A review of the Sri Lankan health-sector response to intimate partner violence: looking back, moving forward

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ABSTRACT
Intimate partner violence (IPV) is a major health concern for women worldwide. Prevalence rates for IPV are high in the World Health Organization South-East Asia Region, but little is known about health-sector responses in this area. Health-care professionals can play an important role in supporting women who are seeking recourse from IPV. A comprehensive search was conducted to identify relevant published and grey literature over the last 35 years that focused on IPV, partner/spousal violence, wife beating/abuse/battering, domestic violence, and Sri Lanka. Much of the information about current health-sector response to IPV in Sri Lanka was not reported in published and grey literature. Therefore, key personnel from the Ministry of Health, hospitals, universities and nongovernmental organizations were also interviewed to gain additional, accurate and timely information. It was found that the health-sector response to IPV in Sri Lanka is evolving, and consists of two models of service provision: (i) gender based violence desks, which integrate selective services at the provider/facility level; and (ii) Mithuru Piyasa (Friendly Abode) service points, which integrate comprehensive services at the provider/facility level and some at the system level. This paper presents each model’s strengths and limitations in providing comprehensive and integrated health services for women who experience IPV in the Sri Lankan context.

Key words: Intimate partner violence, health-sector response, models of service integration, Sri Lanka

INTRODUCTION
Intimate partner violence (IPV) refers to behaviours by a current or former intimate partner that cause physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.¹ IPV is a global public health issue, with one in three women worldwide at risk.² Based on global estimates published in 2013, the lifetime prevalence of physical and/or sexual IPV among ever-partnered women in the WHO South-East Asia Region was 37%, slightly higher than the estimated global average.¹

A substantial body of literature highlights not only the magnitude of the IPV problem, but also its short- and long-term health consequences for women, and the significant role that can be played by the health-care sector in responding to the needs of women experiencing it. However, because the experience of IPV is unique to each woman and her specific sociocultural-economic context,² it is less clear how best to support women’s efforts to seek recourse from IPV. Moreover, some practices that were formerly considered effective have been called into question. For example, in the past, evidence supported universal, opportunistic or at-risk screening to identify and offer services to women experiencing IPV.⁴ However, more recent evidence has shown that screening for IPV does little to improve a woman’s quality of life.⁵

Early discussions about health-sector responses to IPV were often guided by studies from North America and Europe,⁶ but emerging evidence from other regions has begun to contribute to this discourse. The WHO multicountry study on domestic violence has identified the need for context-specific data related to IPV.¹
Sri Lanka is home to more than 20 million people. It is emerging from a 30-year civil war, which ended in 2009, and provides a unique context to examine a health-sector response to IPV. This paper presents the results of a review that examined the Sri Lankan health-sector response to IPV, in light of service-integration models used in other low- and middle-income settings.

**METHODOLOGY**

A comprehensive search of published and grey literature was conducted using the key words IPV, partner/spousal violence, wife beating/abuse/battering, domestic violence and Sri Lanka, published from 1980 to 2015. The search included electronic bibliographic databases, websites, peer-reviewed journals and reference lists of articles and reports, as well as repositories and archives at universities and libraries in Sri Lanka. A preliminary search identified journal articles, reports, published and unpublished dissertations and theses, conference proceedings and media reports. Although Sinhala and Tamil are Sri Lanka’s official languages, an initial review of collected material revealed that almost all of the relevant work was published in English. The few peer-reviewed journals published in Sri Lanka are in English. The Sri Lankan Government – including the Ministry of Health – and nongovernmental organizations (NGOs) working with the health sector also produce most of their reports in English.

Based on the preliminary search and review, the authors also realized that much of the information about current health-sector response mentioned in agency reports, newspapers and electronic media was not captured in published and grey literature in a very timely manner. Therefore, several key personnel from the Ministry of Health, hospitals, universities and NGOs were also interviewed, to gain additional, accurate and timely information. After reviewing more than 230 abstracts and articles, 23 relevant publications were selected for detailed review. Findings from these publications, and information gathered through interviews, were reviewed and compared with service-delivery models in other settings. The findings are summarized in this paper, in light of the historical and current context of the health-sector response to IPV in Sri Lanka.

