Rural Health Sector Response to Women Survivors of Violence

An initiative by Society for Women's Action and Training Initiatives (SWATI)

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India's National Health Policy (2017) recognises violence against women as a health issue and emphasises the public health sector's responsibility to help survivors. In recent decades, India's urban and peri-urban areas have implemented several crisis intervention and survivor support models. Many are hospital-based, with limited outreach. Higher prevalence of domestic violence against women in rural India, remoteness, and social isolation require a response model that addresses rural needs. An initiative by SWATI that involved ASHAs for early detection of violence against women in remote rural areas is described here

VIOLENCE AGAINST WOMEN IN RURAL AREAS IS DIFFERENT/AN ISSUE IN ITSELF

Violence against women is more prevalent in rural areas

Survivors experience more severe form of violence

Challenges faced by survivors in accessing support services are compounded by distances, lack of transportation, higher acceptance of violence against women in rural communities

(Source: Edwards, 2015; Treat et al, 2022)

Introduction

India's National Health Policy (2017) recognises violence against women as a health issue and emphasises the public health sector's responsibility to help survivors. In recent decades, several crisis intervention and survivor support models have been implemented in India's urban and peri-urban. Many are hospital-based, with limited outreach. Higher prevalence of domestic violence against women in rural India, remoteness, and social isolation require a response model that addresses rural needs. An initiative by SWATI that involved ASHAs for early detection of violence against women in remote rural areas is described here.

SWATI, an Ahmedabad, Gujarat-based feminist organisation works for the advancement of women's rights and entitlements in rural Gujarat, is implementing an intervention to strengthen rural health system response to survivors of violence from rural areas.

The Rural Model

Prevention of violence against women (VaW) is a primary objective of SWATI and recognizing its complexity, it works at several levels to combat it. Establishment of a community upward referral system through ASHA and sub-centres for early detection of domestic violence among women is a culmination of SWATI's work over past eight years in working with three public sector hospitals of highly rural Patan District.

The roots of this initiative lie in SWATI's work with rural women to empower them to prevent violence against women. Over the period, the violence prevention work has evolved and expanded from organising women led gender just initiatives - Mahila Nyaya Panchayats to strengthening the public health system response to violence against women. Through its interactions with the courts and the police, the SWATI team realised that poor documentation by the doctor at healthcare facilities of violence as a cause of health conditions survivors presented with[i] had serious long-term implications for survivors. The poor documentation in turn, was observed to be a result of examining doctors' lack of sensitivity and understanding of the important role they can play.

SWATI responded to this challenge by establishing a hospital-based crisis intervention and support centre – the Mahila Sahayta Kendra – at CHC at Radhanpur (an 80 bedded hospital), in District Patan, Gujarat in June 2012. In response to this challenge, SWATI established the Mahila Sahayta Kendra, a hospital-based crisis intervention and support centre, at the CHC in Radhanpur in June 2012. (An 80-bed hospital in District Patan, Gujarat).

The opportunity to document Dilaasa, a health-care response model to VaW, added substance and structure to our work

It was soon noticed that the services provided by the MSK were much needed, women survivors approached the MSK from as far as 80km away and ASHAs played an important role in facilitating survivors' access to the MSK. SWATI team initiated a systematic dialogue with ASHAs. The work with ASHAs to educate them on domestic violence as a health issue and their role in supporting women survivors of violence gained traction in 2015, when the topic was officially included in the ASHA curriculum.[ii]

By 2016 SWATI had established Mahila Sahayta Kendras in two more hospitals in District Patan the catchment area for these hospitals though rural had distinct characteristics that influenced the survivors' access to services.

Over the next five years, the SWATI team trained over 450 ASHAs on identification violence in the community and exploring ways to engage ASHAs in facilitating rural survivors' access to hospital-based MSK without ASHAs or survivors facing community backlash.

