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Research Article

Mental health and violence against women in Afghanistan, India and Sri Lanka: a situation analysis

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ABSTRACT

Background: Globally, 10–53% of ever-partnered women have experienced physical or sexual intimate partner violence over their lifetime. Women survivors of violence are at high risk of poor mental health. In this study, we investigate women's exposure to violence and mental health conditions in Afghanistan, India and Sri Lanka, while considering the policy and service contexts.

Methods: A situation analysis tool was developed for the study. We extracted information from grey and peer-reviewed literature and other publicly available data investigating the prevalence of violence against women and mental health conditions, policies addressing violence against women and mental health conditions in each country and the services available to women exposed to violence and women with mental health conditions.

Results: Forty-six per cent of women in Afghanistan, 21% of women in India and 5% of women in Sri Lanka reported experiencing physical violence within the last 12 months of the most recent survey. Meanwhile, 7% of ever-partnered women in Afghanistan, 6% of women in India and 7% of women in Sri Lanka reported experiencing sexual violence during their lifetime. In India, 6.9% of disability-adjusted life-years were attributed to childhood sexual abuse and 4.6% to intimate partner violence. In Sri Lanka, 14.6% of women exposed to physical or sexual violence by a partner had engaged in self-harm. We found no data on conflict-related sexual violence and trafficking. All three countries have made commitments to gender equality or preventing violence against women. Implementation of some of these policies, however, is unclear. The countries also have had mental health policies and services, but there is currently little intersection between mental health and violence against women.

Limitations: The situation analysis is limited by the data available and the generalisability of findings.

Conclusion: The three countries have limited data, policies and legislation on the intersection between all forms of violence against women and poor mental health as well as a paucity of mental health service provision.

Future work: Future research should focus on integrating mental health care within social services; translating trauma-informed approaches into service provision and addressing family violence within violence against women.

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Introduction

Defined as public or private actions or threats made to intentionally hurt or harm women physically, sexually or psychologically (such as coercion and loss of freedom),[1] violence against women (VAW) is a human rights violation and global public health problem that adversely effects women's health and well-being.[2] Global estimates suggest that between 10% and 53% of ever-partnered women have experienced physical or sexual intimate partner violence (IPV) in their lifetime.[3,4] These estimates are wide-ranging due to the challenges of collecting accurate data, given stigma, issues of non-response and safety, cultural and gender norms around violence, non-recognition of VAW and issues of privacy and confidentiality, among others.[5] Recurrent and chronic exposure to violence leads to persistent stress and results in poor mental health and well-being.[3] This stress commonly manifests as anxiety, depression, post-traumatic stress disorder (PTSD), self-harming thoughts and/or behaviours and/or substance misuse.[1–3,6–11]

Violence against women is considered a gendered issue. The prevalence of domestic and sexual violence victimisation is higher among women than men. Moreover, VAW exposure places women at higher risk of suffering from depression, anxiety and suicide.[12–14]

Conflict further affects violence prevalence, mental health conditions and the ability of services to respond. Conflict zones have been shown to have some of the highest prevalence of VAW globally,[15–17] and individuals living in them have a greater likelihood of poor mental health than those living in non-conflict settings.[18,19] Research on trafficking has shown similar findings. Trafficked individuals report comparable levels of poor mental health (anxiety, depression and PTSD),[20,21] violence and coercion to survivors of domestic violence, prisoners of war and survivors of torture.[22–25] Factors contributing to adverse mental health and violence among trafficked individuals include differential levels of power and control exerted by traffickers.[22,26,27]

Despite the high prevalence of VAW and coexisting mental health problems in most parts of the world, access to care for women survivors of violence experiencing mental health problems is poor. Health systems have been slow to respond to VAW and provide targeted services.[28] Meanwhile, demand-side barriers like stigma, sociocultural norms and lack of financial resources affect uptake. These barriers could be attributed to the social acceptability of VAW in some settings, overburdened and underfunded mental health systems and the consequent limited capacity of staff to respond adequately.[29,30] Additionally, health systems in conflict-affected settings are particularly fragile, with most of the population being unable to obtain basic health services.[31] In such settings, there is a lack of understanding of how mental health services respond (if at all) to women survivors of violence.

In light of these gaps, there is a need to develop effective mental health and VAW prevention and intervention strategies. The goal of our wider research programme was to develop a package of care to support the mental health of survivors of VAW in Afghanistan, India and Sri Lanka. Importantly, Afghanistan has been in a state of conflict for more than four decades,[32] with a recent escalation due to a change in government in August 2021.[33] Sri Lanka experienced 26 years of civil war (1983–2009)[34] and has recently experienced ethnic and religious tensions and political conflict.[35]

Designing intervention strategies that are contextually relevant requires an in-depth understanding of epidemiology as well as existing policies, legislation and services.[36] Experiences of violence and its mental health consequences are shaped by the social, cultural, political and economic contexts. For example, women living in countries without domestic violence legislation are estimated to be 7% more likely to experience violence than those in countries with legislation. In societies where violence is not criminalised, a perception that it is broadly acceptable tends to dominate public discourse. Survivors of violence may therefore be less likely to seek support from health services, police or community resources, with physical and poor mental health repercussions.[37] In this situation analysis, we aimed to quantify the forms of VAW and mental health conditions in Afghanistan, India and Sri Lanka to identify policies that integrate these two issues as well as existing services for VAW and mental health and their integration.

