Strengthening Health Policy Response to Address Intimate Partner Violence in the Sri Lankan Context

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1. Executive summary

This project aimed to strengthen the health sector response to Intimate partner violence (IPV) in Sri Lanka through collaborative, interdisciplinary partnerships, knowledge building and sharing, and policy change. Various knowledge generating activities we undertook further confirmed that IPV is a serious health issue that disproportionately affects some groups of women than others in Sri Lanka. We identified service integration models in use in Sri Lanka and highlighted the important, yet unrecognized, role played by non-governmental sectors which can be leveraged for a multi-level, multi-sectoral response. We also identified gaps in human resources, healthcare provider capacity, and tools to address IPV in Sri Lanka, and our findings highlighted the particularly urgent needs in post-conflict areas. Through integrated knowledge translation activities we strengthened existing partnerships while building new connections with stakeholders in Sri Lanka and Canada to promote evidence uptake for IPV-related research, practice and policy making in Sri Lanka. Consensus built through these activities helped bring policy makers together to set priorities for action beyond the health sector for solutions to address IPV. One of the key advances made through this project is building relationships with non-health sectors for future work, particularly in post-conflict areas in Sri Lanka, to explore ways of engaging and working with men using a multi-sectoral approach. The lessons learned through this collaborative project are most significant at this time as a national multisector action plan to address IPV is being drafted in Sri Lanka.

2. The research problem

Previous research pointed to high prevalence rates of IPV in Sri Lanka (ranging from 20–72%). However, IPV-related care and services were reported to be limited and overlooked within the health sector. There were considerable knowledge gaps about women's responses to IPV, and health professionals' engagement in IPV-related care. These were key limitations to developing culturally competent, context-specific strategies for improving health care professionals' response towards women who are experiencing IPV in Sri Lanka.

The overall goal of the project was to strengthen the health sector's response to IPV in Sri Lanka through collaborative, interdisciplinary, Canada-Sri Lanka research partnerships, knowledge-building and sharing, and policy change.

The project aimed to achieve this goal by developing new knowledge about 1) community-specific perceptions and responses to IPV among Sri Lankan women from different ethnic groups and of their attempts to seek recourse from abuse, 2) health care professionals' perceptions and responses to IPV.

Through various knowledge generating and sharing activities, the project identified barriers to developing a coordinated response to IPV in Sri Lanka, and provided the research evidence needed to support strategic policy and programming efforts. Further, through these activities we strengthened existing networks and built new collaborative partnerships, locally and internationally, that went beyond the health sector and the mainstream government agencies to

engage with community-based governmental and non-governmental agencies working at the grass-root level in urban, rural, and previously conflict-affected areas in Sri Lanka. The new knowledge gained and partnerships built helped determine the nature of support needed for practice and policy changes that would improve IPV care and services in Sri Lanka . Some of the recent changes in health sector approaches to addressing IPV in Sri Lanka are shaped by the knowledge and relationships built through this project; some of which will continue to evolve with time beyond this project's funding period.

The project's contribution to knowledge includes the following:

- From a research perspective, the project helped to clearly identify the knowledge gaps related to this topic in the Sri Lankan context, thus, inform the direction of further IPV-related research in Sri Lanka.
- It has contributed to capacity building among experienced and novice researchers in Sri Lanka and Canada to both independently and collaboratively move forward in pursing research in similar areas of work.
- From a development perspective, the project underscores the need for better health skills, tools, and resources for health care professionals in Sri Lanka, and calls attention to the urgent infrastructure and human resource gaps in post-conflict areas in Sri Lanka.
- From a policy perspective this work primarily calls for a better alignment of the health ministry's mandate in IPV-related policymaking with the Violence against Women framework under the Ministry of Women's Affairs and Child Development.

3. Progress towards milestones

Milestone	*Progress*	*Evidence*
Activity 1 – Review of literature	Achieved as planned. This includes; 1) a comprehensive synthesis of literature in Sri Lanka, 2) a summary of best practice guidelines in Canada, and 3) a summary of expert opinions from personnel in Sri Lanka and Canada. The knowledge generated about existing research, resources, and services was widely disseminated via various platforms including a website, newsletters, research reports, open-access journals, conferences, and symposia which are accessible to other researchers, students, community partners, service providers, and policymakers in both countries.	Please see Section 6 for a complete list of outputs. They are also listed on the project website www.addressingipvsrilanka.ca
Activity 2 – Research projects	Field work was completed for 6 sub-studies	
• Interviews with women	The first 3 of studies involved individual interviews with 60 women from 3 ethnic groups in Sri Lanka who had experienced IPV. Data collection and preliminary analysis are complete. Further thematic analysis is being carried out.	Five publications that are in preparation based on these studies. The publications will focus on women's experiences and responses to IPV across common and diverse contexts (ethnic groups, post-conflict area); variations in women's pathways to seeking recourse; the role of other agencies in shaping Sri Lankan women's response to IPV; engaging men in addressing IPV; children who witness violence in the private and public sphere in Sri Lanka. An abstract using preliminary data from these studies has been submitted (Please see Section 6 for details).
• Interviews with healthcare professionals	The second set of 3 studies focused on healthcare professionals' (nurses, midwives, and doctors) perceptions and attitudes towards IPV-related services.	The results will be published as four referred journal articles. Each paper will broadly focus on nurses, midwives, and doctors' experiences,

	In addition to completing 12 individual interviews, we have gathered survey responses from 355 doctors, nurses, and midwives working in hospitals and community health centers in the Western, Southern, Northern, and Eastern provinces in Sri Lanka (80% response rate based on the 440 proposed sample). Data entry and cleaning is being carried out. Data analysis is delayed because the data collection commenced later than originally envisaged. The long time taken to obtain ethics and administrative approvals from relevant institutions in addition to the approval taken for previous studies, to develop, validate, and pilot test data collection instruments, and then to train data collectors and conduct the data collection, affected the timeline for data analysis. A comprehensive data analysis will be completed in due course and the results will be disseminated as scholarly articles, lay summaries, infographics, etc. Results from the pilot study was shared with the stakeholders. This study is the largest healthcare professionals' survey about IPV-related care in Sri Lanka and the findings will be useful to highlight some of the urgent resource and training needs to the Ministry of Health and other relevant training institutions in Sri Lanka.	preparedness and training needs, and attitudes towards IPV related services in four provinces in Sri Lanka. Some of variables considered are number of women experiencing IPV seen by healthcare professionals, type of services provided, location, percentage followed up/referred and nature of care provided. The nature, frequency, duration of IPV-related training received by healthcare professionals and details about the trainer/institution, competency, adequacy of training.
	In addition to the above, 5 key informant interviews was conducted with services providers and researchers in Canada to consolidate findings from an environmental scan of policies/frameworks in four provinces in Canada (Ontario, Alberta, British Columbia, and Nova Scotia). Identifying best practices in the Canadian context proved to be challenging and time consuming due to lack of an overarching policy framework, and the service providers' lack of awareness about provincial frameworks.	Some of the results from this work has been presented or submitted as abstracts (please see Section 6 for details), and a manuscript based on this work is under preparation.