### A framework for service integration

Research about various health-sector responses to IPV reveals the complexities of designing, implementing and evaluating them.8 These complexities are evident in the lack of consensus about how to provide effective services to women in health-care settings. There is general agreement, however, that services need to be integrated into existing health-care programmes or systems, to ensure sustainability, uptake and effectiveness.9 However, there is debate about the most suitable entry points and about the most appropriate methods for integrating services into health-care systems.

An integration framework identified by Colombini et al.10 in their review of health-sector responses to IPV in low- and middle-income settings was used in this paper.10 They identified several models of service integration that have been replicated in a number of settings, and classified them, based on the range of options provided and the level and type of integration within and across health-care settings. At the lowest level of integration (Level 1), one or two services are offered in one health-care setting. For example, Family Counselling Centres in India provide immediate medical care and counselling to women seeking services.11 Because selective services are provided by one or more care providers at a single institution, Level 1 is categorized as selective provider/facility-level integration. At the next level (Level 2), a wider range of services is offered by one or more health-care staff within the same site/setting. The aim is to provide comprehensive services in one setting within one health-care institution. Colombini et al. offer the One-Stop Crisis Centre as an example of a Level 2 service-integration model.10 This model was developed in Canada, and later implemented in a number of settings worldwide, including Malaysia, Thailand, India and Bangladesh in the WHO South-East Asia Region.11 The highest level of integration, Level 3, offers the widest range of services at multiple sites/settings. A system of referral and back-referrals across multiple sites/settings provides for an extensive range of services with system-wide, seamless integration between different institutions. For example, the Woman Friendly Hospital Initiative in Bangladesh provides integrated services for women at multiple levels and different institutions, to provide comprehensive maternal and child care and management of violence against women, while ensuring quality of care and gender equity for women.12 The common classification system and identification of services with potential for scaling-up in low- and middle-income contexts make Colombini et al.’s service integration framework useful for the present review of the Sri Lankan health-sector response to IPV.

### RESULTS

In 1978, the Sri Lankan Government took the first step to formally address violence against women (VAW) through the establishment of the Women’s Bureau of the Ministry of Women’s Affairs. Since that time, successive governments in Sri Lanka have ratified five international gender focused policies:13 the Universal Declaration of Human Rights (in 1980),14 the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) (in 1981),15 the Vienna Declaration on the Elimination of Violence against Women (DEVAW) (in 1993),16 the Beijing Declaration and Platform for Action (in 1995)17 and the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women (in 2002), pledging to protect women and girls from all forms of violence directed against them. A number of mechanisms have also been instituted to support the implementation of these policies including: The Women’s Charter of 1993, which affirms the country’s commitment to CEDAW and DEVAW; the National Committee on Women, established in 1994 to address advocacy and policy issues related to VAW, gender discrimination and other breaches of women’s rights; and the National Plan of Action for Women, adopted in 1996 to identify and set action goals for the government.19,20
Early research on VAW in Sri Lanka focused on ‘wife abuse/battering’. The first study was published in 1982,\(^{21}\) and has been followed by other studies.\(^{22,23}\) These studies report a wide range of prevalence rates (from 18% to 72%) for IPV against women in various regions and of various ethnocultural and religious backgrounds. It is difficult to interpret these prevalence estimates because these studies spanned over 30 years, used different enquiry methods (quantitative, qualitative and mixed-methods), had wide variations in sample sizes (ranging from 24 to 2311), focused on a variety of subpopulations (urban, rural, tea-estate populations, low-middle social classes) and geographical locations (predominantly in Western, Central, North Central, Southern and Northern provinces), and employed different definitions/terms related to IPV.\(^{22,23}\) With respect to the latter, terms such as ‘violence against women’, ‘domestic violence’, ‘intimate partner violence’ and ‘gender based violence’ were often used interchangeably to refer to violence against women by marital or cohabiting male partners (even though traditionally some of these terms include non-partner violence). Most studies focused on Sinhalese women; only a handful of research included Tamil and/or Muslim women. The situation of women in the north and east of the country, areas that were predominantly affected by a civil war (from 1983 to 2009), is less well documented. Even though the war ended in 2009, reports suggest that women in the previously conflict-affected regions are more vulnerable to IPV,\(^{24,25}\) similar to women in other war-torn countries.\(^{26}\) Overall, information about IPV in Sri Lanka is limited, and even less is documented about the nature and quality of services available for women.

