately it is still believed so. But now with extensive research it has come to light that even though it is forced sexual violence it is not mandatory to have injuries. These were the guidelines from WHO. Reasons could involve the person is unconscious due to trauma or drugs, fear, lubricant used, etc. Section 375 IPC section 2 explanation states that mere absence of physical resistance should not be construed as consent.

Part of comprehensive care includes getting an informed consent, documentation, treat all physical and surgical needs, mental health assessment and counseling, STD care, follow ups, etc. One needs to avoid those issues which are not going to address the survivor's needs or provide justice. Not all people come to the hospital and openly admit that they have been sexually assaulted. But it is up to the doctor to suspect so. The health and family welfare has put out guidelines like if one finds pain on urination/defecation, abdominal pain, inability to sleep, etc one can suspect sexual violence and probe further. The WCD has put out some guidelines as well but there is a point that states one needs to probe further if there is an enlarged hymeneal ring. This brings out issues of insensitivity and past sexual histories which is a contradiction.

In conclusion, today there are ICMR guidelines, WCD guidelines, Health and family Welfare guidelines but it has been said that the guidelines from the Health and family Welfare will be overarching which would give clarity to all the guidelines and contradictions that are overlapping other laws. If all doctors are honest, transparent and are doing their ethical duties, all documents will be shared and prepared in a uniform manner avoiding ambiguity in the system.

DR. SHUBHADA MAITRA, TATA INSTITUTE OF SOCIAL SCIENCES, MUMBAI

Topic: 'From Shame and Secrecy to Disclosures: Methodology and Ethics in Childhood Sexual Abuse Research'

https://www.youtube.com/watch?v=ViIHlE-lhdo

Dr. Shubhada Maitra is a Professor, at the Centre for Health and Mental Health, School of Social Work, Tata Institute of Social Sciences, Mumbai. She has an M.A. in Medical and Psychiatric Social Work, TISS, Mumbai and a Ph.D. in Social Work from Mumbai University. She is involved in teaching, field action, research and training. Her areas of interest include mental health, gender, sexuality and violence with a focus on women and children. Her PhD thesis focused on mental health consequences of childhood sexual abuse. She also heads Muskaan, the child and adolescent guidance centre of TISS and Tarasha. Currently she is engaged in action research towards sensitizing BMC school children on issues related to gender and violence, funded by ICRW. She is associated with several organizations and engages with issues pertaining to mental health, sexual abuse and sexual harassment at the workplace.

For Dr. Maitra, child sexual abuse is a children's issue and a sexuality issue. This means that affirmative sexuality experiences to children are being negated and it is also an issue of abuse as one talks about patriarchy, power, male supremacy leading to subordination of the woman's very being.

IN WHICH CONTEXT MUST RESEARCH BE LOOKED AT?

One still continues to look at families as safe, nurturing spaces and yet individuals working in the field of child sexual abuse know that lots of abuse takes place in these very 'safe spaces' that are meant to protect children. At a social level a whole lot of dialogue and discourse revolves around CSA giving grounds to a socio-political context to undertake research and lobby for advocacy. There is very little reporting on abuse taking place within the family, making research an extremely sensitive issue.

Dr. Maitra looks at CSA from a wide spectrum ranging from contact to non contact, not just limited to sexual assault and forced intercourse. There needs to be an understanding of varied trends and patterns that emerge across various populations and settings like urban/rural, community, schools, etc. This phenomenon needs to be understood with its full complexity. How can data be collected when this process is so complex? Can one say "did you have experiences of sexual abuse" or be judgmental in a particular way that will put off children or women while doing retrospective studies.

An important concept to be considered is the induction-seduction strategies that are used by the perpetrator like there may not always be sexual violence or coercion. Children may be groomed into the abuse in such a way that they start owning it. interventions need to be planned across the continuum from promotion, prevention to healing, recovery to justice and then study what works at the ground level. Though several interventions do take place all over India, many of them are undocumented.

One also needs to look at various policies that are required at the school levels. Current policies involve presentation and protection against sexual harassment at the work level, but what kind of policies are there at the school level? Research can be used in such issues as a platform to

advocate change.
Child sexual abuse needs to be understood in the paradigm of disclosure. It is a well known fact that disclosures are delayed and that individuals choose to be blind and deaf to discovering incidences concerning sexual abuse. As adults, individuals are failing their children by not recognizing the symptoms.

Dr. Maitra's research focused on mental health in terms of not just morbidity and distress but also on self-modulating relationships, sexuality issues. Objectives of her research were:

- Dynamics and contexts of child sexual abuse. Dr. Maitra wanted to explore 'what happened in their heads' when they were children and now as adults how the experience is being processed.
- Understanding the mental health consequences of child sexual abuse: conducted a quantitative analysis where she looked at women's subjective well-being vis-a-vis child sexual abuse.

Ethical issues need to be considered at the beginning of research. One of the important issues was "how do I look at myself in the research process today". A particular topic to research is picked based on various factors like one's own experiences, theoretical understanding, world views around particular issues, etc. It is very important to start with the self when thinking of conceptualizing any research. Dr. Maitra speaking from personal experience was very clear in her identity of being a social worker first and then a researcher making her research objectives secondary to upholding women's safety. Tools selected hence had to be "quick" and "non-intrusive". One uses psychometric tools but one can also use oneself as a tool and then combine the two.

