SWATI

Identification and Intervention for Prevention of Violence Against Women

A FIELD INQUIRY TRAINING MANUAL FOR ASHA WORKERS

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ABOUT SWATI

Society for Women's Action and Training Initiatives (SWATI) is a Feminist organisation that works on violence against women, health and governance in the rural areas of Gujarat.

In 1994, we set out with a vision of initiating a rural women's movement that focuses on reaffirming the agency and autonomy of women. This vision is a reality today and has allowed SWATI to transition towards achieving a strategic combination of grassroots activism and policy advocacy through collective action, research, and other innovative approaches.

Prevention of Violence against Women (VaW) is a primary objective of SWATI. Empowering women to combat VaW, challenging community mindsets and working to make the criminal justice system -- the police and the judiciary -- responsive to VaW formed the primary thrust of SWATI's work for over 20 years. The SWATI team soon realised that VAW is a complex phenomenon, and the efforts to combat it need to be at multiple levels. Since SWATI's primary work is with rural women, the organisation began to think about ways of working with institutions in rural areas that could substantially impact the prevention of VaW.

The strategy adopted by SWATI for creating an in-depth and broader response for combating VaW has three primary components:

- **At the community level:** Empower and equip women to combat VaW by setting up women-led gender-just mechanisms that support women survivors through mediation, counselling, and legal aid support.
- **At the governance level:** Make Violence against Women a governance concern to be addressed by the rural political leadership and governance bodies, namely the Gram Panchayat.
- **At the health system level:** Make the rural public health system responsive to the issue of VaW.

For more information, visit our website: www.swati.org.in

Developed and Published by:
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Note:
Most domestic violence survivors are women, and most perpetrators are their spouses, previous male partners, and family members. While aspects of this manual apply to the prevention, identification, and intervention strategies for all domestic violence situations, the focus is on domestic violence against women.

In this manual, the victim is often referred to as female and the perpetrator as male. Please note that domestic abuse also occurs in same-sex relationships, dating relationships, and among elders. In a minority of cases, the perpetrator of abuse is female. No person deserves to be abused, and every victim is entitled to effective treatment, irrespective of their gender.

ABBREVIATIONS

ASHA	:	Accredited Social Health Activist
ANM	:	Auxiliary Nurse Midwife
AWW	:	Anganwadi Worker
CHC	:	Community Health Center
CHV	:	Community Health Volunteer
DV	:	Domestic Violence against Women
GBV	:	Gender Based Violence
HCP	:	Health Care Practitioner
HW	:	Health Worker
NFHS	:	National Family Health Survey
NHM	:	National Health Mission
NGO	:	Non-Government Organization
PHC	:	Primary Health Center
SWATI	:	Society for Women's Action and Training Initiative
VaW	:	Violence against Women
HIV/AIDS	:	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome

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BACKGROUND

The World Health Organisation recognises that violence against women, particularly spousal or intimate partner violence, is a significant public and clinical health concern and a violation of women's human rights, affecting women in India and worldwide, effectively reflecting the scale of gender inequality and discrimination against women. In India, 29.3% of married women between 18 and 49 experienced spousal violence. 31.6% of rural women face violence compared to their urban counterparts (24.2%)[1].

Women of all age groups, irrespective of income, class, race or ethnicity, are subjected to some form of violence, in varying degrees, during their lifetime. The consequences are devastating and long-term. In addition to the immediate trauma caused by abuse, Domestic Violence (DV) contributes to several chronic health issues, including depression, substance abuse, and sexual and reproductive health-related problems. This often limits the ability of women to manage other chronic illnesses such as diabetes and hypertension. Health-care providers (HCPs) are thus uniquely placed to identify women who have experienced violence and provide appropriate clinical care and referrals. Despite these facts, a critical gap remains in delivering health care to battered women, with many providers discharging a woman after treating just their visible injuries, leaving the underlying cause unaddressed.

Subsequent to the Nirbhaya rape case in Delhi in 2012, in which a 23-year-old physiotherapy student died after being brutally raped by six men on a moving bus, causing global outrage, the Government of India recognised an urgent need for a multi-sectoral response to Gender-Based Violence (GBV) and sexual assault. Along with several other initiatives, such as new legislation and legal reforms and support services for women facing violence, it has made conscious efforts to make the reduction of Violence against Women an integral part of all its development initiatives. Some of the actions to reduce GBV in the country are:

- The development and dissemination of the National Guidelines on Medico-Legal Care for Survivors/Victims of Sexual Violence (2014).

- Development of operational guidelines for setting up of One Stop Crisis Centres (OSCCs) and setting up of OSCCs in over 170 districts across 32 states of India.

- Inclusion of Violence against Women in training modules for the Accredited Social Health Activists (ASHAs), who are a vital link between the healthcare system and rural populations under the National Rural Health Mission (NRHM).

The Government of India's National Health Policy 2017 recognises VaW as a public health issue and mandates a health sector response by service providers at all levels of the public health system. (https://nhp.gov.in/nhpfiles/national_health_policy_2017.pdf)

ABOUT THE TRAINING MANUAL

Since 2019, SWATI has been working to build a model of the rural health sector's response to Violence against Women. It has been SWATI's experience that the challenges in rural areas are markedly different from those in urban areas and require an approach different from the one adopted by urban models. SWATI's model to prevent gender-based violence in villages has involved the multi-layered and differentially-located public health system to ensure women's access to violence prevention and support services*.

Barriers such as the lack of anonymity and social taboos that prevent rural women from seeking help from formal support institutions have been negotiated through an upward referral chain in the health care system. Thus health care providers at the village and district level, such as ASHA workers and Community Health Centres (CHCs), have been made a part of an upward referral chain to support women facing violence. ASHA workers have been a critical element of this chain.

*The Mahila Sahayta Kendra (MSKs) are Crisis Intervention and Support centres set up by SWATI in three different hospitals in the district of Patan in Gujarat. - One is based at Referral Hospital, Radhanpur, the other is at GMERS medical and teaching hospital, Dharpur, and the third is at General Hospital, Siddhpur.

The MSKs facilitate access to an integrated range of services, mainly counselling and mediation and referral to other support services like medical, legal, shelter home, other NGOs, and child protection.

ASHA workers are supported at the village level by Village Health and Sanitation Committees, Aanganwadi workers, Auxiliary Nurse Midwives (ANMs), and medical officers. They are also in regular contact with the block-level CHCs/tertiary care hospitals, as they bring women to CHCs for antenatal check-ups. The intervention by SWATI has been to leverage this support structure by training ASHA workers to identify women who present themselves with symptoms of violence. Based on the need, ASHAs have been referring women to established Violence against Women Intervention and Support cells (Mahila Sahayta Kendra or MSK), located in three hospitals of the district Patan in Gujarat.

This manual is an outcome of four years of work with over 400 ASHA workers. It is aimed to orient and build the skills of Community Health Care Providers (CHPs) in the identification and facilitation of referrals of domestic violence survivors and help prevent further abuse. Sensitized ASHAs learn how to help women break the silence against violence and take steps towards seeking support for leading violence-free lives. The objectives of the manual thus are:

- To help ASHAs gain an in-depth understanding of violence against women, the rural health structure and response mechanisms in cases of violence against women.

- To help ASHAs develop an understanding of the need for the early identification of violence against women cases and their role in the prevention of violence against women.

WHO CAN USE THE MANUAL?

This manual is aimed at NGOs, who work in the health sector and can also be used by the ASHA Supervisors/Facilitators, Department of Health and Family Welfare and the Government of India. With some adaptation the manual can be used for sensitization and training of medical staff at all levels of the health system.

STRUCTURE AND DELIVERY OF THE MANUAL

The training manual has 7 sessions, each ranging from 50 to 90 minutes. Every session has more than one activity, and each activity includes learning outcomes, materials needed, process instructions for the facilitators and content-related handouts. At the end of each session, activity handouts are given as take-home material for the participants. These can be printed or photocopied and included in the training kit.

The training is envisaged for 7 hours, with a mix of theory and participatory training methodologies. Sessions 1 to 3 focus on understanding violence and its forms, its causes and consequences, and the impact of violence on women's health. Session 4 is on understanding the rural health structure and the vital role that ASHAs can play in identifying women facing domestic violence. Sessions 5 and 6 focus on ethical guidelines and pathways of referral that can be followed by ASHA or Primary Health Care Providers in referring women facing domestic violence. Finally, Session 7 aims at getting feedback from the participants about the sessions.