Research group

Our group consisted of researchers based in non-governmental organisations (NGOs) and universities in Afghanistan, India, Sri Lanka and the UK. Partners in

Afghanistan were based at the Humanitarian Assistance for the Women and Children of Afghanistan, an NGO that supports women and children across Afghanistan, including survivors of violence. Partners in India were based in Mumbai [Society for Nutrition, Education & Health Action (SNEHA)] and Goa (Sangath). SNEHA includes a group that works with communities to prevent and address VAW, while Sangath works to improve mental health by addressing the psychological and social needs of individuals and families. Partners in Sri Lanka were based at the Department of Psychiatry in the University of Colombo.

Methods

As a detailed approach to identifying the barriers, facilitators, resources, challenges and opportunities within settings,[38] a situation analysis was deemed to be the most appropriate method, given the paucity of information available on mental health context in the context of VAW within these settings. The evidence was collected by mapping grey and peer-reviewed literature and other publicly available data. It did not include empirical data collection. Development of the package of care did, however, involve qualitative work with providers and survivors. This is detailed in the synopsis article in the National Institute for Health and Care Research Global Health Research journal. To guide data collection, we developed a situation analysis tool covering three domains and the following inclusion criteria: (1) the prevalence of violence and mental health conditions among women (prevalence of different forms of violence, help-seeking behaviours, prevalence of mental health conditions, such as depression, anxiety, PTSD, substance use, suicide and self-harm, etc.); (2) policy context (policy and legislation for mental health, VAW and trafficking) and (3) mental health services (mental health human resources, treatment coverage, violence and mental health screening). The situation analysis tool was designed by our transdisciplinary research team. The team also supported the interpretation of the findings. We adapted the Programme for Improving Mental Health Care situation analysis tool created to guide a district-level situation analysis in preparation for the implementation of mental health interventions in primary care in five countries.[39] Adaptations reflected our focus on mental health care for women survivors of violence and on national or regional indicators. Indicators were determined by consulting with members of the research group who had expertise in VAW, trafficking and mental health conditions. We made a pragmatic decision to focus on the regional- and country-level indicators due to the lack of locally specific data and the possibility that, as part of our research programme, interventions would be implemented at more than one site within each country.

The situation analysis tool was initially completed by in-country investigators (ND, UB, THRS) in October 2018. The tool was used to search data between October and December 2018. A revision of the data in all countries took place in August and September 2022 (MQ-D). Data were primarily drawn from public domain health surveillance data, household survey collected through the Demographic and Health Surveys,[40] academic publications, policy documents, governmental and non-governmental reports and the World Health Organization (WHO) Mental Health Atlas (see *Appendix 1* for a list of main data sources by country). Data collected for Afghanistan were under the previous government. Meaghen Quinlan-Davidson, Ayesha Ahmad, Abhijit Nadkarni, Alexis Palfreyman, Laura Asher and Urvita Bhatia reviewed the data for completeness and accuracy. Although we did not use a systematic approach, we tried to establish the plausibility of data by triangulating with grey and unpublished literature where possible and by checking with members of our research group with relevant expertise.

The situation analysis is part of a larger programme of work that included a transdisciplinary group with team members from Afghanistan, India and Sri Lanka. These countries were included as team members and aimed to develop a support package for the mental health of women survivors of violence and modern slavery. In addition, exploring evidence across select South Asian settings contributes to a much-needed intervention-based work in a high-VAW burden region. The idea was not to represent South Asia but to bring together a range of settings and stakeholders who work in the prevention of VAW, mental health as well as academics conducting research on the topic.

Results

The prevalence of violence and mental health conditions

Women's exposure to violence

We found that multiple forms of VAW were common (*Table 1*). Prevalence of violence was highest in Afghanistan, where 46% of women[41] had experienced physical violence within 12 months preceding the survey (53% in their lifetime)[41] and 7% of ever-married women had experienced sexual violence.[42] There were high rates of marital control; for example, 35% of ever-partnered women reported psychological abuse (defined as jealousy or anger if they talked to other men), and 35% reported

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TABLE 1 Types of VAW in Sri Lanka, India and Afghanistan