Negotiating consent is an ongoing process. What are the principles through which one gets consent and how does one uphold the principles while conducting research?

Memory and recall: any retrospective work done on this kind of an issue will come in question around issues of memory and recall and that's why it is important to do it closer to the experience. Dr. Maitra works from a feminist perspective and believes that child sexual abuse is out there in the community and not there in clinical populations. If it is so prevalent it should have been easy to spot.

Dr. Maitra did not want to do a clinical based study but a community based study instead. Researching CSA needs a starting point for discussion and her methodology was changed to a preliminary quantitative study on assessing the current status on mental health followed by a screening instrument based on CSA. Through this mode participants were selected. College students 18 years and up from varied socio-economic groups across Mumbai and another city belonging to survivor groups.

Phase 1: Subjective well being inventory. Conducted with 214 women

Phase 2: In depth interviews over multiple sessions

Findings involved 77% of the women reporting any kind of abuse from contact to non contact. Almost an equal percentage of women reported both contact and non contact abuse and more than half the women had experienced both the contact and non contact abuse.

Most time perpetrators were strangers in 65% of cases. 55% of the cases perpetrators were known to the women. 17% of the women were abused by very close family members; nearly 50% were abused by those in the social network and about 9% of the women were abused by both family and non family members.

On the qualitative side, 30 in depth interviews were conducted, 17 had experienced abuse by close family members which makes it more than 50%.

One thing that was brought to notice was that if there was contact abuse, there was also non-contact abuse. Therefore any woman or child reporting non-contact abuse would go to the extent of first exploring contact abuse as well. For 19 women abuse was recurrent and extensive lasting for between 6 months to 11 years.

On self-hood women reported lowered self-esteem, not believing that they were good at anything, lowered self-worth, "I'm my worst enemy", no notion of boundaries, multiple sexual partners, difficulty in establishing relationships, self-harm, suicidal ideation, clinical disorders, etc.

Dr. Maitra ends by reiterating that this is a sensitive area of engagement. One needs to move beyond the morbid to assess the current strengths and aspirations of women. One cannot ever tell a woman "to forget these experiences". The tendency is to forget the positives but to store every minor negative and hence it is extremely important to acknowledge that "it was not my responsibility" and to realize that one is more than just this experience and to move on.

MR. SUHAS CHAKMA, ASIAN CENTRE FOR HUMAN RIGHTS, DELHI

Topic: 'India's Hell Holes – Can the gaps to prevent child sexual abuse in juvenile justice institutions be addressed?'

https://www.youtube.com/watch?v=H8SjzReMvjI

Mr. Suhas Chakma is the Director of Asian Centre for Human Rights and serves as a member of the Core Group of NGOs of the National Human Rights Commission. He is an expert on international human rights standards and procedures, and author of several reports on the rights of the child. Significant among his many writings is the 56-page report titled 'India's Hell Holes: Child Sexual Assault in Juvenile Justice Homes' which highlights 39 emblematic cases of systematic and often repeated sexual assault on children in the juvenile justice homes.

Mr. Chakma begins by talking about how child rights was not the initial focus for Asian Centre for Human Rights. They were more concerned with issues involving human rights, especially civil and political rights issues. At some stage during research on abuse of children in custody of the law, a need to look into state responses was felt. The report does not attempt to address the problems faced but focuses on children who are in the juvenile justice system – the state is held responsible. When the abuse takes place under the care of the state, the culpability is much more than being done outside. The JJ Act came up in 2000. In 2014 today not all shelter homes are even registered with the authorities. Reports on sexual abuse in these homes show that many of these homes are unregistered.

There is not a single home at least the ones run by the government, where children have not been repeatedly sexually abused either by the staff or other inmates. It is brutal and takes place on a regular basis. Children who are in need of care and protection, who cannot live in their own houses, go to state institutions thinking that they will be protected and safe. What is safe then? Looking at Delhi itself there are prominent activists working in this field. One of the homes started by one of the joint commissioner of police has registered numerous series of sexual abuse cases going on within the home. So does this speak of accountability or administration issues?

From the Supreme Court to the government to the NGOs, no one has the capacity to address such problems. Is there a possibility that one can prevent abuse in the juvenile justice institutions? On one hand it is possible, but on the other hand if one cannot register the homes in the available states, then how can one even prevent abuse from taking place.

Abusers in such homes are basically two sets of people - either the staff or owners or senior inmates. It is necessary to separate children as per their age or crime to prevent contamination of other children. But so far in no state has this segregation happened. Because the JJ Act is unclear about what happens when a child turns 18, there are many homes where children who needed protection when they were 14 or 15, continue to stay till their 20s, increasing the possibility of crimes committed. In many places both boys and girls are kept together. This is literally like creating an opportunity for sexual abuse.

Looking at the actions of the states, NGOs, national institutions in the last 14 years there has not been a single mention of inspection committees. There have been number of petitions pending in the Supreme Court and there are laws that state there must be an inspection cell constituting of 5 members with representation from the state government, the Juvenile justice board or committee of state commission of protection of child rights, Human rights etc., but nothing has come up yet.