Ideally, this training should be conducted on a single day, over 7 hours, including breaks for tea and lunch. If a full-day training is not feasible, the training can be delivered over two days, with the first day having 3 sessions, and the second day having 4 sessions.

TRAINING SCHEDULE

TOPIC AND OBJECTIVES	TIME REQUIRED
SESSION 1	
CONTEXT SETTING	
Activity A: Registration, Welcome, and Pre-Assessment Forms	**30 minutes**
Activity B: Introduction of Participants	**15 minutes**
Activity C: Sharing the Training Design and Norm-Setting	**15 minutes**
SESSION 2	
UNDERSTANDING DOMESTIC VIOLENCE AGAINST WOMEN	
Activity A: Extent and Forms of violence against women	
• To get participants acquainted with the extent and forms of violence and the WHOs definition.	**20 minutes**
Activity B: Causes and Consequences of Domestic Violence against women	
• To recognise patriarchal social norms and women's subjugation as the cause of domestic violence. • To understand the deep and wide impact of violence on women and society.	**30 minutes**
SESSION 3	
UNDERSTANDING THE IMPACT OF VIOLENCE ON WOMEN'S HEALTH AND THE IMPORTANCE OF HEALTH SECTOR RESPONSE	
Activity A: Impact of Violence on Women's Health	**30 minutes**
• Understand the impact on women's health and related signs and symptoms of domestic violence. • To illustrate the importance of developing and implementing appropriate public health responses to domestic violence survivors.	

TOPIC AND OBJECTIVES	TIME REQUIRED
Activity B: Importance of Health Sector Response: Violence against Women - A Public Health Concern • To establish the fact that DV is a health issue for the women, their families, and the health practitioners. • To illustrate the importance of developing and implementing appropriate responses to DV survivors.	**45 minutes**
SESSION 4 **IDENTIFICATION OF VIOLENCE AND EXTENDING SECONDARY PREVENTION SUPPORT: ROLE OF ASHA** **Activity A: Understanding Secondary Prevention in the Context of Violence against Women** • To equip ASHA with knowledge and skills on identification and Secondary prevention of domestic violence.	**25 minutes**
Activity B: Identification of Domestic Violence against Women at the Community Level • To develop an understanding of the signs and symptoms of VaW.	**25 minutes**
Activity C: Important Role ASHA can Play in Addressing Domestic Violence against Women at the Community Level • To recognize the important role ASHA can play in addressing domestic violence. • To build skills in responding to domestic violence survivors in the community.	**40 minutes**
SESSION 5 **ETHICAL GUIDELINES** • Establishing guidelines for inquiry based on ethical principles that healthcare providers should follow.	**60 minutes**

TOPIC AND OBJECTIVES	TIME REQUIRED
SESSION 6 **FACILITATING REFERRAL OF SURVIVORS** • To collaboratively prepare a direct referral chain that provides a series of actions to take in cases of violence with different severity.	**60 minutes**
SESSION 7 **POST-TRAINING ASSESSMENT AND FEEDBACK** • To measure the training outcomes in terms of change in understanding, knowledge and skills of the participants. • To get participant feedback on training methodology and facilitation of sessions.	**60 minutes**

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Session 1

CONTEXT SETTING

ACTIVITY A

Registration, Welcome, Pre-Training Assessment forms

MATERIALS

- Copies of the pre-training assessment forms (Annexure 1).
- Training kits consisting of notebooks and pens, along with printouts of the handouts provided with activities.

Duration
30 mins

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Since this is the first training session, begin by extending a warm welcome to the participants. Further, provide an overview of the training.

2. Introduce the pre-assessment form provided in Annexure 1. Inform the participants that this is not an evaluation but an exercise to help the facilitator plan the training according the participant's current knowledge.

3. At the end of the session, distribute the training kits that include training schedule, pen, notepad, copies of relevant handouts, and all content specific reference materials. You can choose to give the handouts at the beginning of the training or at a particular session time.

ACTIVITY B
Introduction of Participants

LEARNING OUTCOMES

- To acquaint the participants with each other and build a relaxed learning environment.

Duration
15 mins

Method
Group Activity

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Ask each participant to introduce themselves by telling their name with adjective attached with it that begins with the same alphabet as their name—for instance, 'Playful Puja', 'Surili Sejal'.
2. Continue the activity till every participant in the room has had a chance to introduce themselves.

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ACTIVITY C
Sharing the Training Design and Norm Setting

LEARNING OUTCOMES

- To enable participants to be clear about the training program and its objectives.
- To enable participants to lay down ground rules for self-learning.

Duration
15 mins

Method
Presentation and discussion

Materials
PowerPoint presentation, sticky notes or cards of size 5 inches x 3 inches (at least two per participant), double-sided tape, chart paper and marker pen.

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Paste a flip chart on the wall that says Ground Rules. Give sticky notes or cards with double-sided tape to the participants and ask them to write one rule they think is essential for their self-learning. For example, being on time, putting the phones in silent mode, active listening, active participation, questions, clarifying doubts, etc. Make sure that only one rule per note is written. Collect the notes; ask one of the participants to read these out loudly for the group. Paste these on the flip chart. The facilitator may add missing rules. Inform the participants that all will follow these ground rules throughout the training.
2. After setting the ground rules, present a detailed agenda for the training. This can be projected or written on a chart paper. End the activity by taking any questions that the group might have.

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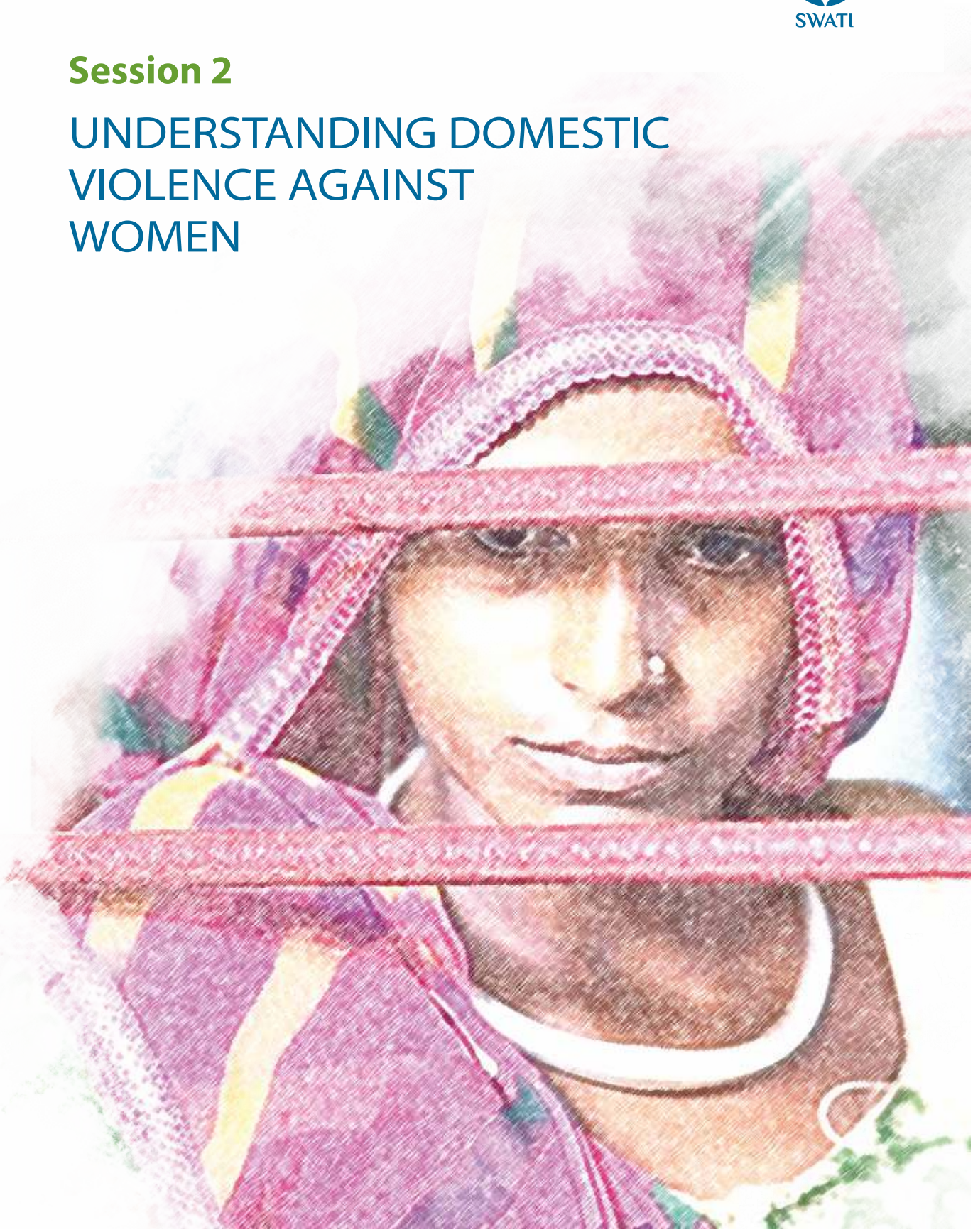
Session 2