Activity 3 – National forums	Completed as planned. One the largest national forums on IPV was held at the Bandaranaike Memorial International Conference Hall in Colombo, on October 13, 2015 with the participation of more than 80 stakeholders from the Ministry of Health, Ministry of Social Services, NGOs, Police, Universities, UN organizations, and independent research institutions from different locations in Sri Lanka. In addition to the presentation of key findings from literature reviews and preliminary field work, a penal of speakers including the president of the SLMA, the national level policy representative from the Ministry of Health (the gender focal point), the executive director of the leading NGO (Women in Need), an international violence against women researcher/regional UNFPA representative, as well as a regional expert from the Tata Institute of Social Sciences, India, shared their own experiences related to research, advocacy, and evidence uptake. The forum participants divided themselves in 4 groups to discuss 4 areas: challenges faced by healthcare workers in providing IPV-related care; challenges faced by NGOs, social services, and others; challenges in post-conflict areas; and challenges in advocating for and implementation of preventive programs in Sri Lanka. The summary of the group discussions were presented to the large forum and the key points were summarized in a report to be shared with policy makers.	Please see Annex for a copy of the forum proceedings.

Activity 4 – Policy dialogue	Completed as planned Two half-day forums were held on October 13, 2015 and December 16, 2015 in Colombo to engage key policy makers including representatives from the Ministry of Health, Sri Lanka Medical Association, Ministry of Social Services, Universities, NGOs (Women In Need, Zonta Club, Community Concern, Sarvodaya), UN Agencies, WHO, independent research institutions, and public health and mental health specialists in Sri Lanka. Although one policy maker meeting was proposed, holding 2 separate meeting at different stages of the project helped on-going engagement with policy makers. The first meeting provided an opportunity to share key project findings and stakeholder views gathered during the national forum to identify key practice and policy problems, and the nature of support needed to address these problems. The second meeting specifically focused on discussing the way forward, in terms of the support needed and the project role in the multi-sectoral policy framework and action plan being proposed and drafted to address IPV in Sri Lanka.	A summary report of the national forum proceedings was shared with policy makers. Policy briefs highlighting key policy problems, options to address the problems (in terms of a multisector response), and considerations related to its implementation, is being developed in consultation with a small group of key stakeholders.
Activity 5 – Toronto Forum	Completed as planned. A meeting was held on January 20, 2016, at Ryerson University, Toronto with the participation of research team members (Vathsala Jayasuriya, Ilene Hyman, Robin Mason, Karline Wilson-Mitchel), Sri Lankan collaborators (Dr. Nalika Gunawardena, SLMA and Sujatha Senevirathne the University of Sri Jayewardenepura); Firdhosi Mehta, former WHO country lead in Sri Lanka, and Rajini Tarcicius from	A summary document outlining policy frameworks in 4 provinces was shared with the attendees (Please see Annex for a copy of the summary).

	Jane Finch Community and Family Centre in Toronto. The forum provided an opportunity to share learnings from both Sri Lankan and Canadian contexts and to explore further IPV-related research in low-middle income countries and among immigrant women in Canada. Following this forum, the Canadian and Sri Lankan Collaborators' submitted a joint proposal to hold a knowledge sharing event with the Sri Lanka Medical Association, which is planned to be held in October 2016 as part of their annual academic sessions.	

4. Synthesis of research results and development outcomes

1) Identify current gaps in knowledge, skills, and resources, as well as best practices/innovative initiatives to address/prevent IPV in healthcare delivery in SL

A comprehensive synthesis of literature and gathering expert opinions about existing research, resources, and services helped to consolidate research-based evidence over the last 35 years about IPV in Sri Lanka and to identify gaps in knowledge, skills, and resources to inform future research as well as practice and policy changes.

- IPV prevalence rates in Sri Lanka are based on studies from a few provinces and experiences of legally married women. The nature and extent of the problem in diverse geographical settings and among women in cohabiting/dating relationships are not known. Individual, family, and societal risk factors for IPV have been studied, but their complex relationships have not been comprehensively investigated, particularly in the context of the post-conflict situation in the country.
- Health consequences of IPV have been reported, with particular attention to women's physical health effects. Mental health consequences of IPV are not well known.
- There is also evidence that women experiencing IPV do not disclose it and/or recourse for IPV in Sri Lanka. Those who seek help primarily turn to their family, friends, neighbors, and community members such as religious leaders. Few women seek help from hospitals, police, and agencies providing IPV-related services. Most reports do not lead to legal action against their abuser.
- There is a lack of published up-to-date work and grey literature about the current health-sector response to IPV in Sri Lanka. In Sri Lanka, as is the case in many other countries, health sector response to IPV has been slow, limited to a few centers (i.e. Gender Based Violence (GBV) desks and Mithuru Piyasa service points.
- GBV desks utilize an NGO-led approach that rely on community resources without much dependence on government resources. Mithuru Piyasa, in contrast, is a government-led initiative which is being scaled up to the national-level (in essence, 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, they lack necessary program and policy supports to continue their work.
- A review of studies evaluating programs and interventions that engage men in addressing and/or preventing IPV in the global context over the last 20 years revealed several gaps in knowledge. Engaging men in behavior change is complex, and there is a lack of evidence about effective ways of engaging men from diverse backgrounds and in countries like Sri Lanka and Canada.

2) Strengthen existing research networks and build sustainable, mutually-beneficial, collaborative relationships with community, academic, and policymaker partners at different levels in SL and Canada.