It means that in the last 14 years none of the juvenile justice homes have been inspected by these inspection committees which the government said they would set up. This results in a conflict with the best interest of the child.

When Mr. Chakma and his team indulged in state studies, they could not visit any juvenile justice home without prior permission of the District Magistrate. But knowing that a team was visiting, everything in the homes looked perfect. Unless one provides an environment where the children can express themselves, the biggest problems in these institutions is that one goes, inspects and comes back but children continue to remain vulnerable. Unless one can talk to the children in absolute privacy without the presence of any officials maintaining confidentiality and being given a chance to repeat the process, one will not be able to gain the trust of the children. There have been situations in some states where the members of the CWC in the name of counseling have been responsible for additional abuse. So where does one go?

Situations arise where the abuse is taking place every day; when it becomes very big, it is highlighted by the media only to be forgotten a few days later. Yet institutions are not even being held responsible for non-registering. If one does not register a children's home and the children are being subjected to neglect, one can definitely be held responsible. There are hundreds of child welfare institutions in the country out of which at least 50% are being funded under the child protection scheme. If the government is spending money there should be some form of accountability. But it is shameful because one does not even know how many children are there in these homes since it is a mobile population. This makes one realize that individualistic activism and powers are extremely limited. The problem is that as a nation there is no belief in accountability. Very few governments in various regions have adopted various child protection schemes which take into account all aspects relating to children. If CSA needs to be prevented the primary focus must be on accountability and this accountability cannot be done only by NGOs due to the sensitivity of the issue.

According to Mr. Chakma, if child sexual abuse takes place in churches and the Pope is willing to speak about it, why can't the government of India speak about it? Unless one does not admit and acknowledge the intensity of the issue, one cannot resolve it.

Mr Chakma ends on a heavy note wherein he states that there is no basic recognition of the problem even from higher authorities. If one has to look at the ground level situation, being pessimistic may look like the only option since the judiciary, national institutions or NGOs do not function which comes as a serious threat.

VIDYA REDDY, TULIR

Topic: 'Navigating the Labyrinth: Working towards a common denominator'

https://www.youtube.com/watch?v=Bmc4mkFFaPA

Tulir - Centre for the Prevention and Healing of Child Sexual Abuse is a non profit, non-governmental organization committed to working against child sexual abuse in India, and is involved with both direct intervention and advocacy activities at various levels across the country and South Asia region. Tulir's mandate of addressing child sexual abuse besides public education includes child focused programs, creation and strengthening of support networks especially for legal assistance and psychosocial healing of abused children and their families, and developing information resources. Technical assistance and training related to professional response sector involvement are also significant activities besides fostering coalitions and networks to influence policy and legislative initiatives. The strategies which underpin Tulir's programming are designed for broad scale changes, not only of individuals but also of systems and norms.

As an organization Tulir is interested in looking at a large scale systemic change and to make the larger stakeholder – the government - accountable for anything that has to be done in relation to sexual abuse. One of the key factors involved in working with the government is to see that the change is institutionalized, thus sustaining it over a period of time. The community too plays a large role in protecting the child and it takes each individual to ensure that the child is protected. Various sectors involved in this process make it a labyrinth and navigating through this is quite difficult.

While dealing with children one tends to look at the more obvious manifestations of disadvantages (such as education, health, sanitation etc.) before looking at the things that impinges on the quality of life (like sexual violence). The costs of sexual violence are "not really out there" and may not be quantifiable and hence one really needs to get to the root cause of things. There are barely a handful of NGOs working on sexual violence against children and that is something that needs to be questioned. Is it because it makes one uncomfortable? Or one does not know what to start with?

The organization's ideology of working with the government is that every individual has an obligation to see to it that the child is not abused and if the child is abused to see that there is an appropriate and effective response. The government needs to be an active stakeholder in this process. Some of the ways of doing this would be:

Initiating constructive dialogue: The World day for Prevention of Child Abuse is November 19th and that is used as a great leverage while working across the board. For example in Chennai there are 165 police stations and on this particular day every police station is thrown open to kids of the schools in their neighbourhood. The children visit the police stations, understand what the police are all about. In this way the children and police get familiar with the idea that at some point the police and the child might have to interface either as people who are complainants or people who are in conflict with the law.

As another part of police initiative, in 2010 the organization got the Chennai police to start

something called Child Abuse Investigation Teams working specifically on sexual violence cases.

As a part of their education programs the organization also works very closely with the education department of Tamil Nadu. For e.g. every school has a notice board of 6ft x 4ft talking about CSA put up outside the principal's office so that the children feel more confident about disclosure and talking to the principal and teachers about things that would usually not be spoken of. Principal's of various schools and police inspectors of various jurisdictions are regularly invited for meetings, to build bridges between the police officers and principals who usually never meet except under difficult circumstances.

On November 19th flyers are distributed to all the children of all elementary schools in the Corporation of Chennai system and the Mayor is invited for the presentation. This is also covered by the media giving the cause a larger base of awareness. The idea is to get the Corporation of Chennai and the system to realize that this is a major issue.