UNDERSTANDING DOMESTIC VIOLENCE AGAINST WOMEN



ACTIVITY A

Extent and Forms of Violence against Women

LEARNING OUTCOMES

- To get participants acquainted with the extent and forms of violence and understand different definitions of DV.
- To understand patriarchal social norms and the causes and consequences of DV.

Duration
20 mins

Method
Presentation and discussion

Materials
PowerPoint presentation, chart paper and markers, copies of Handout 1 (Forms and Types of Violence) and Handout 2 (Definitions of Violence against Women).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Ask the participants to reflect and share what violence against women means to them. Tell them to think about violence based on their own experiences and their experiences from the field.
2. Take as many responses as possible, and then present a comprehensive word map of examples of domestic violence against women.
3. Ask the group if they can see any broad categories emerging. After taking the responses on a chart, take the examples they have given and discuss if there are any other forms of violence that the group might have missed. If so, the facilitator needs to add them to the list.
4. Create four broad categories - physical, sexual, emotional and economic violence based on the answers.

5 Facilitate the group to build a collective definition of DV. Pin up a pre-prepared chart with the definitions of DV by different agencies written on it. Discuss the similarities and variations in these definitions.

6 End the session by distributing handouts on domestic violence against women, forms and definitions of DV or VaW by different agencies.

NOTES FOR THE FACILITATOR

1 You can add another category while naming kinds of violence, i.e., social violence, perpetrated by social customs and practices

2 Discuss with participants violence and its forms. Give examples/situations of abuse/certain behaviour or acts, and probe the participants to consider whether these could be regarded as acts of violence.

HANDOUTS

1 **Forms and Types of Violence** (Pg 20)

2 **Definitions of Violence against Women** (Pg 21)

HANDOUT 1- FORMS AND TYPES OF VIOLENCE

Acts or Forms of Violence can be categorised or classified into four categories as follows:

PHYSICAL VIOLENCE

Slapping, fractures, cuts, bites, hair-pulling, beating, thrashing, punching, kicking, causing injuries with or without a weapon, burns, pushing, acid attacks, poisoning, strangling, and spontaneous abortion (miscarriage) caused due to abuse.

SEXUAL VIOLENCE

Sexual offences like rape or an attempt to rape, marital rape, forced sexual encounters or forcing someone to have sex with another person, forced sex work, forced pornography, disfiguring genitalia, eve-teasing, molestation, stalking, sexual trafficking, forced and child marriage, sexual harassment at workplace, denying the use of contraceptives, sexual advances from family members, child sexual abuse, forced and painful sex, withholding sex as leverage, forced abortion, denying access to abortion facilities, pre-conception and pre-natal sex determination tests.

ECONOMIC VIOLENCE

Denial of the rights to inherit property and access to money, forcing someone to sign property papers, forcing someone to beg for daily needs, deprivation from food, clothing, education and healthcare, not allowing women to work, aggressively demanding an explanation for expenditures, dowry demands, unpaid domestic labour or harassment by those who are influential or in positions of power, destroying personal belongings.

EMOTIONAL VIOLENCE

Neglect, mental trauma, threats to cause harm or kill, Isolation, stalking, verbal abuse, suspicion, denying paternity of the child, insulting or humiliating women in front of family members/in public or in private, fault-finding in every activity.

HANDOUT 2 - DEFINITIONS OF VIOLENCE AGAINST WOMEN

DEFINITIONS

Different agencies have defined Violence against Women. Here, for your reference, we have provided some definitions:

1. **The Committee on the Elimination of the Discrimination Against Women (CEDAW)**, 1993 defines violence against women as any form of physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.

2. **The World Health Organization** defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in, or has a high likelihood of resulting in, injury, death, or psychological harm, maldevelopment or deprivation.

3. According to the **Protection of Women from Domestic Violence Act 2005, India,** any act, omission or commission, or conduct of the respondent shall constitute Violence against Women in case it:

a. Harms or injures or endangers the health, safety, limb or well-being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse or economic abuse; or

b. Harasses, harms, injures or endangers the aggrieved person.

ACTIVITY B

Causes and Consequences of Domestic Violence against Women

LEARNING OUTCOMES

- To understand the root causes that contribute to domestic violence against women.
- To recognise and understand the consequences of domestic violence against women.

Duration
30 mins

Method
Small group activity

Materials

Sticky notes or cards of size 5 inches x 3 inches of different colours--preferably brown and green (at least two cards of each colour for each participant), double-sided tape, a chart paper with a line drawing of a tree drawn on it, Case studies on the causes and consequences of violence (Annexure 2).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Divide the participants into groups of 4 or 5, each depending upon the total number of participants. Give each group a case study. Provide each group with sticky notes or cards of two different colours--preferably brown and green (at least two cards of each colour for each participant). Explain that the brown-coloured cards represent the tree's roots, and the green coloured cards represent the tree's leaves.
2. Let each group review the case study given to them, discuss and identify the causes of DV and its consequences; and how it affects women's lives, families, and communities.
3. Ask the participants to write the **causes** on the brown cards and the **consequences** on the green cards.

4 When all the groups have finished the task, ask the groups to share their case study in brief and paste or pin the cards on the line drawing of the tree, the brown cards on the bottom, in place of the roots (causes) and the green cards on the top, in place of the leaves (consequences).

5 Keep this tree chart of root causes and consequences pasted on the wall for reference throughout the training. Discuss with participants that if the root causes are not addressed, then it may have the consequences as shown on the tree, and violence will continue. This may have a negative impact on the lives of the women, family members, communities, and the children who witness violence.

6 Discuss each of the causes and consequences and ask the participants: Can they take any action, or have they taken any action to address these? What are these actions? Encourage participants to share their personal experiences of taking positive steps to address violence.

NOTES FOR THE FACILITATOR

1 Alternatively, one big picture of a tree with roots drawn on a chart paper can be given to each group. Ask participants to write the causes on the roots and the consequences on the leaves.

Important: Emphasize to the participants that no cause justifies violence and the actions of the abuser, nor should it be used for rationalising such behaviour.

HANDOUTS

3 **Causes and Consequences of Violence against Women** (pgs 24-25)

HANDOUT 3 - CAUSES AND CONSEQUENCES OF VIOLENCE AGAINST WOMEN

CAUSES OF VIOLENCE

Many things are said to cause violence; however, it is essential to remember that gender inequality and social norms are at the root of violence against women. Through these stem the following actions of men or other family members. Through these, the abuser gains power over the woman to perpetrate violence. Some of these are:

- **Intimidate:** frighten or overawe her, especially in order to make her follow his wishes
- **Isolate:** control mobility and limit her independence in public and private life
- **Humiliate:** lower her self-esteem and confidence
- **Physical and sexual abuse**
- **Threaten**
- **Control decision making**
- **Economic abuse:** denying her access to money, not letting her work to earn money

CONSEQUENCES OF VIOLENCE[4]

Violence against women has serious consequences, not only on the woman as an individual but also on families, communities and the country.

Woman/Individual

Physical Health: injuries--bruises/burns/disability/fractures/death/chronic health problems/digestive problems.

Mental/Psychological Health: low self-esteem, self-harm leading the woman to attempt or commit suicide, depression, anxiety, eating and sleeping disorders.

Reproductive Health: unwanted pregnancies, abortions/unsafe abortions, pregnancy complications, spontaneous abortions, premature births, maternal deaths, increased risk of stillbirth, increased risk of sexually transmitted diseases including HIV, chronic pelvic infections, urinary tract infections etc.