Sri Lanka has both publicly and privately funded health care.\(^{27}\) The Ministry of Health is responsible for overall health-policy formulation and governance, and public health-care funding at the national and provincial levels. The Family Health Bureau oversees maternity and child health programmes and has created a gender focal point. All formal IPV services provided through the state health system fall under the purview of the Family Health Bureau. The *National Policy on Maternal and Child Health* outlines the strategies for prevention and management of gender based violence issues and includes in its mandate capacity-building for health-care professionals and establishment of related services.\(^{28}\)

Historically, counselling services for women experiencing IPV in Sri Lanka were led by faith-based organizations, women’s rights groups, NGOs and civil society organizations.\(^{29}\) The Good Shepherd Sisters, Salvation Army and Family Planning Association were pioneers of such services in Sri Lanka, dating back to 1924.\(^{29}\) Currently, Women in Need, Sevelanka, Women’s Sarvodaya Collective and Women’s Development Centres are some of the better-known NGOs providing counselling, shelters, legal aid and financial support to women experiencing IPV.\(^{29}\) Despite their long history of service provision, especially among marginalized communities across the county, several barriers have made it hard for these agencies to provide consistent levels of service. First, civil society organizations in Sri Lanka have not received any substantial state support and have to rely on financial contributions from international NGOs and donors.\(^{20}\) Second, since the end of the civil war in 2009 the government placed restrictions on international and local NGOs’ access to war-affected areas.\(^{30}\)

Third, a tendency by government officials to label all NGOs’ work as anti-government or pro-separatist, affected their ability to work in Sri Lanka.\(^{24}\) NGOs allege that the government and state institutions have failed to ensure women’s rights and, as a result, failed both to recognize the need for IPV services, and to provide support for IPV service delivery in the country.\(^{30}\)

The earliest documented health-sector response to IPV in Sri Lanka was in 2002, when a short-term, pilot project was implemented in the North Central province.\(^{31}\) This initiative was mainly an awareness-raising programme in the form of a two-day training for doctors, nurses and midwives from local hospitals and the community. A specific service point was not established, and although the training was supported by hospital administration, there was limited commitment by staff and administration for continued IPV service provision.\(^{31}\) Alongside this training, all women attending the antenatal and gynaecological clinics of participating hospitals were screened for IPV and referred to a centre managed by an NGO (Sarvodaya) for counselling services. Building on the experience gained from this pilot programme, two service models were developed – Gender based violence (GBV) desks and *Mithuru Piyasa* (Friendly Abode) service points.

### Gender-based violence desks

One of the earliest health-sector initiatives to provide in-hospital services for women experiencing IPV was the GBV desk.\(^{29,31}\) GBV desks are service points for IPV-related care and counselling that make use of easily accessible first contact points for women in the hospitals, including outpatient and emergency departments, health education units and clinics. Dedicated spaces were identified in these locations to provide a private space to talk to women. Nurses and doctors from the hospital provide a limited range of services at GBV desks, including befriending (supportive listening), and referral to other in-hospital clinics/services. Because the number of hospital-based counsellors is generally quite limited, most GBV desks have had to rely on staff from local NGOs to provide services within the hospital.\(^{29,32}\) NGO staff have also been able to use their own networks and resources to offer women a wide range of services, including access to safe homes, legal aid and social services that are located outside the hospital setting.\(^{29,32}\) In fact, in some locations, NGO staff have identified the need for IPV-related services and worked with the local hospital administrators to establish GBV desks.\(^{32}\)

GBV desks played a key role in the north and east of the country during the civil war and after the Indian Ocean tsunami in 2004, when health-care services, in general, were disrupted.\(^{30}\) The large influx of foreign aid and funding for NGOs during the war and after the tsunami helped strengthen their resources and efforts. According to published reports, about 3000 women visited GBV desks across the country in 2009, but because the number of women seeking services was not available from all GBV desks in Sri Lanka,\(^{29}\) this is likely to be an underestimation of actual service utilization. Currently, there are 27 GBV desks in different parts of the country (personal communication, N Mapitagama) and they continue to play a
vital role in identifying women’s needs and referring women to appropriate services within and outside hospitals. However, a formal process for institutionalizing GBV desks was not established and, as a result, they continue to be perceived as an NGO-led initiative, even though government resources and funds are provided for them.