Exposure to violence	Afghanistan	India	Sri Lanka
Percentage of women who experienced physical violence from anyone	Last 12 months: 46%[35] Ever: 53%[35] Pregnant: unknown[35] Postnatal: unknown[35]	Last 12 months: 21%[37,82] Ever: 30%[37] Pregnant: 4%[37] Postnatal: unknown[37]	Last 12 months: 4.8%[30] Ever: 18.9%[30] Pregnant: unknown Postnatal: unknown
Percentage of ever-married women who experienced sexual violence from anyone	7%[35]	6%[37]	7%[30]
Percentage of women who experienced conflict-related sexual violence	No data found/identified	No data found/identified	No data found/identified
Percentage of women who were trafficked	No data found/identified	No data found/identified	No data found/identified
Percentage of ever-partnered women who experienced marital control	Type of controlling behaviour[36]: 60% jealousy or anger 35% knowing where wife is at all times 25% accusations of infidelity	Type of controlling behaviour[37]: 27% jealousy or anger 20% knowing where wife is at all times 9% accusations of infidelity	Type of controlling behaviour[30]: 8% jealousy or anger 9% knowing where wife is at all times 6% accusations of infidelity
Percentage of ever-married women who experienced physical/sexual IPV	56%[29]	33%[37]	20%[30]
Percentage of women who experienced violence by family members (other than intimate partner)	94%[29]	Physical violence since age 15: 42%[37]	7%[30]
Percentage of women victims who sought help in response to violence	Physical and sexual violence: 33%[36] Physical violence only: 18% Sexual violence only: 9% Family: 34% Neighbours: 18% Police: unknown Health service: unknown	14%[37] Family: 65% Police: 3% Health service: 1% Religious leader: 2% Husband family: 29% Friend: 15%	75%[73] Family: 27% Neighbours: 18% Police: 7% Health service: 3% Government institutions: 1.4% NGOs: 0.4% Other: 3%

their partner insisted on knowing where they were at all times.[42] The highest rates of physical violence perpetrated by family members were also reported in Afghanistan (40% of ever-married women aged 15–49 years).[41,42]

In India, 21% of women reported experiencing physical violence perpetrated by anyone within the last 12 months (lifetime estimates of 30%).[43] Sexual violence was prevalent, with 6% of women reporting it in their lifetime.[43] Meanwhile, 33% of ever-married women reported ever experiencing physical, emotional or sexual violence by their current partner.[43] Marital control among ever-married women was reported as the following: 27% experienced jealousy or anger if they talked to other men; 20% on knowing where they were at all times and 9% were accused of infidelity.[43] Nearly one-third of ever-married women (32%) in India also experienced family physical violence, which includes the husband's family and step-family members.[43]

The COVID-19 pandemic appears to have increased VAW in India. In a rapid online survey across India in May 2020, 18% of women reported currently experiencing spousal violence (n = 560). There was a 33% increase in spousal violence since lockdown. The rates of physical, sexual, verbal and emotional violence were estimated at 35%, 11%, 65% and 44%, respectively. Meanwhile, 76% of women reported being sad or depressed due to violence and 37% reported having thoughts of harming themselves.[44] In a qualitative analysis of 586 women during lockdown between April and July 2020, 86% of women at initial consultation reported experiencing emotional abuse, 76% economic violence, 70% IPV, 64% physical violence, 56% neglect, 56% controlling behaviours and 35% sexual violence; 86% reported surviving more than one of these forms, while 22% had experienced all of these forms of violence; 27% of women were still surviving violence during lockdown and 28% were surviving intimate partner or family violence.[45]

In 2019, Sri Lanka conducted the first national Woman's Wellbeing Survey exploring VAW among ever-partnered women of reproductive age (15–49 years). The prevalence of physical violence among ever-partnered women within 12 months of the survey was 5% (lifetime estimate 19%).[34] Sexual violence was prevalent, with 7% of ever-partnered women (15–49 years) having experienced sexual violence.[34] Approximately, 20% of women had experienced physical or sexual violence from a partner during their lifetime.[34] Approximately, 19% of ever-partnered women reported experiencing controlling behaviours by a partner (during their lifetime), of whom 9% reported that their partner insisted on knowing where they were at all times; 8% experienced jealousy or anger if they spoke with another man and 6% were accused of infidelity.[34] Approximately, 7% of ever-married women reported experiencing physical violence by a non-partner; of this, 42% was perpetrated by male family members, while 27% was perpetrated by female family members.[34] Concurrent to our situation analysis, WHO's 2018 country profile on VAW reported a wide range of 18–72% lifetime prevalence among women of reproductive age, indicating how prevalence data are informed, by what forms and how VAW is researched in a given context.[46]

Mental health problems

Table 2 illustrates the burden of mental health conditions across the three countries. Evidence on mental health conditions among survivors of violence in Afghanistan was scarce. A randomised controlled trial evaluating women's empowerment in Afghanistan showed that, compared to unexposed women, women exposed to violence in the last 12 months were six times more likely to have suicidal thoughts.[47]

In India, the Global Burden of Disease Study (2020)[50] analysed mental health conditions between 1990 and 2017. The prevalence of depressive, anxiety and eating disorders was higher among females than males. The authors attributed these differences in prevalence to violence, sexual abuse, gender discrimination, negative sociocultural norms and pregnancy and post partum stress.[51–54] The study also showed evidence for the contribution of risk factors such as childhood sexual abuse and IPV to mental health conditions.[50] Estimates suggested that 7% and 5% of disability-adjusted life-years for depressive disorders were attributed to childhood sexual abuse and IPV, respectively, and were significantly higher among females than males. Women with depressive disorders were also more likely to die by suicide than males.[50] Indeed, the suicide death rate among women in India was nearly three times that of countries with a similar Sociodemographic Index,[55] with married women representing the largest proportion of suicide deaths among all women.[56,57] Indeed, prior cross-sectional studies conducted on suicide attempts in North India have showed a higher proportion of suicide attempts and psychiatric comorbidities among women.[58–60]