Reduced social, educational and economic opportunities

Families/Children

- Breakdown of family
- Abuse and neglect of children
- Exposure to violent behaviours at an early age may lead children to adopt such behaviours at a later stage, creating a cycle of violence.
- Children's mental health is affected, leading to absenteeism or dropping out from school, which affects their education.

Communities

- Negative reputation of community
- Disrupts community cohesion and well-being
- Affects support systems

Country

- Loss of economy
- Loss of productivity with women unable or restricted to work
- The increased cost of medical, justice and support services
- Loss of reputation of the country
- Inter-generational trauma

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FACILITATOR'S NOTES

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Session 3

UNDERSTANDING THE IMPACT OF VIOLENCE ON WOMEN'S HEALTH AND THE IMPORTANCE OF HEALTH SECTOR RESPONSE

ACTIVITY A

Impact of Violence on Women's Health: Body Mapping

LEARNING OUTCOMES

- To develop an understanding of the impacts of violence on women's health.
- Understand the health-related signs and symptoms of DV.

Duration
25 mins

Method
Group Work

Materials
Chart papers, marker pens, copies of Handout 4 (Impact of Violence on Women's Health).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Place or paste two sets of chart papers on the floor to cover an area large enough for a person to lie down on. Divide the participants into two groups. Call for two volunteers from each group. In each group, ask one of the volunteers to lie down and the other volunteer to trace an outline of the body on the chart paper so as to create a visual outline of a woman's body. Once the outline is drawn, ask the volunteer lying down to get up. Now ask both groups to fill the two body outlines by drawing and labelling different body parts in them.
2. Ask the groups to study the body maps. Start from head to toe or vice versa. Let each group start marking, with a pen, the body parts that are affected by violence. E.g., if a woman is hit on the head, then mark the head.
3. Ask the participants to think about the forms of violence discussed in the earlier session. Now, ask them to look at the body maps and discuss how each of the parts (external and internal) would be affected by violence.

4. When both the groups have finished the task, ask them to present the body maps and explain to the larger group the body parts and the health impacts of violence on women.

5. If any body part or its health impact has been missed or not marked, explore reasons for not marking it and encourage the participants to share it openly.

6. Ask the participants to put up the body maps for others to see and use as a reference during the training.

7. End the session by distributing handout 4 (Impact of Violence on Women's Health).

NOTES FOR THE FACILITATOR

Some cues that can be used for facilitating the discussion can be:

1. Are all of the ailments mentioned above/problems given the same kind of attention?

2. Is there more hush around some?

3. Which one is the most obvious?

4. As a health worker, which one do you notice the most?

5. Out of these ailments, which one is the easiest to find help for?

6. Is primary or secondary medical care available for all these ailments in your area/district?

ACTIVITY B

Importance of Health Sector Response: Violence against Women - a Public Health Concern

LEARNING OUTCOMES

- To establish that domestic violence is a health issue for the women, their families and the health practitioners.
- To illustrate the importance of developing and implementing appropriate responses to DV survivors.

Duration
45 mins

Method
Video of film Sambhavana and discussion (https://www.youtube.com/watch?v=MvooY4k175Q)

Materials

Body mapping picture, pre-prepared health implications chart, copies of handout 5 (Factsheet on Violence Against Women) ,copies of handout 6 (Elements and Guiding Principles for an Improved Health Care Response to Violence against Women Survivors).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Ask the participants how often do they think Violence against Women occurs? Is it very rare or a common problem? Discuss that Violence against Women is a severe and widespread problem affecting women in India and worldwide. Provide the National Violence against Women statistics (handout 5), to illustrate the magnitude of the problem.

2. Summarise by emphasizing that violence against women is prevalent throughout the society, and health care professionals can play a critical role in responding to violence as they are the first entry point to treat their injuries and they may assist

survivors in accessing or guiding in seeking assistance from violence-prevention support services. End the session by distributing handouts on the guiding principles for an improved health care response to violence against women.

3 Screen the film 'Sambhavana', based on SWATIs work in three hospitals. Follow this up with a discussion on key components of the health sector response to violence.

4 Distribute handout 5 (Elements and Guiding Principles for an Improved Healthcare Response to Women Facing Violence). Discuss the film around the guiding principles given in the handout.

HANDOUTS

4 **Impact of Violence on Women's Health** (Pg 32)

5 **Factsheet on Violence against Women** (Pg 33)

6 **Elements and Guiding Principles for an Improved Health-care Response to Violence against Women Survivors** (Pg 34)

HANDOUT 4 - IMPACT OF VIOLENCE ON WOMEN'S HEALTH[5]

Domestic violence has a significant impact on the health and well-being of women, both in the immediate and longer-term.

Immediate health impacts may include:

- Physical injuries: cuts, bruises, fractures, dislocated bones
- Hearing loss
- Vision loss
- Spontaneous Abortion or premature delivery
- Sexually Transmitted Diseases
- Death

Long term impacts may include[6]:

- Gastro-intestinal disorders associated with stress
- Headaches
- Back pain
- Fainting
- Seizures
- Gynaecological problems
- Anxiety
- Depression
- Eating disorders
- Post-traumatic stress disorder
- Sleep disturbances
- Alcohol and substance misuse
- Smoking throughout pregnancy
- Homelessness
- Suicide
- Homicide

HANDOUT 5 - FACTSHEET ON VIOLENCE AGAINST WOMEN

Violence against Women is preventable. The health sector has an important role to play to provide comprehensive health care to women subjected to violence and as an entry point for referring women to other support services they may need(WHO fact sheet)[7].

- Worldwide, almost one-third (27%) of women aged 15-49 years faced physical and sexual violence by their intimate partner.
- 42% of women who experience intimate partner violence report an injury due to this violence[6].
- In India, 29.3% of married women between 18 and 49 experienced spousal violence, 31.6% of rural women face violence compared to their urban counterparts, 24.2%[6].
- Women in rural areas (31.6%) are more likely than those in urban areas (24.2%) to experience one or more forms of spousal violence.
- 3.1% of women (age 18-49) in India have experienced physical violence during any pregnancy.
- Among rural married women, eight out of 18 states showed an increase in physical violence during pregnancy[2].
- Some studies have even revealed the prevalence of domestic violence in rural India to be as high as 57% (George et al., 2016)[7].
- Research in primary care settings indicates that 3.4-5.5% of patients have experienced domestic violence within the last year[8].
- According to NCRB 2019 report, a rape case was reported every 17 minutes in India[9]. NCRB (National Crime Records Beuro) report - 2019 https://ncrb.gov.in/sites/default/files/CII%202019%20Volume%201.pdf

HANDOUT 6 - ELEMENTS AND GUIDING PRINCIPLES FOR IMPROVED HEALTH-CARE RESPONSE TO VIOLENCE AGAINST WOMEN SURVIVORS[14]

1. Identification of domestic violence based on clinical or social symptoms

2. Assess the health and psychosocial impact on the survivor

3. Conduct intervention by:
   - Giving the survivor validating messages
   - Providing information about violence against women
   - Assisting in safety planning
   - Referring the survivor to appropriate support and advocacy services
   - Providing follow-up support, wherever possible

4. Document the violence

SWATI

Session 4

IDENTIFICATION OF VIOLENCE AND EXTENDING SECONDARY PREVENTION SUPPORT: ROLE OF ASHA

SWATI

ACTIVITY A

Understanding Secondary Prevention in the Context of Violence against Women

LEARNING OUTCOMES

To equip ASHAs with the knowledge and skills on identification and Secondary prevention of violence against women.

Duration
25 mins

Method
Brainstorming/Game

Materials
Charts, marker pens, copies of Handout 7 (Signs and Symptoms of Violence).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Ask the participants what is meant by early identification? Give some examples like early registration of pregnancy, early initiation of breastfeeding, and the early identification of symptoms of TB. Now ask, in the context of domestic violence against women, what would early identification mean? What would be the signs based on which you would identify violence?

2. Explain that identification of violence is essential to prevent further distress. Violence, if not stopped, may lead to serious health consequences. Emphasise the significance of domestic violence as a public health issue. Community-level health care providers such as ASHAs can make a difference because they are in close contact with the women in the community, have information about, and share a good rapport with them.