In April 2009 a program was conducted where TULIR talked about how it is important that the school system address child sexual abuse. A media scan was done of all articles in the Tamil papers from 2008 – 2009 where it was evident that every case of school based abuse reported in the papers was because the school had not responded in an appropriate timely fashion. There were 'morchas' in front of the school and that's when the school had to get involved. This made them realize that they should start at an initial stage rather than letting the media get involved with negative publicity.The meeting was held with the Secretary and Director of Education.

In 2011 a very interesting workshop was conducted in Chennai called "Evolving a Child Protection Policy". The invitees included the government and the Secretary of Education. In 2012 the government came up with this directive which said "any teacher who has been found guilty of abuse will not just be dismissed but their B.Ed will be taken away."

The government has also started using TULIR's material at the back of school notebooks which the government gives out and every semester a new set of books and textbooks comes out with a personal safety message at the back. One of the most important initiatives is that in every teacher's handbook they have a whole chapter dedicated to handling Child sexual abuse and addressing it.

Another huge area of interest for the organization is policy. They believe that "the power lies in policy" and Ms. Reddy speaks of how they went about bringing about awareness on the intersection between sexual violence and technology and working with the judiciary of India to include Section 67B in the Information Technology Act.

TULIR also works very closely with and engage with the media so much so that they monitor them. The media uses TULIR as a repository of any information related to children. The organization also works with the disability sector bringing out a brail flyer because they believe that children with disabilities are completely out of purview.

Ms. Reddy concludes by comparing them working with the government to building a spider's web. One keeps spinning but the web gets pushed and one has to start all over again and somewhere this web will continue to remain.

POOJA TAPARIA, ARPAN

Topic: 'Empowering the child: An overview of Arpan's personal safety education model for Prevention and Healing of Child Sexual Abuse'

https://www.youtube.com/watch?v=yxuN_ToxfJk

Pooja Taparia, founder and CEO of Arpan, is a graduate in Applied Art/Graphic Design and in Commerce. However, Pooja has spent most of her professional career working in social change and development. She started work on CSA in 2006 with her NGO Arpan. Arpan is an NGO based in Mumbai with a mission to prevent the occurrence of Child Sexual Abuse (CSA) and heal those who have been affected by it. Arpan runs various activities, workshops, teaching, training and counselling services to deal with CSA. Arpan has so far reached out to over 60,000 children and adults directly and over 170,000 individuals indirectly. Pooja has recently been selected for the 'Architects of the Future Award 2013-14'. Pooja also won the Karmaveer Purasakar in November 2010 for her work on child abuse. She also led Arpan to win the CFBP Jamnalal Bajaj Award 2011 and the India NGO Award 2011 for doing exemplary work.

Ms. Taparia presents Arpan's personal safety education model for Prevention and Healing of Child Sexual Abuse that they have been conducting for the last 6 years. Arpan is a 40 member team with a mission to empower individuals, families and communities so that the occurrence of child sexual abuse can reduce and heal it's ill effects. They work across four strategies:

- Direct services that is prevention and intervention work
- Training and capacity building
- Research and Development
- Public And policy advocacy

However much of their focus is on direct work which is prevention and intervention work. They have 8 projects:

- Sensitization of public at large: conduct street plays, exhibitions, participate in the Kala Ghoda arts festival, policy advocacy etc
- Personal safety education done with children in schools, communities, institutions
- Awareness sessions
- Counselling and psychotherapeutic services : long term therapy with adult survivors, males, females, adolescent girls in institutions and children
- Training and Capacity building is done with teachers, NGO professionals, Police, officials
- Primary and Secondary research is something that has recently been started along with resource development.

Personal safety education is an innovative method to empower children and adults. Its aims are:

- To empower children with personal safety skills so that they can prevent sexual abuse
- Provide children with age appropriate information, skills and build their self esteem
- Reach out to adults and make them aware of their role in keeping children safe.

It also aims at achieving three levels of prevention. The primary level prevention is aimed at creating self awareness, secondary level of prevention is aimed at evolving immediate responses and coping mechanisms both post abuse and creating an immediate support system for the child. Tertiary level prevention is aimed at referring children to various therapeutic services.

The program was first started in 2008. The core philosophy has been drawn from the Centre for prevention and Treatment of Child Sexual abuse. Steps in implementing this program involve advocating and sensitizing the Principal and management of schools. Next, awareness sessions are conducted with teachers and personal counselors. Further a pre-session is done with parents following lesson plans with children and individual sessions with every single child. Counselling sessions are conducted with any children who have disclosed any history or any ongoing occurrence of abuse and/or inappropriate behaviour not just limited to child sexual cases. Counselling sessions with parents and counselling sessions with child victim/survivors continue. Post-session with parents on parenting skills, giving them more tips on how they can be key role players in protecting the child, any inhibitions, anxieties that have come up are addressed. The next step is to help the school institutionalize the program.

The concepts covered in the personal safety education includes body parts, body access, touching, safety rules, feelings, support systems addressing guilt, secrets, assertiveness and building self-esteem. Lesson plans are discussed in detail and letters are sent to parents after every lesson plan so that parents are kept in the loop. Worksheets are provided after every lesson plan. Methods used include energizers, prompters, group discussions, participatory reflection analysis along with personal reflection.