According to the service-integration model described earlier, GBV desks fit with Level 1 selective provider/facility-level services because of the limited range of services offered to women by one or more service providers. In other countries, Level 1 integrations tend not to provide referrals to outside service providers, however, because the GBV desks are regularly staffed by NGOs, a wider, multisite integration of services has been possible (albeit in an ad hoc manner). Although no efforts have been made to carefully evaluate the effectiveness of GBV desks in Sri Lanka, available information suggests that they have faced several challenges. For example, the sustainability of some GBV desks has depended on NGO support because hospital resources available for these additional services have been limited. In addition, NGO staff collaborating in service provision at GBV desks have reported a lack of support from hospital staff and marginalization by doctors at their hospital. At some GBV desks, care provision has been affected because hospital staff lacked knowledge about and/or held negative attitudes towards IPV.

GBV desks have the potential to be scaled up to a multilevel integration model, Level 2 or Level 3 service integration. The strength of the GBV desk model relates to its low resource utilization, which imposes little burden on already constrained human resources within hospitals. Similar NGO-led, hospital-based initiatives have been scaled up to national-level programmes in India and Bangladesh. However, in Sri Lanka, this service is being scaled down and in some cases replaced altogether by the second type of service provision (Mithuru Piyasa) described next. A detailed evaluation of GBV desks as a service-integration model could have proven useful for resource-poor settings that are seeking to introduce and/or integrate IPV-related services. Unfortunately, the lack of a formal evaluation of GBV desks means that, in the case of Sri Lanka, this opportunity may have already been missed.

**Mithuru Piyasa (Friendly Abode) service points**

The Ministry of Health commenced a formal process of institutionalization of hospital-based services in 2007, with the establishment of a service point at a government hospital in the Southern province. Similar NGO-led, hospital-based initiatives have been scaled up to national-level programmes in India and Bangladesh. However, in Sri Lanka, this service is being scaled down and in some cases replaced altogether by the second type of service provision (Mithuru Piyasa) described next. A detailed evaluation of GBV desks as a service-integration model could have proven useful for resource-poor settings that are seeking to introduce and/or integrate IPV-related services. Unfortunately, the lack of a formal evaluation of GBV desks means that, in the case of Sri Lanka, this opportunity may have already been missed.

In-hospital referral may include counselling services from a psychiatrist, reproductive health care from a gynaecologist, or trauma care from a surgeon, etc. Out-of-hospital referrals may include those to local NGOs providing short-term housing, counselling, legal aid or financial aid. As part of this initiative, awareness-raising and capacity-building activities have also been implemented, including training for hospital staff and public health staff working in the community, and posters and flyers about IPV that are targeted towards health-care professionals and the public.

Alongside the Mithuru Piyasa initiative, the Ministry of Health also implemented a health-promotion programme using a range of information, education and communication (IEC) strategies, including posters, a manual and a short film. These strategies aim to address community misperceptions about gender roles and promote healthy relationships among marital partners, for primary prevention of IPV.

The Mithuru Piyasa programme was led and funded by the Ministry of Health, as part of the state response towards addressing GBV. The United Nations Population Fund (UNFPA) and other international NGOs supported this initiative, providing resources and funding for staff training and capacity-building. There are currently 33 Mithuru Piyasa service points throughout the country and efforts are being made to set up additional centres countrywide (N Mapitigama, personal communication).

The Mithuru Piyasa model shares some characteristics with One-Stop Crisis Centres in other settings such as Malaysia, Thailand and India, in that it provides a comprehensive range of services for women at one setting. However, unlike the original One-Stop Crisis Centre model, the Mithuru Piyasa model allows for a much wider range of services and integration at multiple sites and levels. For example, hospital staff are able to refer women to out-of-hospital services because the training and capacity-building they receive through this programme enables them to identify local resources, create networks and formalize referral mechanisms with a range of service providers, including the police, NGOs and social services. This has allowed Mithuru Piyasa staff to provide shared, integrated services that are beyond the scope of a traditional One-Stop Crisis Centre. The awareness-building components of the programme for hospital staff and public health staff (for example, training workshops for doctors and nurses and introduction of relevant education content into public health midwives’ curricula) have also helped shift health-care professionals’ negative attitudes towards IPV care provision.