3. End the session with the participants discussing the role that ASHAs can play in identifying and Secondary prevention of violence. Ask them how they can take action and make a difference in the women's lives.

ACTIVITY B

Identification of Domestic Violence at the Community Level

LEARNING OUTCOMES

- To develop an understanding of the signs and symptoms of DV.

Duration
25 mins

Method
Group Work

Materials

Sticky notes or cards of size 5 inches x 3 inches (at least two cards per participant), double-sided tape, chart papers, marker pens.

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Start the session by informing the participants that the signs and symptoms of violence are the consequences of violence. While some signs are visible, some are not. Inform that all signs do not necessarily need to be physical. Women tend not to speak openly about violence for various reasons. In that case, how do we identify a violence survivor in the community? What signs and symptoms should we look for in a woman we suspect to face violence?
2. Bring up the body map once again and discuss the signs and symptoms.
3. End the session by distributing Handout 7-Signs and Symptoms of Violence Against Women.

HANDOUTS

7. **Signs and Symptoms of Violence** (PP 38-39)

HANDOUT 7 - SIGNS AND SYMPTOMS OF VIOLENCE

PHYSICAL SYMPTOMS

1. Injury Related

- Cuts and bruises
- Burns
- Fractures, ruptures, muscle injuries
- Ear injury, bleeding or difficulty in hearing
- Rectal and genital bleeding
- Broken or loose teeth

2. Non-injury Related

- Headache
- Neck pain
- Chest pain
- Urinary tract or reproductive tract infections, especially when occurring numerous times in succession. These can be identified by symptoms such as the need to pass urine more often, pain or burning feeling while passing urine, fever with chills, and cloudy urine.
- Sexually transmitted infections, including HIV/AIDS. STIs can be identified by symptoms such as vaginal itching, abnormal discharge, lower abdomen pain, rash, swelling in the groin or sore in genital area.
- Multiple pregnancies, with minimal spacing.
- Spontaneous abortion (miscarriages) with no other medical complication
- Multiple recurring requests for abortions
- Menstrual problems, including amenorrhea, menorrhagia, dysmenorrhea and irregular periods
- Anaemia, and consequent malnourishment

HANDOUT 7 - SIGNS AND SYMPTOMS OF VIOLENCE

MENTAL-HEALTH RELATED SYMPTOMS AND BEHAVIOURAL CHANGES

- Changes in clothing and appearance, suddenly does not feel like dressing well as before
- Loss of sleep and appetite
- Hypersomnia-sleeping throughout the day
- Not engaging in usual activities
- Chronic fatigue
- Avoiding socializing with friends and acquaintances
- Prevailing mistrust, loss of confidence, guilt, shame and feelings of helplessness

SOCIAL SYMPTOMS

- Women having only female children are at more risk of violence
- If the family wants a male child, they might subject a woman to violence
- Refusing a tubectomy despite ASHA's suggestion
- Not getting their children vaccinated
- Has the woman herself decided the spacing between her children?
- Having a family member who is addicted to alcohol, drugs or any other substance.
- A husband who displays controlling behaviour, or is unwilling to leave the woman's side when a service provider tries talking to her

ACTIVITY C

Important Role of ASHA in Addressing Domestic Violence against Women at the Community Level

LEARNING OUTCOMES

- To recognise the critical role ASHAs can play in addressing violence against women.
- To build skills in responding to violence survivors in the community.

Duration
40 mins

Method
Question and Answers, Brainstorming, Role-plays

Materials

Sticky notes or cards of size 5 inches x 3 inches, double-sided tape, chart papers, marker pens, Roleplay Situations (Annexure 4).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Start the session by distributing three to four cards to each participant. Ask the participants to think about the different health problems women approach them for. Ask the participants to write down one problem per card. Tell them to write about the most common problems and those that are not so typical. Paste the cards on the chart for participants to look at.

2. Club the similar problems. Give time to the participants to look at and review the issues written by others.

   a. How often are they presented with each of these specific health problems?
   b. Can this health problem be related to violence against women?
   c. How do they respond to such health problems?
   d. How can we integrate this into our daily work?

3 Inform the participants that we will now practice how to respond to women whom we suspect of facing DV. Form four groups. Pass around a bowl of chits with different situations written on each chit.

4 Ask each group to pick up one chit from the bowl. The group should read the situation and discuss it within the group.

5 From each group, ask two volunteers to do a role-play in which one plays the role of a survivor, and the other plays the role of ASHA.

6 Give 10 minutes for each group to prepare. Each group will get 5 minutes for the role-play, followed by 20 minutes for discussion.

- Ask the volunteers to perform the role-plays.
- Tell the participants that the role of ASHA here is to provide empathetic support and motivate the woman to seek help. Ask the participants to observe the response of ASHA in each part played and write down their observations in the notebooks.
- After the role-play, discuss what made the response helpful or not helpful?
- What could have been done differently by her?

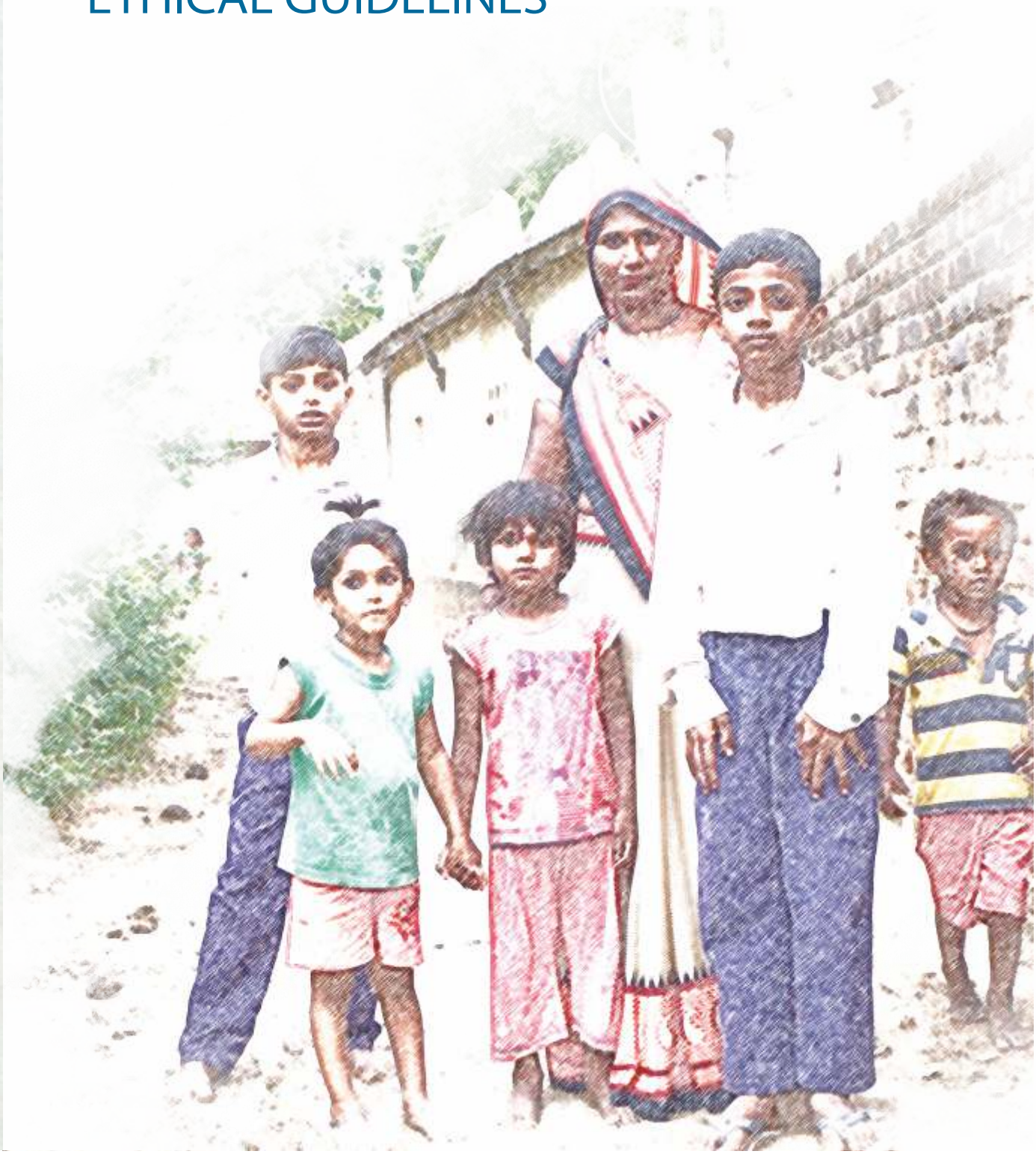
7 Summarise the session by once again reminding them about the discussion on the elements and guiding principles of an improved health sector response.