Assessing short term and long term impact to assess PSE programs - Short term impact is assessed through pre and post forms used with children and feedback forms with parents and teachers. Long term impact- initiated a project with the IMRB international to assess the awareness of PSE programs that children attended; how much did they understand of the program and its effectiveness. Immediate outcomes included almost a 60% shift in knowledge through the pre and post; about a 40% shift in skills and 20% shift in attitude with children. Ongoing abuse stopped when children reported it to the trainers and parents. Parents shared that they now have open conversations with their children; children are now more particular about touches and wearing clothes in front of other people. Parents and teachers have an increase in knowledge by 85%. IMRC also found that in schools that had institutionalized the program, the recall was much higher than schools that had had just a one-time intervention by Arpan.

Arpan conducts 3 – 5 days of training that covers topics of gender, power, sexuality, CSA, impact of CSA and trauma, mock implementation of personal safety education lesson plans, disclosure and protocol building. A 3-day training is also conducted on basic counseling skills so that teachers and NGO professionals are equipped to handle a first level disclosure and provide first level counseling to children. It covers trauma, neurobiology and a lot of role play to learn and understand counseling skills.

Challenges faced include schools not believing that personal safety is imperative; reluctance of

teachers in sparing 3-5 days for trainings; lack of parental attendance, reluctance in teaching vocabulary of private body parts; poor school infrastructure; extremely high number of children per class etc.

In the next 3 years Arpan plans to finalize modules for grade 7 and 8; develop modules for grade 9 and 10; develop modules for pre-primary children; develop Personal safety workbook in multiple Indian languages; continue training for parents and teachers and develop films and storybooks to reiterate this message.

External Papers

TEN IMPORTANT IDEAS FOR TRAUMA THERAPISTS

Rani G. Raote

The following article outlines the importance of ten ideas that are useful when doing Trauma Therapy. These ideas are drawn from the author's experience in working with adult survivors of childhood trauma which includes emotional, physical and sexual abuse and also, adult survivors of sexual assaults in adulthood. Additionally, these suggestions are based on the author's experience of supervising and training counselors and therapists working with NGOs, in private practice and in schools. The article outlines areas of study with special focus on the Indian Trauma Therapist.

The challenge for the trauma therapist is to help the trauma survivor maneuver through a painful maze of intense emotional and physical reactions, shattered beliefs, anguished questions, frightening flashbacks…..and move confidently towards healing and creating a new life. If the trauma therapist is not anchored in skills, knowledge, vision and methods of trauma treatment, there is a danger of the therapist becoming overwhelmed, disillusioned and burned out. This ends up in the worst betrayal for the trauma survivor – because when survivor looks in the eyes of the therapists, the only one they are depending upon, and sees helplessness, hopelessness, confusion and defeat, the survivor has no one else to turn to and nowhere else to go!

Trauma therapy is indeed a challenge and one that can be just as empowering and inspiring for the therapist as it is for the trauma survivor. It can be journey of awe and celebration of the resilience of the human spirit as the therapist and survivor (or client, these terms are used interchangeably through the article) together discover the capacities of the human mind to rise up no matter what has happened.

Here are ten useful ideas which can help make the journey empowering for the trauma therapists. Each idea is important and not presented in any order of importance. It is the combination of all these that really makes it empowering for the trauma therapists.

AREAS OF STUDY IMPORTANT FOR TRAUMA TREATMENT – when working with trauma one needs to learn simultaneously about five important areas of work – *Trauma & Neuropsychiatry, Attachment, Dissociation, Memory and Methods of Trauma Treatment* based on recent findings in Neuropsychiatry. Each of these areas of study contributes to the understanding of the effects of trauma on the human brain and functioning.

For instance, research findings of neuropsychiatry clearly show that during trauma certain parts of the brain over function while the functioning of other areas related to thinking, understanding, reasoning are compromised. This pattern leaves an imprint (van der Kolk, 2007) which keeps getting activated when triggered much after the trauma has happened. In fact, that is the trauma – not so much what happened, because the traumatic event ends at some point in time. It is this reliving of trauma each time the emotional imprint is activated which is trauma, Trauma is not just in the event but in the way it is stored in the human brain and mind.

This understanding is important when choosing methods of trauma treatment – are we choosing treatments which are geared towards working with these imprints (Eye Movement Desensitization and Reprocessing, Sensorimotor Psychotherapy, Somatic Experiencing) or are we choosing methods which heavily employ reasoning, thinking, understanding (talk therapy, focusing on irrational beliefs, giving advice and suggestions) which completely bypass these emotional imprints?

Dissociation helps us to understand how the mind copes and survives horrendous trauma and still continues to function. Those aspects of the experience that clients had to dis-associate from during the trauma just so they could move on, are the ones that need to be re-associated and integrated in therapy in order for the survivors to heal. Unless we appreciate this fascinating aspect of human functioning we may not be able to help the survivor (van der Hart, Nijenhious, & Steele, 2006).

Models of Memory help us to understand how aspects of the our experiences which we cannot even "remember and put into words" still affect us in the form of expectations, and body symptoms (van der Kolk,2007, Seigel, 1999)

STUDY THEORY TO KNOW TECHNIQUE – Most of us think that theory belongs in the classroom and what is needed with clients is knowledge of techniques, of the specific things we can do. Ironically, only a solid background in theory, as mentioned above, will really allow us to know the rationale for the technique and how it works with the client.