Estimates from the 2011 Mental Health Atlas in Sri Lanka showed that the suicide mortality rate was higher among males (44.6) than females (16.8 per 100,000 population).[61] Evidence from 2009 showed that approximately 2% experienced PTSD (7% of people affected by conflict).[62] In a cohort analysis of police and hospital data on suicide, Knipe and colleagues (2014) showed that suicide rates were highest among women aged 17–25 years between

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TABLE 2 Indicators of poor mental health and treatment in Sri Lanka, India and Afghanistan

Prevalence of mental disorders	Afghanistan	India	Sri Lanka
Suicide rates (per 100,000 population)	5.7 per 100,000[118]	Overall: 17.9 per 100,000 individuals[46] Females: 14.7 (13.1–16.2)[46] Males: 21.2 (14.6–23.6)[46]	12.9 per 100,000[119] Males[49]: 44.6 Females[49]: 16.8
PTSD (%)	No data found/identified	General population: 0.2%[83] Survivors of VAW: 14%[120,121] Survivors of conflict: 19%[121]	General population: 2%[49] Survivors of conflict: 7%[50]
Common mental disorders (anxiety and depression) (%)	No data found/identified	General population: 10%[82] 3% (adults)	Survivors of conflict: 33%[50] (anxiety) 22%[50] (depression)
Alcohol abuse/dependence (%)	No data found/identified	General population: 4.6%[82]	General population: 5%[49]
Severe mental disorders (schizophrenia and other psychotic disorders, bipolar disorder and moderate-to-severe depression) (per 100,000 population)[48]	General population: 47.0[49]	Schizophrenia and other psychotic disorders: 1% (lifetime) and 0.4% (current prevalence)[81] Bipolar: 0.5% (lifetime) and 0.3% (current prevalence)[81]	No data found/identified
Treatment gap (%) (the proportion of people who need but have no access to mental health care and/or are not in treatment)[49]	No data found/identified	70% bipolar affective disorder[82] 75% psychotic disorders 85% major depressive disorder 83% neurosis 86% alcohol use disorder	General population: 68% experience treatment gap[122]

1975 and 2012.[63] A more recent analysis indicates that this trend towards younger female suicides has persisted through the latest national data 2022.[64] In research on perinatal women, those with a history of IPV were four times more likely to report suicidal ideation and/or behaviour during their pregnancies compared to women without this violence history.[14] The Sri Lanka Women's Wellbeing Survey (2019) reported that women exposed to violence were more likely to exhibit emotional distress than those who were not exposed to violence.[34] Estimates suggest that 15% of women who experienced physical or sexual violence by a partner engaged in self-harm when compared with 1% of women who had never experienced violence. At the same time, 36% of women who experienced physical or sexual violence by a partner had suicidal thoughts when compared with 7% of women who had not.[34]

Policy context

Where there were policies on VAW and mental health, they focused on prevention (*Table 3*). The countries varied in their policy, programme and strategy responses to VAW and trafficking. In addition, mental healthcare policies for women survivors of violence were largely absent from the literature.

Afghanistan, India and Sri Lanka have ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[65] as well as the Convention on the Rights of Persons with Disabilities.[66] Sri Lanka has ratified the United Nations Declaration on the Elimination of Violence Against Women (EVAW),[67] while India has committed to it.[68] All three countries are signatories to the Sustainable Development Goals (SDGs) (SDG 5 aims to achieve gender equality)[69] and the Palermo Protocol (see *Table 3*).[70]

Afghanistan has shown some commitment to address VAW. In 2009, a Presidential Decree was issued on the Law on the EVAW, but it was opposed in Parliament in 2013 and its current status is unclear.[71] In 2017, Afghanistan passed a law prohibiting human trafficking and migrant smuggling. The law was expected to be scaled up across the country, but security, corruption and warlord control have hindered its implementation.[72] The Penal Code in Afghanistan recognises VAW, violence against individuals with mental health conditions and trafficking as crimes.[73] The National Action Plan for the Women of Afghanistan (NAPWA) (2007–17) aimed to pursue gender equality and women's empowerment through intersectoral strategies to prevent VAW. The country has experienced a shortage of lawyers to advocate for women's rights, but women's activists are working to prevent VAW and support improved mental health of women survivors of violence (see *Table 3*).[74]

Afghanistan made efforts to improve the mental health of its population. The National Mental Health Strategy (2011–5) aimed to promote mental health, tackle stigma and discrimination associated with mental health conditions; reduce the impact of mental health conditions on individuals, families and the community; prevent the development of mental health problems and mental health conditions; and provide quality, integrated, evidence- and rights-based care for people with mental health conditions. However, implementation of the strategy was challenging due to chronic and multiple conflicts and an underdeveloped mental health infrastructure in an existing weak health system.[75] The country has recently introduced the National Mental Health Strategy 2019–23, which aims to improve access to services, increase mental health resources and strengthen the capacity of mental healthcare providers to respond to the population's mental health needs. It also includes developing an integrated programme and package of mental health services and support to women survivors of violence.[76] With the recent change in government in Afghanistan, the progress in its implementation is unclear.