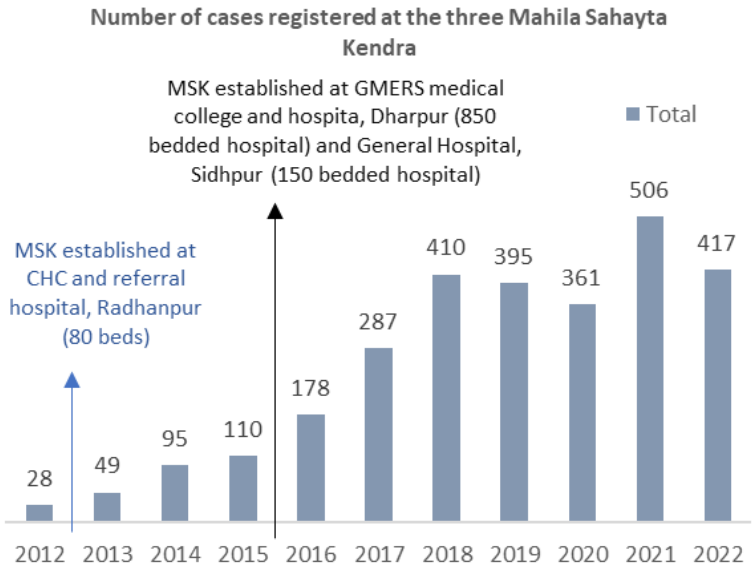
RURAL MODEL FOR STRENGTHENING HEALTH SYSTEM RESPONSE TO SURVIVORS OF VIOLENCE

Hospital based Mahila Sahayta Kendra with women counsellors trained in feminist counselling and women paralegal worker

Orientation of hospital based medical and support staff, ASHA and staff at SC, PHC to violence against women as a health issue and role of health system in responding to survivors

Establishing referral pathways and feedback mechanisms to facilitate referrals from health care providers at various levels of health care delivery system

Strengthening communication with ASHA community level health care providers and health care providers from the hospitals where MSK are located



During the COVID pandemic-induced lockdown, as VaW increased, ASHAs sought advice and assistance from counsellors. When ASHAs referred survivors to the SC, counsellors began visiting the sub-centres/health and wellness centres on specific days. Referrals to MSK have increased as a result of this process, and more survivors have been able to access services. It has also resulted in the early detection of violence in the community.

Aside from ASHA referrals, the hospital-based MSK receives referrals from hospital-based health care providers, old clients, and other community members.

Reach of the Rural Model

Over 2016-22, SWATI team oriented 1150 medical and support staff from hospitals, 454 ASHAs. Over this period the three MSK provided services to 2714 women survivors (new cases registered). The increase in number of cases registered indicates need for the services. Referrals from hospital-based health care providers account for one-third (32%, 859/2714) of the cases registered. 20% (547/2714) of registered cases are referred by ASHA, 12% (328/2714) are referred by old clients and another 7% (190/2714) are referred by members of community – thus suggesting acceptance of the MSK at community level.

EARLY DETECTION OF VIOLENCE AGAINST WOMEN AT COMMUNITY LEVEL THROUGH ASHA

Early detection = Secondary prevention

ASHA suspect violence based on health symptoms and social conditions

Refers women to MSK counsellor visiting the sub-centre/health and wellness centre

Survivor gets help before she experienced severe social consequences such as being thrown out of the house by the abusive marital family

Violence detected before permanent, serious harm caused to survivor's health

Early detection at community level through ASHA – Observations from MSK at Gujarat Medical Education and Research Society (GMERS) Dharpur (2020-22)

MSK at GMERS Dharpur provides services to women from 139 villages from Patan Block of District Patan as well as receives referrals from adjoining blocks. 144 ASHAs from the block were trained by SWATI to suspect violence against women based on health symptoms and social conditions that are known to trigger or aggravate violence. Counsellors started regularly visiting the sub-centers/health and wellness centres since April 2020.