- The collaborative approach in knowledge generating and sharing was mutually beneficial in a number of ways. For example, Sri Lankan partners provided access to unpublished material, connected the Canadian team with additional relevant/key stakeholders especially beyond the health sector, and helped to contextualize the findings in light of the changing social and political situation in the country.
- The Sri Lanka Medical Association (SLMA) served as a strategic local partner for the national forum that was held in Colombo Sri Lanka that was attended by more than 80 stakeholders representing various sectors. In particular, the SLMA's women's health committee has been addressing health care response to IPV for many years, and as such, its chairperson's role as collaborator was highly significant in the local context. The national level highest policy representative from the Ministry of Health (the gender focal point), medical practitioners, women- and children-focused NGOs, multidisciplinary academics, and representatives from WHO, the police, legal aid, NGOs providing IPV-related services, social services, and community agencies attended the forum and helped to identify key issues and set priorities for research and action. Practice and policy gaps in terms of women's access to services, lack of services in post-conflict areas, and challenges to engaging and working with men were highlighted.
- Attendees valued the opportunity to meet stakeholders from different sectors, and provinces within the country, as well as an opportunity to hear from and network with regional (i.e South Asian), Canadian, and other international experts on the topic.
- Providing simultaneous translations in 3 languages (Sinhala, Tamil, and English) made is possible for participants from different parts of Sri Lanka to fully engage in the proceedings and the discussions in their language of choice.
- This forum created awareness about the project at the national level and ensured stakeholder and policy maker buy-in and support in subsequent meetings.

3) Generate new knowledge that can inform practice and policy changes to improve care and services to women experiencing IPV in SL.

To generate new knowledge, we planned two sets of studies to address the following research questions: 1) What are the pathways through which Sinhalese/Tamil/ Muslim women in different geographical settings in SL seek recourse from IPV?, 2) What are the perceptions of and responses to IPV among nurses/midwives/doctors in Sri Lanka (vis-a-vis their gender sensitivity, attitudes towards screening, risk assessment, counseling, record-keeping, and networking with regards to IPV services)?

The first 3 studies involved individual interviews with 60 Sinhalese, Tamil, and Muslim women with experience of IPV from the Western, Southern, Northern, and Eastern provinces in Sri Lanka.

- Preliminary findings from these interviews showed the diverse experiences of IPV for women in different areas. Women's experiences of and response to IPV were both similar and heterogeneous within their specific social cultural, religious, and ethnic contexts. For example, a general societal impunity to violence increased women's vulnerability to IPV

across the country, however, in post-conflict areas, fear of ethno-centric community violence also entrapped women in abusive relationships.

- The intersectionality perspective that guided this work helped revealed how gender, class, ethnicity, and culture, intersect to create a disproportionately higher risk of IPV for some women than others. Emerging results were presented to policy makers in Sri Lanka and provided useful insights into how this knowledge can be used to set priorities for action as set out in objective 4.

The second set of studies involved interviews with healthcare professionals about their perceptions and attitudes towards IPV-related services in healthcare institutions and the community. This study among 400 participants is the largest survey about healthcare provider attitudes and perspectives about IPV-related care in Sri Lanka, to date.

- Preliminary findings show that doctors, nurses, and midwives' they lack of confidence, resources, and tools to provide IPV-related services to women. Short-term training programs they feel do not prepare them adequately to deal with the complexities of IPV experiences.
- Applying an ecological framework to the analysis shows that the current health sector is based on an individual approach to providing care, without addressing the meso and macro level determinants of IPV. Preliminary findings from this study were shared at the large national forum held in Colombo which was attended by officials from the Ministry of Health to highlight some of the urgent resource and training needs in Sri Lanka.

4) Determine the nature of and support for policy changes that would improve IPV care and services in Sri Lanka.

This objective was achieved through a number of inter-connected and related activities. In addition to the knowledge gathering, synthesis, and sharing at the large national forum, holding 2 meetings with more than 25 key policy makers provided opportunities to discuss key practice and policy problems, and seek options to address these problems. The second forum specifically focused on the way forward, in terms of the nature of support needed in support of a multisector response.

5) Advance the health sector's response to IPV in Canada

Key informant interviews with services providers, researcher scientists, and academics in Canada, an environmental scan of policies, frameworks, guidelines, and practices with regards to IPV-related services in four provinces in Canada (Ontario, Alberta, British Columbia, and Nova Scotia) revealed significant knowledge and policy gaps.

- The response to IPV in Canada appears uncoordinated. National and provincial Action Plans (where they exist) outline the need for uniform definitions and standard protocols for providing services to women experiencing IPV. However, there is a lack of congruency between the community/institutional level actions and the principals of practice outlined in the Action plans.

Interviews with frontline workers who provide services to the Tamil community in the GTA showed that:

- Newcomer immigrant women's access to healthcare is often limited, due to individual and systemic barriers to accessing formal healthcare services.
- Tamil immigrant women are more likely to seek support from informal networks and Tamil community agencies than from formal health services when experiencing IPV.
- Increasing outreach capacity (using ethno-specific and mainstream media) and helping frontline agencies to create community spaces for newcomer women could help them gain access and benefit from formal healthcare services.

One of the significant findings is related to our understanding about the nature of support needed and provided to women experiencing IPV in the context of restrictive conditions. Women's perceived needs were related to helping the men overcome conditions that result in violence (such as providing services to overcome alcohol and drug abuse, addressing psychosocial health needs in post-conflict, etc). The health sector role was oriented towards helping women to 'deal' with the consequences of abuse as conceptualized from a biomedical/ 'curative' model. Evidence of effective interventions that engage and work with men to address IPV, which could be useful to address this discordance in needs and responses, appeared to be a significant knowledge gap. A critical review of available evidence about interventions that engage men from low-middle income was conspicuous in its absence in the global literature.

Research impact

There has been significant knowledge uptake from this work, although the direct impact is too early to notice, and likely to continue beyond the short term of the protect funding.

The project website was recognized as an important collection of resources about IPV-related services and publications in Sri Lanka on social media by local advocates and service providers.

Publications in the WHO-South East Asia journal of public health, and the Ceylon Medical journal were recognized as significant scholarly contributions by local and regional researchers with some results being tweeted by UN women Asia.

Members of other research groups and networks have shown a keen interest in forthcoming publications and recommendations from the national forums and stakeholder meetings. International violence against women researchers have shown a particular interest in our findings related to engaging and working with men, and best practices in the Canadian context.