In India, the government has committed to gender equality. In its Preamble, Fundamental Rights and Duties, the Constitution states that women have rights and are equal under law.[77] India passed the Protection of Women from Domestic Violence Act (PWDVA) in 2005. The Act articulates the legal rights, financial and other benefits to survivors of domestic violence. This Act has resulted in increased advocacy as well as organisations working to ensure its implementation.[78] In 2016, the Ministry of Women and Child Development developed a National Policy for Women.[79] One of its objectives was to eliminate all forms of VAW in India. This Policy, however, has not yet been launched. India also has the Nirbhaya Fund, which provides financial resources to programmes that support the safety and dignity of women.[80] In 2018, India passed an Anti-Trafficking Bill to protect, rescue and rehabilitate victims of trafficking.[81] The Bill takes a criminalisation approach to trafficking and sex work. However, due to poorly defined crimes and poor enforcement mechanisms, there have been low conviction rates (see *Table 3*).[82]

The National Mental Health Policy (NMHP) in India was implemented in 2014 and the National Mental Healthcare Act (NMHA) in 2017.[83] The NMHP aims to prevent mental health conditions and promote mental well-being and universal access to mental health services.[83] The Policy states that women should not be discriminated

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TABLE 3 Policies, legislation, strategies, plans and programmes on VAW and mental health in Sri Lanka, India and Afghanistan

Policies/ legislation	Afghanistan	India	Sri Lanka
Policies/ legislation addressing VAW	CEDAW (ratified)[51] Convention on the Rights of Persons with Disabilities (ratified)[52] Signatory on SDGs[55] and Palermo Protocol[56] Law on the EVAW[59] Afghan Civil Law and the Penal Code[61]	CEDAW (ratified)[51] Convention on the Rights of Persons with Disabilities (ratified)[52] United Nations Declaration on the EVAW (committed)[54] Signatory on SDGs[55] and Palermo Protocol[56] PWDVA (2005)[66] National Policy for Women 2016 (draft)	CEDAW (ratified)[51] Convention on the Rights of Persons with Disabilities (ratified)[52] United Nations Declaration on the EVAW (ratified)[53] Signatory on SDGs[55] and Palermo Protocol[56] The Prevention of Domestic Violence Act (2005)[76]
Plans/ programmes addressing VAW	NAPWA (2007–17)[60]	No data found/identified	National Plan of Action to address Sexual and Gender-based Violence (2016–20)[75]
Addressing trafficking	Afghan Civil Law and the Penal Code[61] Law Prohibiting Human Trafficking and Migrant Smuggling (2017)[60]	Anti-Trafficking Bill (2018)[71]	Convention on Preventing and Combatting Trafficking in Women and Children for Prostitution (Act No 30, 2005)[75]
Mental health strategy/policy	National Mental Health Strategy 2011–5[78] National Mental Health Strategy (2019–23)[78]	NMHP (2014)[68] NMHA (2017)[68] National Mental Health Programme (1982–Present)[81]	Mental Health Policy of Sri Lanka (2005–15)[96] Mental Health Policy of Sri Lanka 2020–30
Supporting survivors of conflict	No data found/identified	No data found/identified	No data found/identified
Integration of VAW and mental health strategies/ services	National Mental Health Strategy 2019–23 includes developing an integrated programme and package of mental health services and support to women survivors of violence[78]	One Stop Centres for women and children exposed to violence to obtain integrated services, including psychological, medical and legal services, in one location[74]	Gender and Women's Health Unit within the Family Health Bureau to address domestic violence within the health sector[76] Gender-based violence desks and friendly abode/Mithuru Piyasa/ Natpu Nilayam centres provide safe havens for women exposed to domestic violence and operate in tertiary care hospitals[77]

against in the provision of services. It also recognises the disproportionate burden of mental health conditions experienced by marginalised populations (e.g. victims of trafficking, those living in conflict, sex workers, children and sexual minorities). The government provides shelters for homeless women under its social welfare scheme,[84] along with other third-sector organisations which provide shelter for women exposed to violence. The country has also implemented One Stop Centres, state-sponsored service centres for women and children exposed to violence. These provide an opportunity for survivors to obtain integrated services, including psychological, medical and legal services, in one location (see *Table 3*).[85]

The Sri Lankan government has made several commitments to reduce women's exposure to violence and subsequent harm. These include the National Action Plan to Address Sexual and Gender-Based Violence (2016) to eradicate VAW and children using a multisectoral approach[86] and the Prevention of Domestic Violence Act (2005).[87] The country has also had some service developments, including a Gender and Women's Health Unit within the Family Health Bureau to address domestic violence within the health sector[87] and the establishment of Women's and Children's Desks at selected police stations, which aim to be the contact point for survivors and those who wish to report violence, as well as Gender-Based Violence desks and Friendly Abode/Mithuru Piyasa/Natpu Nilayam centres (56 centres in 21 districts) that provide support for women exposed to violence and operate in certain tertiary care hospitals.[46] Sri Lanka has also established the '1936' women's helpline and has been implementing gender mainstreaming programmes. The country also has field officers (Women's Development Officer, Child Rights Promotion Officer and Early Childhood Development Officer) working within communities to link people with available resources, and select police stations have Women's and Children's Desks as focal points for violence-reporting and survivor support, staffed by female officers (see *Table 3*).[46]