FACILITATOR'S NOTES

SWATI

Session 5

ETHICAL GUIDELINES



ACTIVITY A
Ethical Guidelines

LEARNING OUTCOMES

- Establishing guidelines for inquiry based on ethics that healthcare providers should follow while handling a case of VaW.
- Understanding principles of women-centric inquiry into the violence.

Materials
Flip chart

Duration
60 mins

Method
Discussion, Case studies

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. To understand the kind of enquiry ASHA workers are already conducting on-field, ask the participants:
   - What would make it easier for women to reach out to you for help?
   - What do you keep in mind or care about when dealing with a violence survivor?
   - What kind of precautions do you take to avoid any repercussions for yourself?

   Note down the answers given by the group on a flip chart, and keep the charts handy for discussion later.

2. Tell the participants that we will now discuss the ethical principles ASHA workers should follow while dealing with women facing violence. Explain each of the five principles below.

   PRINCIPLES:

   Compassionate Enquiry: Empathy and understanding for the person without

being pitying. Pity can increase their sense of powerlessness. Maintain professional boundaries (be mindful of self-disclosure, sharing personal feelings, the implication of physical touch, length, and timings).

Non-judgemental: Avoid making judgments based on one's personal and especially moral standards. Maintain a non-judgmental approach towards the survivor's belief system, behaviour and values. Accommodate and respect differences in opinions, values, and attitudes of various cultures and different types of people.

Respectful: Each survivor's situation must be treated with equal respect. Recognise and acknowledge the giant step that the survivor is taking, and respect the survivor's dignity. Attentive listening is a must at all times.

Sensitive: Refrain from blaming the survivor for the abuse they have suffered. You need to be aware of the various forms of discrimination in society and how these impact women's lives. Vulnerabilities resulting from social, economic, and other discrimination should be acknowledged so that special measures may be put in place when necessary.

Caution: Be cautious in asking questions or getting information. Ask her when she is by herself or with someone she trusts; maintain her privacy and confidentiality. The information is to be taken only after taking her consent.

3. After explaining all these principles, divide the participants into groups of four to six. Assign one of the principles to each group.

4. Ask each group to demonstrate the application of the principle they have been assigned.

5. Ask each group to think of any situation from their experience and give examples illustrating the same.

NOTES FOR THE FACILITATOR

1. While explaining the principles, try getting as many examples on how do ASHA already uses this principles in her work with community.

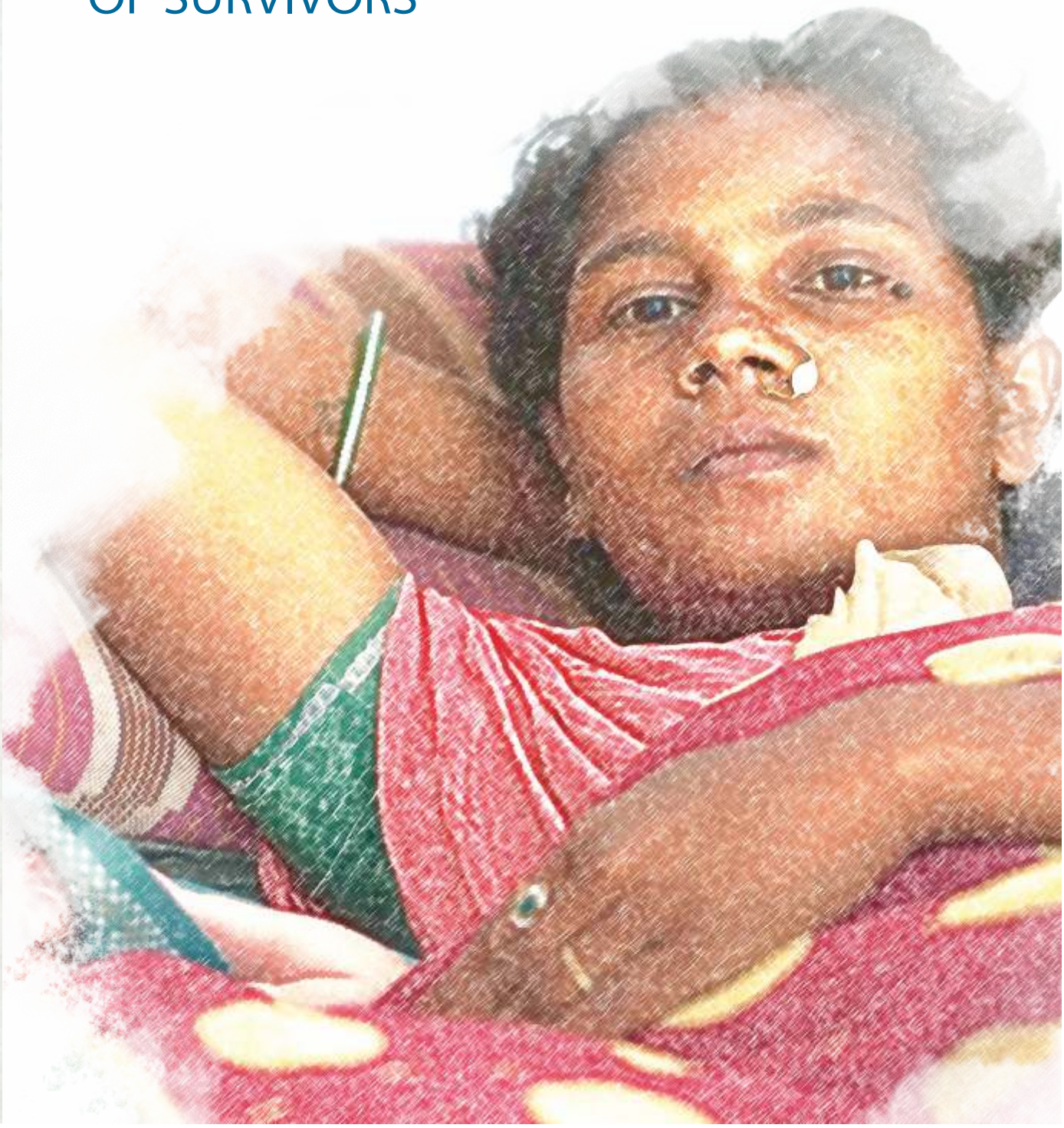
2. You can also highlight the following points to provide an idea of what to do when somebody approaches for help:

   - Remember your role. Say calming words. Listen but never judge. Practice respect. Do not try to solve their problem yourself.
   - Provide reliable and comprehensive information on the available services and support. Let the survivor make their own choices. Know what you can and cannot manage. Even without a GBV organisation in your area, there may be other partners, such as child protection or mental health specialists, who can support survivors that requiring additional attention and support. Ask the survivor for their permission before connecting them to anyone else. Do not force the survivor if s/he says no.
   - Do not proactively seek out GBV survivors, but if you identify or suspect, or are aware of someone, be available to provide support. Maintain confidentiality and respect their wishes. Do not record their personal data without their consent.
   - Remember your mandate. All humanitarian actors are mandated to provide non-judgmental and non-discriminatory support to people in need regardless of: gender, sexual orientation, gender identity, marital status, disability status, age, ethnicity/tribe/race, who perpetrated/committed violence, and the situation in which violence was committed.

SWATI

Session 6

FACILITATING REFERRAL OF SURVIVORS



ACTIVITY A

Facilitating Referral of Survivors

LEARNING OUTCOMES

- To become aware of referral services available to survivors of violence.
- To develop an understanding of the multiple pathways of referral that an ASHA can follow depending on the exigency and situation of the survivor.
- To understand the challenges that may come up in referring a violence survivor and ways to overcome these without putting oneself at risk.

Duration
30 mins

Method
Discussion

Materials

Sticky notes or cards of size 5 x 3 inches, double-sided tape, markers, Hand out 1 (Pathways of Referral)

Note: If the Referral Pathway diagram cannot be printed, please draw the same on chart paper beforehand. The diagram can also be made on a chalkboard/ whiteboard.