Ethics issues

Ethical issues related to field work was navigated effectively through careful planning, detailed protocols, and safety measures put in place. Based on our previous research experience, we were aware that in this setting, some women are resistance and reluctant to put their signature on documents, without the consent of the men (who are considered the head of the household). This can post a problem if we were to require a signature on the consent form, especially in this study of IPV, where women's involvement needed to be concealed from the men. Therefore,

ethics review committees allowed the research assistants to confirm participants consent (once it is given) by signing the form on behalf of the women.

Potential uptake of project results within 3 years of the end of the project.

The survey among healthcare professionals has the potential to inform and support similar studies in Sri Lanka and the South Asia region, to highlight some of the issues related to gender sensitivity, attitudes, and perceptions towards IPV-related service provision within the social, cultural and political contexts. The finding from this study will inform the nationwide training program aimed at capacity building of healthcare staff. The national-level coordinator who attended the national forum will receive key recommendations based on the results of this research. Overall, the project has the potential to be cited as a successful, mutually-beneficial north-south research collaboration.

5. Methodology

The studies used mixed-methods including informal interviews, group discussions, one-on-one interviews, and surveys. Sixty women who had experiences of IPV and 355 doctors, nurses and midwives working in hospitals and public health units (Medical Officer of Health units – MOH) in the Western, Southern, Eastern and Northern provinces of Sri Lanka participated the 2 sets of studies.

Semi-structured interview guides and a self-administered survey forms were used to gather data. Development of study instruments was guided by informal interviews and early data collection. A panel of local experts including an experienced senior health researcher, sociologist, a psychiatrist, a nurse, and a midwife independently reviewed the relevance of the survey questions to the local context.

The data collection and analysis were done simultaneously so that early findings could inform and guide the subsequent interviews. Data analysis was guided by the intersectionality perspective and an ecological framework. The ecological framework helped clarify how individual health is influenced by micro (family), meso (community), and macro (societal) systems. These theoretical lenses revealed that the current health sector response to IPV is contextualized as individual experiences, and as a result, failed to provide an integrated, collaborative effort that is supported by a range of stakeholders within and beyond the health sector.

Qualitative data were transcribed verbatim and in the spoken language, and coded using inductive thematic analysis method. Measures to improve trustworthiness of results, including member checks within interviews and between interviews, participant feedback on emergent findings, and agreement between coding among researchers, etc., was used.

Quantitative data were entered, random checks done for accuracy, and analyzed using SPSS (version 32).

Qualitative methods of research are not commonly used in health care settings in Sri Lanka, and some of the challenges to knowledge uptake could be related to lack of awareness about the methods. For example, some of the hospital administrators are more familiar with survey methods than in-depth interviews, and as a result are more likely to receive the findings from surveys as more useful for hospital practice. However, during local knowledge sharing events, stakeholders recognized the usefulness of narratives and rich qualitative data in highlighting women's experiences and responses to IPV.

Also the project helped to build capacity among local researchers and graduate student research assistants in qualitative research methods as well as provided opportunities to disseminate this work among their peers. Many of them are encouraged to use qualitative methods in their own areas of work related to IPV.

6. Project Outputs

Outputs planned	Completed	Expected
A comprehensive synthesis of literature in SL, a summary of literature and best practice guidelines in Canada, and a summary of expert opinions from personnel in SL and Canada on current gaps in knowledge, skills, and resources in SL	The review of existing research, resources, and services, and some of the early findings from the studies were widely disseminated via various platforms including a website, newsletters, research reports, open-access journals, conferences, and symposia which are accessible to other researchers, students, community partners, service providers, and policymakers in both countries.	One of the key knowledge gaps is related to interventions that engage men in addressing IPV. A critical review of available research of interventions that engage men has been completed, some of the results have been presented at conferences, and a manuscript based on this work is under preparation.
A website for information generated by the project that aggregates data on existing research, resources, and services within the country	The project website www.addressingipvsrilanka.ca provides details about: • Services available in Sri Lanka with a map of Sri Lanka showing the location of services • National policy documents, conventions, regulations, and laws • Country reports • Link to journal articles	To be regularly updated
Symposium proceedings posted on our website to ensure wider access	See www.addressingipvsrilanka.ca Proceedings of the national forum was posted on the project website to ensure wider access, improve awareness of the project, and help gain community support.	
Plain language summaries of the project findings in Sinhalese, Tamil, and English and made available on our website	Creating plain language summaries of the project findings in local languages Sinhalese and Tamil helped share knowledge with nurses and midwives in newsletters and via the website.	Research findings to be presented as infographics and lay summaries in all 3 languages

Research reports and publications in open-access journals (providing opportunities for student co-authorship and ensuring wider access to LMIC	Findings were published in peer-reviewed open accessed journals relevant to and accessible to healthcare providers/healthcare sector in South Asia (South East-Asian Journal of Public Health, the Ceylon Medical Journal, which is the the only indexed, peer-reviewed, open-accessed journal in Sri Lanka, and the Journal of the College of Community Physicians of Sri Lanka, the official publication of the foremost professional body of public health practitioners in Sri Lanka.	Research reports, and journal articles are being developed using data from the research projects
Presentations at SL, Canadian, and international forums (with co-authorship opportunities for students, new/emerging researchers, and healthcare practitioners engaging in our research projects in SL	Peer-reviewed and invited presentations in Sri Lanka and Canada provided opportunities to disseminate findings to different audiences, and for the project collaborators, and research assistants in Sri Lanka and Canada to become co-authors. Students, new/emerging researchers, and healthcare practitioners engaged in similar research projects in Sri Lanka were invited to present their work at the national knowledge sharing forum to create opportunities for others to disseminate their work and identify common areas for further collaborative work. More than 12 research assistants (RAs) in Sri Lanka and Canada have received training in research methods, data collection, research ethics, data analysis, and report writing during their involvement in project work. Research assistants were given opportunities to present their work at the large national forum held in Sri Lanka. See Section 6 for a list of presentations	Further opportunities to present research and co-author work will be available from the research data.

A book highlighting project findings, methodologies, processes implemented, and the health sector response to IPV	An edited book highlighting project findings, methodologies, processes implemented is being commissioned to be published in Sri Lanka. Sri Lankan collaborative partners, health and social science scholars, service providers, and community leaders were invited to submit book chapters reflecting on the social, political, legal, and health dimensions of IPV in the Sri Lankan context.	Although this was proposed to be completed in the first year, this is more useful as an end-of-project reflection capturing the lessons learnt, as well as the perspectives of various stakeholders who have been part of this project.
Best-practice guidelines and policy briefs	Information about best practices in the Canadian context has been presented at conferences and a manuscript based on this work is under preparation. Proceedings of the national forum was published and distributed among policy makers.	A summary of best-practice guidelines and policy briefs is being developed in collaboration with key stakeholders in Sri Lanka and Canada.