The government has shown commitment to address trafficking. Actions include the Convention on Preventing and Combatting Trafficking in Women and Children for Prostitution (Act No 30, 2005); standard operating procedures to identify and refer potential trafficking victims to protection services[88] and training sessions to identify trafficking victims for members of civil society and local, district and state officials, including health, probation, police, immigration, Criminal Investigation Department and National Child Protection Authority officials.[88] Despite these advances, there is a lack of public awareness on the legislation and rights around VAW and trafficking; poor co-ordination between government and NGOs working on VAW and trafficking with mental health services; a lack of shelters for women survivors of violence and trafficking; unequal distribution of resources and services (mainly available in cities); a lack of monitoring and follow-up of existing programmes and minimal funding allocated to the prevention of VAW, trafficking and mental health conditions (see *Table 3*).[89]

The Mental Health Policy of Sri Lanka (2005–15) was passed in 2005 with the aim of establishing community-based, comprehensive mental health services. The policy focused on several areas of mental health services, including service organisation, human resources, management at the national and provincial levels, research and ethics, stigma and mental well-being and the National Institute of Mental Health and mental health legislation.[90] Not all targets were reached under the previous policy, and the recently launched Mental Health Policy (2020–30) proposes to expand services by establishing at least one psychiatric centre or community psychiatric clinic in each Ministry of Health area around the country (see *Table 3*).

Mental health services

Mental health infrastructure has evolved across the three countries through activist grassroots organisations and governmental responses, but mental health services and their accessibility are limited by a range of individual and systemic barriers. Significant treatment gaps were identified in Afghanistan, India and Sri Lanka (see *Table 2*) with limited mental health human resources (*Table 4*). There was limited evidence on mental healthcare resources for women exposed to violence. It was not possible, therefore, to determine if women could safely disclose past or present experiences of violence within facilities, gain the care they needed and if there were adequate diagnostic assessments to understand the psychological impact of violence.

The government of Afghanistan has made some progress with mental health services. Due to the National Mental Health Strategy (2010–4),[91] and its revision in 2015, the integration of mental health services within each level of the healthcare system led to a 75% increase in the number of provinces with an integrated Essential Package of Hospital Services-based mental health services.[92] However, access to mental health care remains a challenge, especially for women. This challenge is attributed to the sociocultural context and ongoing conflict on women's ability to seek and afford health care, especially specialist health care. In addition, mental health stigma, limited awareness and low perceived

TABLE 4 Mental health resources in Sri Lanka, India and Afghanistan

	Afghanistan	India	Sri Lanka
Human resources (per 100,000)			
Psychiatrists	0.34[118]	0.30[80]	0.58[119]
Mental health workers	1.66[80]	1.93[80]	7.14[80]
Nursing officers	0.07[118]	0.80[80]	2.93[119]
Psychologists	0.35[118]	0.07[80]	0.29[119]
Facilities (N)			
Community-based mental health outpatient facilities	2622[118]	1217[80]	20[80]
Psychiatric hospitals	1[80]	136[80]	1[80]
Psychiatric units in general hospitals	4[80]	389[80]	36[119]
Mental hospital beds (per 100,000)	0.26[118]	1.43[80]	6.61[119]

needs and reliance on traditional healers remain barriers to seeking mental health care.[76]

Contributing to these challenges is the paucity of mental health human resources and facilities in Afghanistan. There were an estimated 0.34 psychiatrists, 0.07 nursing officers and 0.35 psychologists per 100,000 population. In addition to mental health outpatient facilities, there was one mental health hospital and four psychiatry units in general hospitals in the country. Afghanistan, therefore, relies on NGOs to provide mental health care under the remit of the Ministry of Health. Most of the NGOs and large public mental health services with trained service providers are located in the major cities (Kabul, Herat and Balkh), with other regions experiencing limited access to services.[93] According to a trans-sectional probability survey of the general population,[92] results showed that 19% of participants who reported any mental health problem received help at some point, with 12% receiving help within the last 12 months. There was regional variation in mental health help-seeking, from 4% in the Central highland region to 22% in the South. Results indicated that mental health help providers included the health sector and non-health sector (e.g. healer or religious leader). Access to mental health care was adversely influenced by the regional exposure to danger (i.e. number of attacks), traumatic events and clinical needs.[92]

India has demonstrated strong political and legal commitments to enhancing mental health services. Since 1982, the country has implemented the National Mental Health Programme,[94] which focuses on expanding access to care through capacity-building and incorporating mental health into primary care. The District Mental Health Programme (DMHP) was created to focus on scaling up services at the community level. By 2014, approximately 20% of districts had implemented a DMHP.[94]