Service integration using the One-Stop Crisis Centre model has faced some challenges in other countries, including lack of collaboration within and between institutions, lack of commitment from health-care professionals, and low institutional capacity to provide supportive services. Although a formal evaluation of Mithuru Piyasa services has not been undertaken, they seem to face similar challenges. For example, some reports indicate lack of interprofessional and intersectoral collaboration. The Mithuru Piyasa model requires a high degree of collaboration between stakeholders, as it aims for multisite referral and seamless service integration.
beyond the provider/facility-level service integration achieved in the traditional One-Stop Crisis Centre model. Additionally, societal and cultural beliefs, in general, and gaps in health-care professionals’ knowledge and skills, in particular, negatively influence their responses to women experiencing IPV in the Sri Lankan context.34

**DISCUSSION**

Health-sector responses to support women experiencing IPV in Sri Lanka are evolving, and currently consist of two models of integration: GBV desks, with facility-level selected integration; and *Mithuru Piyasa*, a modified version of the One-Stop Crisis Centre model, with some system-wide integration.

GBV desks are the longest-standing service model within the health sector, offering services for women experiencing IPV in Sri Lanka. They are an example of an NGO-led initiative to introduce hospital-based services for IPV, similar to the early IPV services in the Maldives, Nepal, Papua New Guinea and Timor-Leste.31 Although limited in the range of services provided at one site, GBV desks have been supported by well-established local NGOs, allowing for system-wide integration of services beyond their individual settings. This service model does not place a heavy resource burden on already limited hospital resources, and has proven to be a well-utilized service, especially in conflict-affected areas.34 However, because they are widely perceived as an NGO-led initiative, hospital staff have generally failed to recognize their relevance and potential as an effective hospital-based service for IPV. A formal evaluation of the GBV model before the GBV desks are replaced could prove useful for resource-poor settings seeking to introduce and/or integrate IPV services into health-care systems.

The more recent *Mithuru Piyasa* initiative aims to provide comprehensive services, with some opportunities for system-wide service integration. *Mithuru Piyasa* is supported by Sri Lanka’s federal and provincial health systems, and is formalized using standard protocols and manuals. Parallel programmes of awareness-raising (staff training, capacity-building and development of IEC material) aim to create a supportive environment to increase uptake of these services.

Similar to the One-Stop Crisis Centre model in other countries, *Mithuru Piyasa* faces a number of future challenges. Although a formal evaluation of *Mithuru Piyasa* services has not been carried out, reports suggest that lack of intersectoral collaboration both within the health system and between stakeholders (government, NGOs) affect integrated service provision. There is also a lack of reciprocity for the NGOs providing out-of-hospital services. For example, the Ministry of Health relies heavily on NGOs to provide shelters to women as part of the comprehensive care package offered through the *Mithuru Piyasa* programme. However, these organizations do not receive government support for their efforts. Additionally, in the post-conflict context, NGOs at grassroots level face increasing restrictions in accessing funds and continuing their work in war-affected areas in the country.30 NGOs providing legal aid and financial support to women are discouraged by existing legislative and administrative barriers. Lengthy court proceedings and lack of support for women going through the legal process become barriers for agencies trying to help women seek legal remedies to address IPV.30

**CONCLUSION**

The GBV desks and *Mithuru Piyasa* service points have integrated IPV services into the health sector in Sri Lanka at the provider/facility and system-wide levels, respectively. GBV desks showcase an NGO-led initiative utilizing community capacity and resources without much dependence on government resources. *Mithuru Piyasa*, in contrast, is a state-led institutionalization of services, which is being scaled up to a national-level programme replacing the GBV desks. In moving forward from an NGO-led model to a government-led service, opportunities for building on the existing partnerships with NGOs have not been fully utilized. NGOs that continue to provide vital, out-of-hospital services to *Mithuru Piyasa* service points should receive the necessary programme and policy supports to continue such work. Expanding and strengthening partnerships with NGOs, and sharing information and resources with them, will facilitate better collaboration and coordination.

Evaluating existing services in terms of women’s access, utilization and outcome of services, as well as health-care professionals’ perceptions of and attitudes towards IPV, and their capacity and readiness to provide services, will help develop evidence-informed interventions to address these concerns. While considerable efforts are being put into establishing countrywide services for women experiencing IPV in Sri Lanka, parallel efforts are needed to address economic, political, social, cultural and other systemic factors that create and sustain gender inequality and oppression of women in general and the perpetration of IPV in particular.

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**REFERENCES**

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