Details of outputs

Manuscripts (published):
Guruge, S., Jayasuriya-Illesinghe, V., & Gunawardena, N. (2015). A Review of the Sri Lankan health sector response to intimate partner violence: Looking back, moving forward. *South-East Asian Journal of Public Health, 4*, 6-11. Available at http://www.searo.who.int/publications/journals/seajph/issues/srilankanhealth.pdf

Guruge, S., Jayasuriya-Illesinghe, V., & Gunawardena, N. (2015). Time to step up: A review of the health sector response to intimate partner violence in Sri Lanka. *Journal of College of Community Physicians of Sri Lanka, 20,* 57-61. doi: 10.4038/jccpsl.v20i1.8071

Guruge, S., Jayasuriya-Illesinghe, V., Gunawardena, N., & Perera, J. (2015). Intimate partner violence in Sri Lanka: A scoping review. *Ceylon Medical Journal, 60*, 133-38. doi: 10.4038/cmj.v60i4.8100

Manuscripts (under-preparation):
Guruge, S., Jayasuriya-Illesinghe, V., & Wang A. Interventions and programs that engage men in addressing IPV against women: an ecological approach.

Plain-language summaries:
Guruge, S., Jayasuriya-lllesinghe, V., Gunawardena, N., & Selvadurai, M. (2015). A review of the Sri Lankan health sector response to intimate partner violence (Tamil). New Vision: Publication of the Graduate Nurses foundation of Sri Lanka.

Guruge, S., Jayasuriya-lllesinghe, V., Gunawardena, N., & Selvadurai, M. (2015). A review of the Sri Lankan health sector response to intimate partner violence (Sinhalese). New Vision: Publication of the Graduate Nurses foundation of Sri Lanka.

Guruge, S., Jayasuriya-Illesinghe, V., & Zahreddine, L. (2015). Intimate partner violence (IPV) initiatives in Canada: A summary.

Reports and proceedings
Guruge, S. & Jayasuriya-Illesinghe, V. (2015). Looking back, moving forward: Proceedings of the knowledge sharing forum in Colombo, Sri Lanka.

Conference presentations:
Guruge, S., Jayasuriya-Illesinghe, V., Gunawardena, N., & Mahendran, R. (submitted). *Children's exposure to parental intimate partner violence: emerging findings from a multisite qualitative study in Sri Lanka*. Submitted to the International Medical Congress, Sri Lanka Medical Association. July 24 - 27, 2016.

Jayasuriya-Illesinghe, V., Chan, J., & Guruge, S. (Submitted). *Improving newcomer immigrant women's access to healthcare for intimate partner violence in the GTA: Tamil community workers' perspective*. Submitted to the Annual Graduate Research Association of Students in Public Health Research Symposium, York University. May 18, 2016.

Jayasuriya-Illesinghe, V. & Guruge, S**.** (Submitted). *Estimating intimate partner violence prevalence among immigrant women in Canada: Implications for practice and policy*. Submitted to the Annual Graduate Research Association of Students in Public Health Research Symposium, York University. May 18, 2016.

Guruge, S., Jayasuriya-Illesinghe, V., & Chan, J. *Perspectives from the frontline: Tamil immigrant women's access to intimate partner violence services in Canada*. (Submitted). APHA 2016 Annual Meeting & Expo. Oct. 29 - Nov. 2, 2016.

Jayasuriya-Illesinghe, V. & Guruge, S. (Accepted). S*caling up health sector response to intimate partner violence (IPV) in Sri Lanka: Implications of adapting the Canadian One Stop Crises Center model*. To be presented at Sparking Population Health Solutions. Ottawa, ON. April 25 - 28, 2016.

Guruge, S., Jayasuriya-Illesinghe, V., & Zahreddine, L. (Accepted). *Putting action plans to action: Policy, procedure, and frameworks for providing services to women experiencing IPV in Canada*. To be presented at Sparking Population Health Solutions. Ottawa, ON. April 25 - 28, 2016.

Guruge, S., Jayasuriya, V., & Selvadurai, M. (2015, June 2). *Are we there yet? A critical review of the health sector response to intimate partner violence in Sri Lanka*. Presented at the Canadian Domestic Violence conference. Toronto, ON.

Guruge, S., Jayasuriya, V., & Selvadurai, M. (2015, June 9). *A critical review of the literature on sexual intimate partner violence in the Sri Lankan context*. Presented at the Daphne Cockwell School of Nursing 7th Research Day: Research leadership: Leveraging intervention research for better outcomes. Toronto, ON.

Guruge, S., Jayasuriya, V., & Seifi, S. G. (2015, June 9). *A Review of Literature on Interventions and Programs that Engage Men in Preventing Intimate Partner Violence.* Daphne Cockwell School of Nursing 7th Research Day: Research leadership: Leveraging intervention research for better outcomes. Toronto, ON.

Jayasuriya, V., Guruge, S., Gunawardena, N., & Selvadurai, M. (2015, July 8). *A scoping review of Intimate Partner Violence services in Sri Lanka: opportunities and challenges*. 128th Anniversary International Medical Congress of the Sri Lanka Medical Association. Colombo, WP. http://conference.slma.lk/

Bhagya, U. (2015, October 13). *A data collector's experiences interviewing women who have experienced intimate partner violence (IPV) in urban and rural areas in Sri Lanka.* Presented at Looking back: Moving forward, Knowledge sharing forum. Colombo, WP.

Mahendran, R. (2015, October 13). *A data collector's experiences interviewing women who have experienced intimate partner violence in Batticaloa district, Sri Lanka*. Looking back: Moving forward, Knowledge sharing forum. Colombo, WP.

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Invited presentations:
Guruge, S., & Jayasuriya-Illesinghe, V. (Accepted) *Limitless: Building partnerships through collaborative research & knowledge exchange*. Faculty of Community Services, Faculty Achievement event (2016, April 7). Toronto, ON.

Guruge, S., & Jayasuriya-Illesinghe, V. (2016, January 25). *Strengthening health policy response to address IPV in the Sri Lankan Context: Project overview and findings*. Scholarly, Research and Creative Colloquium, Daphne Cockwell School of Nursing, Ryerson University. Toronto, ON.