In a period of two years between June 2020 to May 2022, 67% (99/144) of the trained ASHAs referred 980 women suspected of domestic violence to the village-level health and wellness centre when SWATI counsellors visited. Referrals from ASHA are based on a mix of health symptoms and social conditions. (Table 1)

Analysis of this data suggests that when ASHAs referred women to the visiting MSK counsellor, violence was detected before women experienced severe social consequences such as desertion or separation. 91% (52/583) of women referred to health and wellness centres by ASHA were staying with marital family compared to 65% (115/178) women referred to the hospital based MSK by hospital-based health care providers

The data also indicates referral to support services (MSK) before violence caused severe, lasting impact on health. Injuries including fractures (40%,71/178), attempted suicides (23%, 41/178), mental health conditions /disorders (8%, 14/178) were the three most common health conditions among women referred to the MSK by hospital-based health care providers. Whereas among referrals from ASHA, symptoms of stress, sexual and reproductive health conditions and high-risk pregnancies were the most common conditions.

Table 1: Reason for referral among women who admitted facing violence graph)

Basis for referral	No of women n=583 (%)
Mental health conditions/symptoms (Stress, sleeplessness, worrying, neglect of self-etc)	131 (23)
Sexual reproductive health conditions (e.g., excessive white discharge, menstrual disorders, etc)	131 (23)
High risk pregnancy (pregnancy of 4th or higher order, severe anaemia, increased blood pressure, pain abdomen, infectious or non-infectious condition etc)	109 (19)
Childlessness	77 (13)
Only daughters	47 (8)
Poor obstetric history (repeated miscarriages, history of still births, etc)	41 (7)
Woman reported domestic violence	37 (6)
Denied treatment by husband	6 (1)
Prolapsed uterus	6 (1)

EFFECTIVENESS OF THE MODEL

Increased accessibility – women whose mobility is restricted by abusive families too can access services

25 years old Radha had been unable to conceive for past 8 years and faced physical, emotional, sexual violence from husband. She repeatedly begged ASHA to help her with childlessness. Despite ASHA assuring to accompany her to hospital, Radha's family refused to let her seek consultation

When MSK counsellor visited the SC in her village, the ASHA referred Radha to her. The counsellor helped Radha convince the husband for a meeting with counsellor. Convinced with explanation from the counsellor, Radha's husband agreed for a consultation with gynaecologist. After a small procedure and a course of medicines, Radha conceived within a year

Effectiveness of the model

Detection of violence against women by ASHA during routine monitoring, referral to MSK counsellor visiting sub-centre / health and wellness centre and further support through the hospital-based MSK has proved to be an effective model.

- With counsellor visiting the SC at village level, accessibility of support services increased – women who are not allowed to step out of the village too can reach the counsellor
- ASHA need not accompany women since she is not required to leave the village – reduced possibility of ASHA being associated with MSK counsellor – no fear of repercussions from referring survivors for help
- More than three fourth of the women referred by ASHA reach the sub-centre / health and wellness centre to speak with the counsellor – 28% of these seek help at that time, many reach out when violence escalates
- 59% (583/980) of the women referred by ASHA admitted facing violence, and 45% (264/583) sought help from the MSK counsellor during the first session/meeting

- The proportion of referrals from ASHA to new cases registered at the MSK went up from 13% (56/419) in 2016-2019 to 51% (315/617) in 2020-2022
- Most of the cases are resolved through provision of information, counselling and joint meetings with survivor and abuser
- Since all women referred by ASHA are provided with information on health impacts of violence against women and available resources, it contributes to increased awareness among women. Information is shared with other women relatives and spill over effect is noted

SPILLOVER EFFECT

45-year-old Sushilaben was referred to MSK counsellor at a SC for chronic white discharge. She told the counsellor she did not face violence at home but sought help for her married daughter whose marital family beat her severely. Counsellor gave her information about services provided through MSK, 181 helpline which could be used to escape violence in case of emergency and legal provisions for women to escape violence. Two months later Sushilaben brought her daughter along at MSK Dharpur for a consultation with the counsellor

Acknowledgements

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References

i. Documentation of violence as a cause of injury or health condition by a doctor, registration of medicolegal case is regarded as proofs of women having suffered violence in court hearings. In absence of such documentation survivors find it hard to prove their experience of violence
ii. Handbook on Mobilising for Action on Violence Against Women (available on the National Health Mission website) included in the ASHA curriculum discusses forms of violence against women and its health impacts and role of ASHA in helping women facing violence

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