Despite political and legal commitments, the implementation of mental health services has been challenging for India. The country faces a large treatment gap and a lack of accessibility. The most recent National Mental Health Survey of India[95] estimates that there is a large treatment gap for all mental disorders. For example, it is estimated that 85% of people with major depressive disorder do not access evidence-based care.[96] There is also a lack of evidence-based care, while women experience poorer mental health treatment compared to men.[50,97–102] Indeed, women with mental health conditions may be institutionalised without consent.[96] Adding to the treatment gap is the shortage of mental health service providers. The most recent estimates suggest that there are less than one psychiatrist (0.3) and two mental health workers, 0.12 nurses and 0.07 psychologists per 100,000 population.[93] According to the literature, this gap is attributed to seeking mental health care from faith healers[96] as well as a low perceived need for care, stigma[103–106] and discriminatory attitudes of healthcare providers.[103,107]

With the Mental Health Policy of Sri Lanka in 2005, community-based mental health care was prioritised. As a result, there was an increase in district hospital-based clinics, outreach clinics, home-based care, community support centres, domiciliary care, helplines and intermediate rehabilitation centres.[108] Although community services are available to all age groups, treatment services prioritise adults with severe mental disorders, including schizophrenia and substance use disorders.[109] In 2012, Sri Lanka initiated a screening

programme for postnatal depression, embedded in the national pregnancy care programme, but implementation has been uneven and limited.[14]

Sri Lanka faces a shortage of mental health resources. In 2017, Sri Lanka had 0.52 psychiatrists, 1.47 Medical Officers of Mental Health, 3.28 nursing officers and 0.25 psychologists per 100,000 population.[109] The specific needs of women survivors of violence are overlooked, reducing accessibility to available mental health services.[109] Estimates suggest that the treatment gap for common and severe mental health disorders, as well as substance use disorders, is high, at 68%. This treatment gap is attributed to stigma and limitations in cognitive and other forms of access to mental health services.[93]

Discussion

This study is the first, to our knowledge, to investigate data from Afghanistan, India and Sri Lanka on the mental health needs and context of women survivors of violence using a situation analysis tool. The evidence suggests that Afghanistan, India and Sri Lanka share similarities in terms of a lack of data, implementation of policies and legislation on all forms of VAW and limited recognition of women's mental health needs among survivors of violence. Further, there is a paucity of mental health service provision in these countries. These points should be considered in light of the scarcity of data on the topic.

The study showed that women in Afghanistan, India and Sri Lanka experienced multiple forms of violence, with most of the data on violence focused on that which is committed by a partner or family member.[12,15] We were unable to identify data on the percentage of women who had experienced conflict-related sexual violence, or on women who had been trafficked, illustrating gaps in the literature. The lack of data on conflict-related sexual violence and trafficking could be attributed to a fear of intimidation and retaliation against women survivors of conflict-related sexual violence as well as a lack of collection.[110] Similarly, the lack of data on trafficking could be attributed to the difficulty faced by community members, service providers and law enforcement officers in identifying survivors, incomplete reporting and a lack of services targeting trafficking survivors.[111] Without this information, it is difficult to develop prevention and intervention programmes for women survivors of conflict-related violence and trafficking with mental health conditions in these settings. Beyond being influenced by how violence research is designed and conducted (e.g. definitions and tools), the lower rates of VAW reported in Sri Lanka could be attributed to fear of not being believed, embarrassment, the normalisation of violence, protecting family reputation and lack of knowledge of options and support services.[34,112] Meanwhile, limited evidence from India suggests that domestic violence increased threefold during the COVID-19 pandemic.[113–115] There was a lack of data on the impact that COVID-19 has had on VAW in Afghanistan and Sri Lanka. Although we did not have specific age criteria, the data reported were based on estimates for women 15–49 years of age.

There was some evidence on mental health conditions, with limited data on the associations between women's exposure to different forms of VAW and symptoms of depression, suicidality and self-harm in India and Sri Lanka.[34] Scarce evidence was shown in Afghanistan among women exposed to violence and suicidal thoughts.[47] This lack of evidence could be attributed to the paucity of mental health resources and cultural conceptualisations of mental health.[116] Future research could investigate the bidirectional relationship between VAW and mental health conditions, with violence as a risk factor for, and consequence of, poor mental health. Prior evidence has shown a bidirectional, cumulative and dynamic interaction between mental health conditions and violence.[117] Indeed, mental health conditions may influence a woman's decision to stay in a violent relationship in choosing their partner and assessing their risk.[118] At the same time, poor mental health status among women experiencing violence may adversely influence their ability to safely leave.[119] These challenges are compounded by controlling behaviour, wherein women with poor mental health may be less able to protect themselves against violence.[119] The countries need to develop prevention policies and programmes to support women exposed to violence with mental health problems.