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Start the session by asking the participants what they understand by 'referral'. In their work as ASHAs, who/what kind of patients do they refer? Where do they refer them to? How do they decide? Is there a system? What do they do when they notice violence cases in course of their work?

   Let the participants come up with responses. Suggest citing examples for better understanding. List the available services for the violence survivors within the community, outside the village, at the block or the district level.

Inform the participants that such services where the patient or violence survivor is sent or escorted for consultation, review and further action are called referral services.

2 Divide the participants into three groups.

a. Instruct each group to consider the difficulties confronting women in the community and to categorise the circumstances that result from violence as follows:

- Those requiring an emergency response
- Those requiring immediate attention; else, the survivor may face serious repercussions
- Those that are negotiable and necessitate you counselling and guiding the woman as she considers her options and decides on a plan of action.

b. In each situation, ask group members to write down incidents of violence they have witnessed.

c. Following that, allow the groups to brainstorm on each category of the violent situation:

- How should one approach/inquire about a survivor of violence in each category?
- To whom should one refer the survivor?

d. Based on the case situation, each group must consider where the survivor would be referred to and the appropriate actions on the part of ASHA.

e. Allow the groups 15 minutes to discuss. After the talks are over, assign five minutes to each group to present their discussion as steps of referral or as a referral flow diagram.

3 The facilitator can update the missing links or information. Distribute the referral flow handout to the group.

NOTES FOR THE FACILITATOR

Please note that ALL violence needs to be stopped, and this activity does not aim at categorising some cases of violence as worse than others.

For this activity, different instances of violence can be divided into three broad categories:

1. Situations that require **an emergency response** ensure the safety and security of the woman involved.

   (An emergency is an immediate threat to the well-being, and urgency is a threat to the well-being soon. The emergency centres are open 24 hours, 365 days, and provide facilities for life-threatening conditions.)

2. Situations that may require **urgent attention** but are not an emergency.

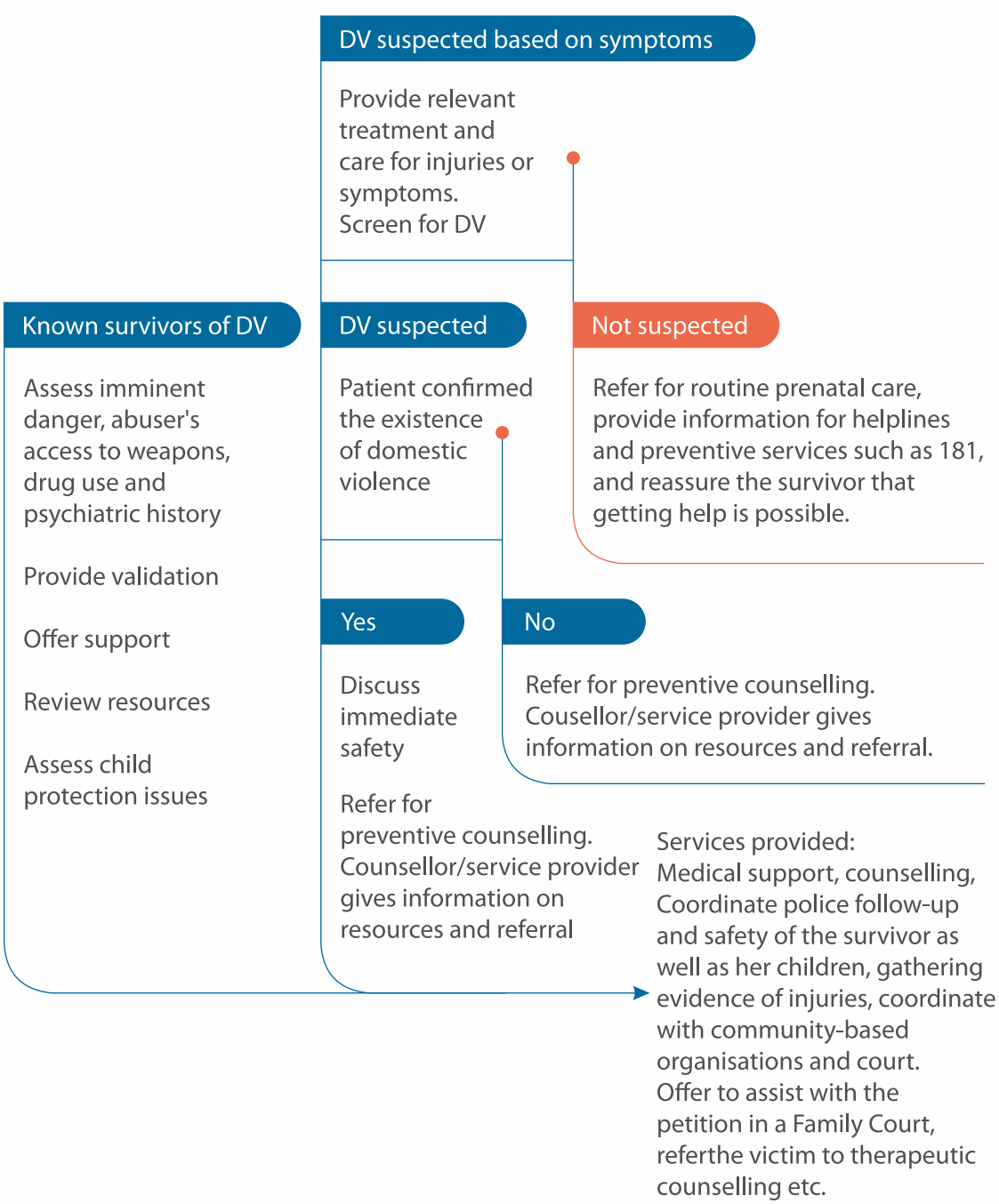
   (In an urgent situation, there is no immediate danger or threat to life or health, but if not taken care of in a given period, it may turn into an emergency)

3. Situations that have the scope for allowing time for a **survivor to seek advice/ counsel or think through her possible options** before embarking on a course of action.

HANDOUTS

1. **Pathways of Referral** (pg 51)

HANDOUT 1 - PATHWAYS OF REFERRAL



FACILITATOR'S NOTES

SWATI

Session 7

POST-TRAINING ASSESSMENT AND FEEDBACK

ACTIVITY A

Post Training Assessment And Feedback

LEARNING OUTCOMES

- Evaluate the training outcomes in terms of the change in understanding, knowledge and skills of the participants.
- Get participant feedback on training methodology and facilitation of sessions.

Duration
60 mins

Method
Discussion, form-filling

Materials
Copies of the Post-Training Assessment Forms (one for each participant) (Annexure 1), copies of the Feedback Form (one for each participant) (Annexure 6).

PROCESS INSTRUCTIONS FOR THE FACILITATOR

1. Distribute copies of the Post-Assessment Form to all participants and ask them to answer the questions based on their learnings from the training.
2. Once everybody has filled out their forms, introduce the feedback form (attached in Annexure 6) to the group, and hand a copy to each participant. Ask the group to be honest while filling out the form.
3. After collecting the filled forms, ask the group if they have any particular 'Light Bulb' moment from the day that they want to share. Document any feedback that is communicated verbally.

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ANNEXURES

ANNEXURE 1: PRE AND POST-ASSESSMENT FORMS

1. **What are the forms of domestic violence faced by women?**

2. **What is the impact of domestic violence on women's sexual and reproductive health? List at least three consequences.**

3. **Impact of domestic violence on other aspects of women's health. List at least two consequences.**

4. **Why is the domestic violence a health system concern? What role can you as an Asha worker play in supporting women facing vomestic violence ?**

5. **During home visits, how will you inquire/talk to women if you suspect violence?**

6. **What do you understand by the term 'Referral'? Which are the situations that require a referral?**

7. **Respond to the following situations:**

   Situation 1. If you suspect a woman of facing domestic violence, what care would you take when you inquire about it from her?

   Situation 2. You know a woman is facing domestic violence, but is not seeking help. What would you do?