It is the theory knowledge that helps us to improvise with clients when a particular technique is not working or when the client is too young to follow the steps of the technique, not insightful enough, not literate or facile with language. When we know the theory we know what it is we are trying to achieve and we can then be creative enough to find various ways that are directly relevant to the survivor. Simply having a bouquet of techniques that we keep pulling out and randomly trying hoping it will have some effect, is in fact rather strenuous on the survivor and on us as well. When we know the theory, there is no need for the trial and error method.

THE CONSENSUS MODEL OF TRAUMA THERAPY -It is important to know the stages in which one works with trauma survivors. The story of what happened, the narrative details are not as important as teaching and helping clients how to feel empowered as they deal with the traumatic events. Using the Phase-oriented Consensus Model in trauma treatment helps survivors to gain strength quickly as they deal with the trauma.

The Consensus Model (van der Hart, et al, 2006) emphasizes three stages of trauma treatment – Stage One Stabilization – where clients learn about trauma and how trauma has impacted them, their emotions, their body symptoms, flashbacks, and gradually learn to handle daily living effectively. Only then, are trauma treatment methods used to target the specific traumatic memories in the Second Stage of Working with Traumatic Memories. In the Third Stage of Integration, clients are helped to assimilate into their lives all the skills they have learned and to move on in normal life with confidence and resilience.

WORKING WITHIN THE WINDOW OF TOLERANCE - This concept which was introduced by Seigel (1999) and developed further by Ogden, (Ogden & Minton, 2000) is very useful to keep in mind as we work with clients in the session. It refers to tracking the physiological and emotional arousal of the client in the session. There are three zones of emotional and physical arousal. At one end is Hyperarousal where we experience racing thoughts, breathlessness, anxiety, restlessness, impulsiveness, inability to concentrate and focus. At the other end is Hypoarousal characterized by listlessness, feelings of hopelessness, lack of energy, depression, collapse, shut down, shame, self-attack, and blank spells.

In the middle is the level of Optimum arousal where we function at our optimum level. It is at this optimum level of arousal that we can think, feel, reason, learn, accept what has happened, plan realistic action plans, be assertive, and feel in charge.

Trauma therapists need to learn how to monitor the arousal level of the client in the session and help him/her to be within the window of optimal arousal for effective processing of the trauma.

LEARN ABOUT MODELS OF TREATMENT BASED ON CURRENT FINDINGS IN NEUROPSYCHIATRY – As mentioned in Point One above, it is important that the methods of treatment that we use don't re-traumatize the client, instead move the client towards healing.

We need to study methods which help to desensitize the emotional and physical reactions to the event and also which help clients to continue to view themselves with respect and dignity in the face of what happened. In other words, they need to be able to resolve the trauma, recognize that it is over, that they are now safe and can greet the world with renewed hope.

Traditional talk therapies which involve recitation of the traumatic events, cajoling, debating, advising the client may not help resolve the pain and anguish of clients. We need to explore the use of methods like Eye Movement Desensitization and Reprocessing, Somatic Experiencing, Sensorimotor Psychotherapy and other such methods which incorporate the findings of neuropsychiatry to target the trauma imprint (van der Kolk, 1996).

PSYCHOEDUCATION OF THE CLIENT IN TRAUMA TREATMENT– One of the most effective ways to help clients to feel empowered is to educate them about the effects trauma has on them, and the mechanisms underlying their symptoms. Helping clients, even very young children who have basic language skills, understand the reasons why and how their bodies and brains are reacting when they get triggered makes therapy a joint effort. It is the client and the therapist who then work together to manage the distress in the session and in their lives outside the session. The hallmark of trauma is the suddenness of the event and the total sense of powerlessness we experience.

Education and knowledge is power, not over others, but over oneself. When clients understand what is happening to them they now have a chance to regain their sense of power as they begin to help themselves. They no longer feel like hapless victims of an assortment of trauma symptoms which are frightening and disorienting. Also, teaching clients what to expect in therapy and the reasons behind the methods we are using helps to get full co-operation from our clients. In order

to do this, the trauma therapist must have a thorough knowledge of the theory and be able to explain it in simple, non-technical language to the client.

SOURCES OF LEARNING – In this age of the internet there are tremendous opportunities for learning. One can learn from discussion lists on various methodologies (EMDR Discussion list run by the EMDR Institute, USA) topics related to trauma (Dissociation Discussion list part of the International Society for the Study of Trauma and Dissociation), various Webinars on treatment and trauma theory, Web consultation with experts working in the field of trauma, and numerous articles, e'books, journals and power point presentations which are freely available on the net. Also, with the opening of many e-bookstores in India ordering technical books on a variety of topics is very accessible. The learning opportunities available to trauma therapists in India now are exciting, varied and often inexpensive.

STUDY IN GROUPS - Embarking on this kind of study for most trauma therapists coming out of academic programs is intimidating. Often what we work with in the field appears to bear no resemblance to what we learned in the classroom. Also, much of the technical language of the books, articles, discussion lists takes awhile to become familiar with.

One of the best ways of dealing with this problem is to form small study groups and discuss the material that one is reading, figure out ways in which it applies to the client, share difficulties, and learn from the success stories of members in the group.