Jayasuriya, V. (2015, March 18). *Researching IPV in Sri Lanka: The transnational experience and the global context*. Guest lecture organized by the Women's Health Expert Committee, Sri Lanka Medical Association, Department of Community Medicine, University of Colombo. Colombo, WP.

Online resources
www.addressingipvsrilanka.ca provides links to:

- Services available in Sri Lanka (Gender equality/women's empowerment organizations, Community development /empowerment organizations, Community development /empowerment organizations with a women's program, Psychosocial support organizations, Community health organizations, Children's organizations, Legal Aid organizations, Youth organizations, Human Rights Organizations, Religious organizations)
- Location of services on a Sri Lanka map
- National policy documents, conventions, regulations, and laws
- Country reports
- Related publications

7. Problems and Challenges

While the project began with the support of an extensive network of community partners, participant recruitment required building even wider networks. Having a research team with extensive community contacts (outside of established organizations) proved to be an asset in working with diverse communities. Agencies which have long history of involvement and pre-existing working relationships with the investigators tend to be more eager to contribute to collaborative work.

Recruiting women for a study related to IPV is challenging in any setting/country, and it was even more so to do so in two different languages and in four provinces of Sri Lanka that included post-conflict locations. Even though the conflict has ended there are some areas still under military control and research in such areas is still met with administrative barriers.

8. Administrative Reflections and Recommendations

None

Annex

Review

Access this article online
Website: www.searo.who.int/publications/journals/seajph
Quick Response Code:

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

Sepali Guruge[1], Vathsala Jayasuriya-Illesinghe[1], Nalika Gunawardena[2]

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

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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.[2,3] 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.[3]

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,[6,7] 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 Mapitigama) 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,[10] 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;[31] 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.[32] At some GBV desks, care provision has been affected because hospital staff lacked knowledge about and/or held negative attitudes towards IPV.[32]

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.[31] 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 already have 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.[31,33] Similar to the GBV desks, *Mithuru Piyasa* centres are also located in easily accessible outpatient and emergency care settings within hospitals. Women may self-identify as needing services and visit a *Mithuru Piyasa* centre, or may be referred by health-care staff from clinics/wards within the hospital. Nurses and/or doctors greet women and take on the role of a befriender, helping women to feel comfortable about discussing their concerns related to IPV. A detailed history is taken, to assess women's health status and to identify their immediate care and service needs. Following this, they may be offered in-hospital and/or out-of-hospital services, through an already established system of referrals. 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.[31] 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.[31,33]

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.[28] 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.[10,31] 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.[10] 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.[22,23,32] 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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Intimate partner violence in Sri Lanka: a scoping review

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(Index words: intimate partner violence, scoping review, violence against women, Sri Lanka)

Abstract

South Asia is considered to have a high prevalence of intimate partner violence (IPV) against women. Therefore the World Health Organisation has called for context-specific information about IPV from different regions. A scoping review of published and gray literature over the last 35 years was conducted using Arksey and O'Malley's framework. Reported prevalence of IPV in Sri Lanka ranged from 20-72%, with recent reports of rates ranging from 25-35%. Most research about IPV has been conducted in a few provinces and is based on the experience of legally married women. Individual, family, and societal risk factors for IPV have been studied, but their complex relationships have not been comprehensively investigated. Health consequences of IPV have been reported, with particular attention to physical health, but women are likely to under-report sexual violence. Women seek support mainly from informal networks, with only a few visiting agencies to obtain help. Little research has focused on health sector responses to IPV and their effectiveness. More research is needed on how to challenge gendered perceptions about IPV. Researchers should capture the experience of women in dating/cohabiting relationships and women in vulnerable sectors (post-conflict areas and rural areas), and assess how to effectively provide services to them. A critical evaluation of existing services and programms is also needed to advance evidence informed programme and policy changes in Sri Lanka.

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Introduction

Intimate partner violence (IPV) is defined as physical, sexual, and/or emotional abuse by a current or former marital or non-marital partner in the context of coercive control [1]. Most victims of IPV worldwide are women. The World Health Organisation recently reported that South-East Asia had a high prevalence of physical and sexual IPV among ever-partnered women worldwide (37.7%) [2]. A review of data from 81 countries revealed that South Asia has the second highest prevalence of IPV (41.7%) [3]. Context specific information about IPV in South Asia is needed to understand these alarming prevalence rates, as well as to identify the determinants of IPV and how these factors generate the conditions under which women experience IPV in these settings.

Despite sharing many characteristics with other South Asian countries, Sri Lanka consistently ranks better in terms of maternal and child health, and life expectancy and educational attainment of women, yet available research suggests that the country has high rates of IPV [4-6]. Sri Lanka is currently transitioning from a low-to middle-income country and is emerging from a 25-year-long civil war, so it is a unique context within which to examine the topic of IPV. In this article, we review literature about IPV in Sri Lanka to describe the prevalence, consequences and risk factors of IPV, and women's and health systems' responses to it.

Methods

A 'scoping' review is a technique used to 'map' relevant literature in a field of interest and is useful when the topic has not been comprehensively reviewed before. Scoping reviews help to summarise research findings by examining the extent, range and nature of the existing research. Unlike systematic reviews, scoping studies do not critically appraise the quality of the literature [7]. We used Arksey and O' Malley's five stage framework: developing a research question, identification of relevant literature, selecting a subset of literature for inclusion in the review, charting information from selected publications and summarising and presenting the results [7]. The broad research question that guided the review was: what is known from existing literature about IPV in Sri Lanka? We searched published and gray literature from 1980-2015 using different combinations of the following keywords: wife abuse/beating/ battering, domestic violence, intimate partner violence, spousal abuse, partner

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abuse, gender-based violence and Sri Lanka. Sources of information included electronic bibliographic databases (such as MEDLINE, PsychINFO, CINAHL, Healthstar, EMBASE, Scopus), websites, peer reviewed journals, reference lists from articles and reports, repositories or archives at universities and libraries, as well as media reports, published and unpublished dissertations and theses, and conference proceedings. Studies were included if they focused on IPV against women by a male partner. Our initial search identified 271 articles, which were scanned using the following inclusion criteria: (1) focused on or included IPV against women; (2) focused on the Sri Lankan context; (3) written in English. Peer reviewed journal articles, conference presentations and published and unpublished dissertations and theses were included. After removing duplicates, narratives, expert opinions, and review articles, the number of articles included in the review was 39.