Although mental health policies were present in Afghanistan, India and Sri Lanka, a lack of resources and individual barriers contributed to poor policy implementation. For example, there are challenges to developing a standardised mental health infrastructure that addresses the needs of women survivors of violence. Evidence has shown that mental health providers may not be trained on how to identify or screen for VAW.[120] There is also a lack of clinical reporting of women exposed to VAW.[121] Due to limited health resources, the workload that mental healthcare providers have within these settings may prevent them from adequately and appropriately attending women exposed to violence.[122] Further, women survivors of violence have reported discrimination by clinicians.[123] To address these challenges, mental healthcare services could screen for VAW, with referral mechanisms to

specialised services and programmes. The services could ensure that mental health providers are appropriately trained to effectively treat women survivors of violence. In addition, there needs to be greater collaboration between community-based organisations and the mental health system to provide support networks for women survivors of violence.[123] Task-sharing, including the use of alternative technologies, is another strategy whereby non-specialists and community health workers can be trained to deliver mental health services for women survivors of violence.[124,125] Safety and confidentiality would be important considerations.

Evidence from the situation analysis illustrates an opportunity to develop mental health interventions, policies and programmes for women survivors of violence in the three countries. A targeted, intersectoral approach to identify and treat mental health conditions among women survivors of violence is needed, with a particular focus on designing, testing and refining interventions.[57,103,126,127] For example, there is a possibility of integrating mental and physical/sexual health and protection services with access to housing, legal and financial services as well clear referral pathways.[30,121] Integration implies ensuring the availability of adequate mental health services and appropriately trained service providers, flexible service hours, seamless referral to other services, greater community awareness of these services and the institutionalisation of a trauma-informed approach.[128]

We have identified some limitations to the study. Given that the analysis included sources in the public domain, it is important to consider the rigor with which the data were collected. Our analysis was limited by the data available, and their limited availability also precluded the direct comparison of findings across countries. For example, further research needs to be conducted on mental health resources in each country. In addition, some of the data collected and presented in this analysis are limited due to data collection and recruitment strategies, affecting the generalisability of findings. For example, approximately 69% of women respondents from the rapid online survey on spousal violence in India identified as being from upper and upper-middle income. Variability between regions, especially in a large country such as India, restricted our ability to assess the implementation of VAW and mental health programmes. Future research needs to be conducted on women's economic and employment opportunities in relation to violence exposure and poor mental health. It should be noted that the analysis for Afghanistan covers up until the country came under Taliban control again in 2021. Where feasible and safe, new research should be conducted on VAW since the Taliban took over. This analysis did not include engagement with political and professional stakeholders, service users and communities in the co-design of the situation analysis and interpretation of findings, but the wider work did involve qualitative data collection and engagement with survivors and service providers.[129–131]

The utility of this knowledge is to provide a roadmap for how services could be updated in future work centred within these settings. In addition, and as part of the larger programme of work, additional research is required on integrating mental health care within social care, identifying ways to incorporate trauma-informed approaches into service provision and addressing family violence.

Conclusion

This is the first study to investigate data from Afghanistan, India and Sri Lanka on women's exposure to violence and mental health conditions. Based on the findings, the three countries experience a lack of data, prevention policies and legislation on different forms of VAW and limited recognition of women survivors' mental health needs. There is also a paucity of mental health service provision in these countries. These findings have implications for the development of effective VAW prevention and mental health promotion strategies.

Community engagement and involvement

Community engagement and involvement was not included in the situation analysis. It was, however, part of the larger project, in which three different communities were involved, including survivors of domestic violence and human trafficking, counsellors, caseworkers, psychologists, psychiatrists and lawyers.

Equality, diversity and inclusion

Power differentials were considered across the entire, larger project in terms of knowledge and participant status. To address these power dynamics, one-to-one interviews were held with survivors of violence; we also engaged people with lived/living experience in workshops.

Additional information

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Data-sharing statement

Due to the methods employed in this article, there are no data that can be shared.

Ethics statement

Ethical permission for the research activities was granted by the UCL Research Ethics Committee (2744/007, 29 November 2018).

Information governance statement

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List of abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DMHP	District Mental Health Programme
EVAW	Elimination of Violence Against Women
IPV	intimate partner violence
NAPWA	National Action Plan for the Women of Afghanistan
NGO	non-governmental organisation
NMHA	National Mental Healthcare Act
NMHP	National Mental Health Policy
PTSD	post-traumatic stress disorder
PWDVA	Protection of Women from Domestic Violence Act
SDG	Sustainable Development Goal
SNEHA	Society for Nutrition, Education & Health Action
VAW	violence against women
WHO	World Health Organization

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Appendix 1 Main sources of data by country

Afghanistan

Websites from Ministry of Women's Affairs; Afghanistan Independent Human Rights Commission; WHO Mental Health Atlas (data is routinely collected every 3 years); US Department of State; Demographic and Health Survey (routinely collected household survey, every 5 years); and National Mental Health Strategy.

India

Websites from Demographic and Health Survey (routinely collected household survey, every 5 years); Ministry of Home Affairs, US State Department, Global Status Report on Alcohol, National Health Portal.

Sri Lanka

Websites from the Ministry of Women and Child affairs; Ministry of Health and Indigenous Medicine; Director of Mental Health; Family Health Bureau; National Child protection Authority Sri Lanka; Sri Lanka Police Children and Women Bureau; Department of Social Services; WHO Mental Health Atlas (data are routinely collected every 3 years).