Since much of the research on trauma and treatments is not done in India, we will need support from the group to learn how to translate the work and make it applicable to the Indian client we are dealing with. Sadly, much of the research and methods are summarily dismissed by Indian therapists as inapplicable in the Indian cultural context. We forget that the brain structure, functioning and the way trauma impacts the neural mechanisms does not differ culturally. We need to work in groups to be able to sift out those aspects which are universal from those which are culturally unique so that we can effectively use the vast knowledge for the benefit of our clients.

Such study groups which meet regularly and are committed can even think of pooling resources to jointly buy and share books, journals, conference presentations etc.

SELF-CARE OF THE CAREGIVER –In India, the numbers of traumatized people are huge and it appears as if the contribution of the therapist is a mere drop in this vast sea of suffering. This motivates the therapists to extend themselves limitlessly, giving selflessly to this consuming work of dealing with traumatized clients with no care for self. Unfortunately, such good intentions quickly result in burnout, compassion fatigue, cynicism, disillusionment and an embittered sense of alienation.

It is vital that the therapist use various self-care methods like mindfulness techniques, physical exercise, rest, balanced nutrition, spirituality, play and recreation. Brown's (2009) research on play suggests that regular periods of play actually increase work efficiency, positivity, creativity and resilience - all qualities which enhance the effectiveness of the trauma therapist.

Keep an open curious mind to new techniques – Many trauma therapies use unconventional ways of treating trauma, like the eye movements in EMDR, or the shaking and trembling encouraged in Somatic Experiencing, or what seems like exaggerated focus on tracking body sensations, breathing and movement in Sensorimotor Psychotherapy. These techniques don't look like any that one has studied in the classroom and hence it is easy to dismiss these methods as some mumbo-jumbo. (Most of us even feel silly doing these methods at first) To disqualify such therapies would be a great disservice to us and our clients. Instead, we need to keep an open mind and see how the proposed rationale of change underlying such unconventional methods of treatment connects with the theory of trauma, memory, dissociation and findings of neuropsychiatry. Ultimately, the priority should be the results these treatments are able to achieve rather than how poised we look as therapists in the session!

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WEBSITES OF INTEREST

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The International Society for the Study of Trauma and Dissociation http://www.isst-d.org/

David Baldwin's Trauma Pages http://www.trauma-pages.com/

EMDR Institute http://www.emdr.com/

WENLIDO-EMPOWERING GIRLS FOR PERSONAL SAFETY

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Abstract

Shaishav actively works towards preventing sexual abuse against girls by teaching Wenlido self-defense. Developed by females for females, Wenlido teaches both physical and psychological safety.

During training, girls learn to evaluate dangerous situations and distinguish between different attacks. They master self-defense techniques such as releases and counter-attacks, awareness, breathing, mental control and safety techniques. Shaishav has further developed the Wenlido model by creating special age-specific curriculum, for ages 6-10, 11-14 and 15-19. By teaching beyond traditional self-defense techniques and addressing sociological and psychological safety, Wenlido provides a holistic type of self-defense training to girls which differs from tradition martial arts.

BACKGROUND

Gujarat's historically conservative culture creates a complicated background in which to cultivate change is a challenging task. Society maintains prejudices and practices deeply rooted in conservative traditional systems, which results in communities purposefully avoiding discussion around issues like sexual abuse or rape. In addition, since the Delhi Rape Case, stories have

trickled out of rural India of girls being blamed for their own rapes. According to the Government of India's 2007 Study on Child Abuse, "India has the world's largest number of sexually abused children, with a child below 16 years raped every 155th minute, a child below 10 every 13th hour and one in every 10 children sexually abused at any point of time."1

Shaishav works with children on the ground, fighting for their rights and protection and help them to become good citizens. Shaishav worked since 1994 in Bhavnagar, Gujarat. Originally, the founders focused on ending child labour through education. However, over the past twenty years, Shaishav has rapidly evolved into a large child-rights organization. Shaishav partners with people of all ages in local slum communities to empower and support female children and youth, reversing gender exclusionary practices through our programs. One of our tools of change is Wenlido, which directly arms girls, protecting them against child sexual abuse through holistic self-defense training.

WENLIDO: A PREVENTATIVE TOOL TO FIGHT AGAINST CHILD SEXUAL ABUSE

Wenlido, which stands for "Women's Path of Strength," is a holistic type of self-defense taught by women to women and girls. It was originally created in 1976 by a group of Canadian feminists hoping to physically and psychologically prepare women across the globe to respond to attacks and safeguard themselves. Therefore Wenlido is much different than any traditional self-defense techniques as it is designed keeping in mind the situation that women are facing and it is delivered only by women to women and girls. These techniques are never publicized and never shared with any men. During training, females learn how to realize their own strength, recognize and evaluate potentially dangerous situations and distinguish between different attacks; learning awareness, breathing and mental techniques, as well as releases and counter-attacks. Emphasis is placed on practical techniques for self-defense and minimizes the amount of time spent on theory. It is not just physical techniques but mental and emotional liberation.