Most of the studies were quantitative (n=18/39) and mixed methods (n=11/39) research. Some studies (30%) were based on convenience samples of women (n=31 to 356) who were accessed and recruited from hospital clinics, medico-legal units, antenatal clinics, and other institutions [8-18]. Others (70%) were community based studies (n=62 to 2311) [19-44]. Sri Lanka was also one of the countries included in a multi country study on men and violence in Asia and the Pacific and in the GENACIS study (Gender, Alcohol and Culture: an International Study) [20]. These were the first studies on IPV in Sri Lanka to include men: the former was a large community based study including 1658 men and 653 women from four locations (Western, Central, Eastern, and North Central provinces); the latter was a qualitative study involving 7 men and 17 women. A few studies focused on children or adolescents who witnessed their mothers' experiences of IPV, and others studied IPV in the context of self-harm or as a consequence of the experiences of civil war [17, 30, 34, 35, 38, 39].

Most of these studies were conducted in the Western province (n=15), followed Central (n=8), Northern (n=8), Eastern (n=7), and North Western provinces (n=5). Two studies included participants from more than one province [18, 32].

Figure 1 displays the number of studies on IPV over time, showing that research on the topic peaked after 2006 (i.e., beginning one year after the passage of the 2005 Domestic Violence Act of Sri Lanka and ending shortly after the cessation of the civil war in 2009).

Results

We reviewed the results of the 39 relevant studies on various aspects of IPV in Sri Lanka. The findings are presented in the following sections, which focus on the prevalence of IPV, health consequences of IPV, risk factors for IPV, women's responses to IPV, health system responses to IPV, and factors affecting women's care-seeking behaviour, in Sri Lanka.

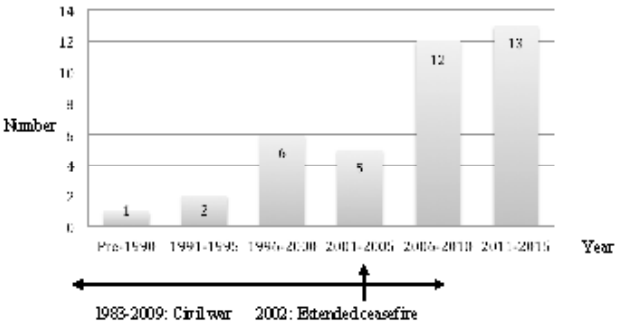

Figure 1. **Number of studies over time.**

IPV in Sri Lanka was first investigated by Saravanapavanthan in 1982 with a specific focus on 'wife abuse,' and this was followed by similar studies focusing on 'wife abuse,' 'wife battering,' and 'wife beating' [9, 15, 19, 27, 46, 47]. Since 2010, research on IPV has included both marital and cohabiting relationships [8, 20, 21, 25, 26, 37]. We found only two studies that examined IPV in the context of dating relationships [37, 48].

Together, the literature suggests that 20-72% of women in different locations in Sri Lanka have experienced IPV. The highest prevalence rates were reported by women living on tea plantations in the Central Province (72%) and in the urban poor areas of the Western Province (60%) [21, 27]. As some of these prevalence rates are from studies conducted 10-15 years ago, these findings are unlikely to reflect the current rates of IPV in Sri Lanka. Recent community based surveys reported that 24-34% of women in various regions of Sri Lanka experienced IPV [25, 26]. The most recent survey conducted in 2013, reported that 22% of women experienced IPV from a male partner, and 24% of male participants perpetrated IPV during their lifetime [20].

A number of studies (n=15) were conducted in the Northern and Eastern Provinces, which were affected by the civil war from 1983-2009. Notably, several of these studies reported that IPV was more common than non-partner violence against women even during the conflict period [13, 41]. In addition to the civil war, the Indian Ocean tsunami of 2004 severely affected these provinces. Several studies focused on the post-tsunami context in these conflict affected areas, some did not document IPV from women's perspective [30, 34]. For example, one study interviewed non-government organisation (NGO) workers from this area, and another included children's accounts of parental conflict [30, 34]. According to the study involving school children in an area affected by the tsunami in the Northern Province, 41% of children had witnessed violence directed against their mother by their father [34].

Experiences of IPV were documented for women in all stages of life, including adolescents, pregnant women, older adults and the types of IPV experienced included physical, sexual, emotional, and verbal abuse, and various

controlling behaviour in varying frequencies [23, 27, 49]. However, the majority of studies predominantly reported physical violence. Overall, sexual abuse was one of the least reported forms of IPV in Sri Lanka, with rates ranging from 5 to18% [20, 25, 26]. The highest reported sexual violence rate (20%) in Sri Lanka was based on men's self reports, and in the same study only 18% of women reported experiencing sexual abuse.

Physical health consequences of IPV in Sri Lanka have been documented, including head injuries, black eyes, contusions, abrasions, lacerations, and burns [10, 13-15, 19, 21, 27, 45, 50]. A number of studies were conducted in medico-legal settings, where physical injuries are more likely to be reported than other consequences of IPV. Only a few studies documented the psychological and mental health consequences of IPV: lowered self-esteem, suicidal ideation and suicide attempts [15, 23, 27, 39]. In one study, 12% of women reported IPV as the main reason for attempted suicide [17]. In another study, conducted in four provinces of Sri Lanka, 25% of the women who had experienced IPV reported having suicidal thoughts, compared with 7% of women who had never experienced IPV [20]. Studies investigating IPV during pregnancy reported that 5-42% of women experienced IPV during pregnancy, resulting in pregnancy and labour complications and other adverse outcomes for themselves and their newborns [12, 47, 51]. These outcomes were reportedly 2-3 times higher among women who had experienced IPV during pregnancy compared with their counterparts [12, 20].