ANNEXURE 1: PRE AND POST-ASSESSMENT FORMS

8. Rank the steps given below in the order of the steps that you will take based on the situation provided below. Place your ranking in the boxes provided under each statement

- Someone informs you that a woman is facing DV

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

- A woman who is seven months pregnant is bleeding

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

- You enter a home and find the woman with bruises on her face

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

- On a home visit, a woman tells you that she is facing severe abuse

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

STEPS

1) Talk to the victim
2) Call 108 ambulance
3) Contact the medical officer of the PHC and ask for their advice on where to refer
4) Contact the police
5) Call 181 domestic violence helpline
6) Contact other family members
7) Contact Mahila Sahayta Kendra/OSCC or NGO
8) Give her information on what support system or help is available

ANNEXURE 2: CASE STUDIES

CAUSES AND CONSEQUENCES

CASE STUDY 1

Sushila is 45 years old and has three children--two daughters and a son. Sushila cannot read or write. She could not study as her father did not think girls needed to study. Even after 25 years of marriage, her husband insults her by calling her illiterate in front of others. Sushila would like her daughters to go to college, but her husband feels that they should save money for their son's education. He loves his daughters but insists that they stop going to school.

CASE STUDY 2

Nirmala was married nine years back. Her husband is much less educated than her. She is from a city, but she was married in the village due to Satta Patta custom in their community. Nirmala's husband does not allow her to leave the house alone as he believes that city girls are of loose character. Nirmala has never gone out without him. She feels like committing suicide.

CASE STUDY 3

Jaya and her husband had a love marriage. Jaya's family does not speak to her as she has married a person of her choice. Her in-laws abuse her for coming empty handed. Jaya gave birth to a daughter. Now her husband's family ill-treats her more. They neglect her daughter too. Jaya asks her husband to take up a separate house. He gets angry, slaps her and asks her to leave him if she cannot adjust.

ANNEXURE 2: CASE STUDIES

CASE STUDY 4

Meeta is married into a well-off family in her village. Meeta's husband faced loss in his business and started drinking liquor. The rest of the family now ill-treats her, saying she and her husband are a burden. One day her father-in-law asked her to go and get money from her parents. She refused. Her father-in-law threw her clothes out in the courtyard, saying she could no longer stay in the house. Her husband did not say a word.

CASE STUDY 5

Reshma and Anil had a love marriage. Anil's family broke ties/relations with him, as he had married a girl from another community. Anil worked in another city. Hence Reshma stayed with her parents, and Anil would come and meet her every month. After a year, Anil came to visit in Bharatpur, and both Anil and Reshma started staying together. Anil could not find a proper job because of which they had fights.

Meanwhile, Reshma's sister Divya came and started staying with them. Anil and Divya fell in love. Reshma came to know of this and told her parents. Reshma's parents got wild and beat Divya. They accused her of spoiling her sister's married life. Divya was then made to come and live with her parents. Soon her parents married Divya to another man, and Reshma went back to live with Anil.

ANNEXURE 3: UNDERSTANDING LEVELS OF PREVENTION AND EARLY IDENTIFICATION

LEVELS OF PREVENTION

There are three levels of prevention – Primary, Secondary and Tertiary. These levels encompass several inter-related dimensions related to when intervention occurs, who the target audience is, what the interventions are trying to achieve, and the types of the activities undertaken. There is not always a clear distinction between them.

There are different terms and definitions of Primary, Secondary and Tertiary prevention. We have chosen definitions consistent with the WHO literature.

PRIMARY PREVENTION

Primary prevention aims to stop violence before it occurs. It is the most effective form of prevention but the most difficult to achieve. The aim is to change the social norms contributing to attitudes and behaviours that support violence, including gender norms. This means that primary prevention strategies should be designed to simultaneously work on multiple levels of the social ecology.

Given the range of factors contributing to violence, primary prevention activities need not explicitly focus on violence. For example, initiatives addressing factors contributing to violence, such as poverty and structural inequalities, including gender inequality, can be classified as primary prevention. Because the consequences of and solutions to violence against women affect society in general, primary prevention activities are focused on populations rather than individuals. Primary prevention approaches are usually described as universal or selective approaches.

ANNEXURE 3: UNDERSTANDING LEVELS OF PREVENTION AND EARLY IDENTIFICATION

SECONDARY PREVENTION

Secondary prevention focuses on immediate responses to violence, often in a crisis. It is often thought to apply to individual survivors and perpetrators, but the concept has broader applicability.

- For survivors, it aims to minimise the short-term harms of violence and the risk of re-victimisation. Secondary prevention might include, for example, emergency services or treatment for sexually transmitted diseases following rape.

- For perpetrators, secondary prevention can include interventions aimed at preventing the escalation of violent behaviour. These are known as indicated interventions.

- Secondary prevention can also include actions such as training professionals to improve crisis responses to victims or measures to ensure greater accountability of those who must protect survivors of violence.

TERTIARY PREVENTION

Tertiary prevention focuses on long-term care in the wake of violence, such as rehabilitation and reintegration of perpetrators, and attempts to lessen the trauma, or reduce the long term disability associated with violence, e.g. psychological therapies for abused children, screening and support services for survivors of intimate partner violence.

At the tertiary prevention level, indicated interventions for perpetrators focus on high-risk individuals who have detectable problems, such as sex offenders.

ANNEXURE 3: UNDERSTANDING LEVELS OF PREVENTION AND EARLY IDENTIFICATION

EARLY IDENTIFICATION

Early identification refers to measures that can be taken to diagnose a disease or a disorder as early as possible when the condition is easiest to treat. Methods of early identification can include screening, which means to inquire when no symptoms are present. The behavioural patterns of the individual broadly inform screening for early identification.

The basis of early identification is screening, and it is the testing of people at high risk of developing a disease to identify previously undiagnosed conditions or defects. It aims to detect early disease before it becomes symptomatic.

PRINCIPLES OF EARLY IDENTIFICATION

1. The condition sought should be an essential public health problem.
2. Medical history should be adequately understood.
3. There should be a latent or symptomatic change.
4. There should be accepted and effective treatment for the patients.
5. Facilities for diagnosis and treatment should be available.

ANNEXURE 4: ROLEPLAY SITUATIONS

CASE SITUATION 1

Anita is 32 years old and has three children. Anita is pregnant again. She had been advised against this pregnancy, but she went ahead with this. ASHA worker scolds her vehemently for not using family planning methods. Anita only nods her head. Anita is losing weight. One day an ASHA worker finds her crying. Upon asking, Anita cries. A few days later, ASHA gets a message. Anita has suffered a miscarriage and is bleeding profusely. ASHA calls an ambulance and takes her to the hospital.

What should ASHA have done differently to avert this situation?

CASE SITUATION 2

Rehana is 22 years old and has been recently married. You attended her marriage. Rehana is a shy introvert girl. For the last few months, you noticed that she looked depressed. She is no longer interested in dressing up. Her clothes are crumpled, and her hair is uncombed. You have tried to ask her, but before Rehana can respond her mother-in-law answers. One day you asked her husband the reason for Rehana's situation. He got angry and asked you not to interfere in his personal matters.

What should the ASHA do?

CASE SITUATION 3

Geeta lives with her family on the outskirts of the village. ASHA saw black and blue marks on her body. Yesterday she heard loud sounds coming from Geeta's house. She decided not to go in. Today when she went, Geeta was cooking while her husband ate. Geeta had a bandage on her ear.

ANNEXURE 4: ROLEPLAY SITUATIONS

What can ASHA do? Should she approach Geeta? How?
How does she motivate her/ support her to seek help?

CASE SITUATION 4

Jagruti lives with her husband on the outskirts of her village. Her husband works in a factory. Jagruti often suffers from STDs. Her husband refuses to use a condom.

How can ASHA help in such a situation?

ANNEXURE 5: FEEDBACK FORM

Q1. Was the environment during training conducive to learning?

- Yes. Very conducive
- Yes. Somewhat conducive
- No. Not conducive

Give reasons for your answer.....

Q2. Which session did you enjoy the most and why? Give reasons for your answer.

Q3. Which session did you not enjoy and why? Give reasons for your answer.

Q4. Tell us three new pieces of information you did not know earlier and have learnt in this training.

Q5. Tell us a skill that you did not have earlier and have learnt in this training.

Q6. Rate the training on quality of:

- Facilitation
- Knowledge
- Activities used to facilitate learning
- Handouts

Q7. Please suggest any topics that should be included

Q8. Any suggestions for improvement and making the training more useful?

SWATI

FACILITATOR'S NOTES