Shaishav originally learned about Wenlido in the year 2002, when its staff was invited for a training of trainers in Baroda, Gujarat. ParulSheth, the executive director of Shaishav, spoke with the trainer, expressing her desire to become a Wenlido trainer as well. They also spoke about adapting this self-defense training, traditionally for women, for girls and female youth. She subsequently completed the "training of trainers" circuit and was certified to train women and girls in Wenlido in 2003. After gaining experience training girls in Wenlido, Parul had a strong desire to create a special age-specific curriculum for girls based on their age, capacity, experiences, learning style and ability. In collaboration with the her Wenlido trainer, Gitta Ritter, Parul created new, age-specific training methodology, organizing a different syllabus for girls in different age groups, targeting girls ages 6-10, 11-14 and 15-19. Depth of training ranges; from introductory training that is 2-6 hours, to basic training which runs for about 20-25 hours, advanced training which runs for 7 days and a "training of trainers" course which runs for 27 days (delivered in 3 nine-day residential sessions).

WENLIDO FOR GIRLS AGE 6-10

Training for girls age 6-10 is typically for one day, occurring for ten hours. In this training, girls learn adapted methods of self-defense, created because of their differing capacity (e.g. girls age 6-10 are physically smaller than 15-19 year olds or adults), and their exposure to the topic of sexual assault.

Wenlido trainers recognize the importance in defining sexual assault for younger girls, who may have never heard of the concept. Wenlido training for younger girls does not go into deep discussion about sensitive issues like rape, but does make important distinctions between safe and unsafe touch and how to prevent and/or respond to 'unsafe touch'.

Training also speaks about identifying dangerous situations through asking "safety questions" (observe the situation, identify how you feel and state your needs), what it is to be in "victim mode," how to identify that you are being victimized and how to come out of victim mode, how to ask for help and how to say no. They do "body mapping" activities to understand the female and male anatomy, learn how to break boards with their hands and self-defense techniques called "body weapons." For these younger girls, activities are framed largely as group activities and are extremely interactive, using games and songs designed to hold the attention of these young girls. By the end of the ten hour training, girls should be able to identify potentially dangerous situations, respond both physically and mentally when attacked and are emotionally strong.

WENLIDO FOR GIRLS AGE 11-14

Wenlido training for groups age 11-14 builds on the training for girls age 6-10; differing in the methods of self-defense taught (which change based on the average height and weight of girls age 11-14) and the depth in which discussions around rape and other gender-specific topics are facilitated. Girls learn about mental and emotional safety in conjunction with stereotypes. After learning these techniques, girls are split into small groups to have serious discussions around their experiences with gender-based discrimination and assault. At the end of these sessions, one situation is anonymously volunteered to share in front of the group, and the group uses techniques such as role play to address the situation. This personal and important activity helps girls heal and liberates them from past events, and helps other girls learn how to face similar situations.

WENLIDO FOR GIRLS AGE 15-19

Wenlido training for girls age 15-19 closely mirrors Wenlido training for adults. In addition to learning about mental and physical self-protection, victim mode and gender-based discrimination, older Wenlido students will have the opportunity to discuss sexual assault in depth, including break-out sessions to share personal stories of sexual assault and/or rape. They discuss the positive use of fear and techniques to conquer fear such as breathing techniques. These students will go through a series of activities to promote healing and closure.

WENLIDO SUCCESS STORIES

Shaishav is periodically contacted by Wenlido trainees, receiving feedback about their use of Wenlido in dangerous situations, listening to girls as they describe feelings of empowerment after successfully defending themselves and escape their attackers. For example, a female Balsena member (Shaishav's children's collective) and Wenlido trainee left her school in Bhavnagar to photocopy some papers. A female stranger (an adult) approached the young girl and asked her for directions. The young girl crossed the street with this woman and the woman knocked her unconscious. She woke up in the back of a car which was parked on the side of the Bhavnagar-Ahmedabad highway.

The girl knew she was in trouble and needed to escape the situation. She remembered her Wenlido training and remained calm, searching the area for potential weapons to use against the man standing outside of the vehicle. She grabbed her school bag which was full of books and bolted out of the vehicle, proceeding to beat the man guarding the car over the head with her book bag. Seeing the woman who initially attacked her, accompanied by a group of other men in the distance, the girl began to spring down the highway away from her attackers, and jumped on a bus to Ahmedabad. She was lucky enough to be carrying cash. Once she arrived to Ahmedabad, she called her family who immediately got her help and arranged for her safe transport back home. This is just one of several Wenlido success stories reported to Shaishav over the past ten years of administering Wenlido training. In the past ten years, Shaishav has trained about 7,500 girls in Wenlido to date; and has never received any negative feedback from any group of individuals after giving a Wenlido training, whether the trainees be young girls, adults from a diverse array of backgrounds or the police department. We are confident in the power of Wenlido to arm girls and women against assaults, and are confident that Wenlido training is empowering girls to protect themselves against child sexual abuse.

CONCLUSION

In a conservative culture that doesn't have sex education in schools, where communities find the subject of sex taboo, it is imperative that young girls receive education about inappropriate touch, rape and victimization from a young age. By teaching young girls about safety and self-defense, Shaishav promotes the idea that "prevention is better than a cure," meaning that preventing sexual assault is better than healing a girl who is assaulted. By administering Wenlido training, Shaishav prepares the girls living in Bhavnagar's slums to defend themselves against sexual abuse and stand up for the protection of their rights as females!

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