Studies identified a number of individual risk factors for IPV in Sri Lanka, including a woman's young age, low socioeconomic status and low educational attainment [9, 22-27, 44]. Abuser characteristics were also reported, including alcohol or drug abuse, unemployment, depression, and childhood experiences of violence [9, 13, 19, 20, 22-27, 44, 48, 51]. Some relationship factors were reported as being associated with IPV, including suspicions of infidelity, sexual jealousy, extramarital relations, and marital disharmony [20, 21, 23, 25, 33, 48]. The role of these factors in increasing women's risk of IPV is not clear. For example, some studies identified alcohol abuse or community violence as risk factors for IPV, while others found that these factors are not consistently associated with IPV or only operate in combination with other factors such as low socioeconomic status [23, 27]. Several studies reported that risk factors for IPV in Sri Lanka, as in other patriarchal societies, are grounded in societal level risk factors such as 'traditional' gender roles and expectations [20, 29, 30, 32, 35, 37]. For example, one study found that up to 97% of men believed women should obey their husbands, and the majority of participants (both men and women) consider men to be the decision-makers in the family [20]. Another study found that obeying the husband was associated with a lower risk of IPV. Although dowry related violence appears to be less common in Sri Lanka compared with other South Asian settings [4, 20, 25], Sri Lankan women, like their counterparts, are expected to wear conservative clothing in public places such as courts and other government institutions, occupy traditionally 'female' occupations, and face double standards in terms of sexual entitlement, sexual promiscuity, and pre- and extramarital sex [4, 13, 20, 25]. These risk factors are more significant for Sri Lankan women in certain regions and vary over time due to changing social and political situations. For example, IPV directed at women reportedly increased in the Northern and Eastern provinces after the end of the war [31].

The majority of the studies reported that Sri Lankan women, in general, do not disclose IPV to anyone and may continue to live in abusive relationships, in some cases for as long as 10 years [10, 13, 20, 23, 25, 33]. Those who sought help were more likely to approach family, neighbours, friends, and community leaders rather than formal services such as hospitals, police, or agencies providing services [23, 25, 52, 53]. Several studies reported that most of the women who seek help from healthcare services do not disclose IPV [13, 15, 23, 25, 45]. The most recent survey of IPV in Sri Lanka conducted in 2013 found that only 32% of women who sought healthcare for IPV-related health problems reported the abuse to their healthcare providers [20]. Nevertheless, the reporting rates in 2013 were higher than those reported in the past [15, 25]. Few women made a complaint to the police or took legal action against the perpetrator [15, 52]. One study reported that 13% of women who reported IPV made a complaint to the police and another reported that only a minority of complaints resulted in legal action against the abuser [20, 52].

Research aimed at documenting the health system responses to IPV is limited in the Sri Lankan context. A few reports by NGOs document services provided by them such as legal aid, counselling, and shelters. According to these reports, during and after the period of civil war, and following the Indian Ocean tsunami, NGOs set up services in the regions most affected by these events and provided counselling services with the support of foreign funding agencies [4]. The first state supported health sector initiative for women experiencing IPV (the Gender-Based Violence (Desks) was implemented in 2002 [54]. The services, however, were primarily delivered by NGOs. Later, in 2007, a One Stop Crisis Center called 'Mithuru Piyasa' was set up in a government hospital, and similar centers have since been established in 20 government hospitals. The latter initiative, led by the Ministry of Health, provides for national level integration of IPV services. However, no studies have examined whether women access either type of centers, or whether the services meet their needs. Public Health Midwives (PHMs) in Sri Lanka have been trained to deliver a programme of education to recently-married couples which includes information about healthy relationships, family life and conflict resolution [4]. This

health education programme is described as a pioneering IPV prevention programme, but, published literature about programme implementation and its effectiveness is not available [43].

Limited research has focused on perceptions and attitudes about IPV among healthcare providers. A study involving 30 nurses from public and private healthcare sectors in Sri Lanka revealed a range of personal and institutional barriers that affect how nurses care for women experiencing IPV [18]. Personal barriers included lack of knowledge and skills, and institutional barriers included lack of support from colleagues and other healthcare professionals, lack of communication and collaboration between professional groups, managers, and administrators, and lack of opportunities for developing relevant knowledge and skills. A study involving undergraduate male medical students revealed attitudinal barriers that could potentially affect IPV care provision; 33% of students surveyed believed wife beating was justified, 63% blamed women for instigating the violence, and 23% stated that occasional violence by a husband against his wife could help maintain the marriage [26]. A few studies involving women who sought services at healthcare institutions also reported stigmatizing attitudes toward women among health care providers, which discouraged the women from seeking services again [4, 23, 25]. A study describing the first-ever training programme for PHMs in 2009 study shows that their knowledge of IPV, perceived barriers to care provision, responsibility and confidence to identify and assist women experiencing IPV, improved 6 months after the training programme [26]. PHMs were more likely to identify, discuss and followup women experiencing IPV. Even though similar training is being provided to midwives in other areas of the country [4], more than 5 years since its inception, the effectiveness of this training has not been documented [4].

Discussion

Of the 20 million people in Sri Lanka, 55% (10.5 million) are girls and women [55]. Available research indicates that IPV is a widespread problem in Sri Lanka affecting 1 in 3 women in the country. Based on the recent, most representative data, the overall prevalence of IPV in Sri Lanka is about 25–30%, lower than estimates for other countries in South Asia. However, the prevalence rates of IPV in Sri Lanka must be considered with caution as they are primarily based on small studies, conceptualisation of IPV as occurring within the context of legal marriage, and only in a limited number of geographical locations. They also do not capture the heterogeneous nature of women in terms of their social, cultural, religious, economic, educational, and political backgrounds. Similarly, although IPV occurs in all forms of intimate relationships, and despite an increase in non-marital or co-habiting relationships, IPV in Sri Lanka continues to be conceptualised within the context of legal marriage. As a result, women in 'non-marital' intimate relationships are under represented in IPV research, so their experiences of IPV are poorly understood. Also, a general taboo on sexual matters and the lack of legal recognition of marital rape means that sexual violence and rape within marital relationships are largely overlooked. Also, the consequences of IPV for women in Sri Lanka have been primarily understood from a medico-legal perspective with a narrow focus on physical injuries.

The available studies suggest that individual and community level factors interact to make the situation worse for some women or some groups of women in Sri Lanka, but very little is known about the intersecting micro-, meso-, and macro-level factors in the Sri Lankan setting. As in many other countries, many of the factors that increase the risk for IPV in Sri Lanka are grounded in patriarchal relations and expectations prescribed for men and women, so the status of women relative to men in society in general, and within the context of marital relationships in particular, is of relevance [20, 30]. Restrictive policies and practices increase Sri Lankan women's susceptibility to violence and tolerance of violence, while decreasing their ability to respond to IPV in a way that is most effective for them. For example, a recent government policy required women to seek permission from their husbands before leaving for foreign employment [57].

Overall, there appears to be an increase in the number of women who visit hospitals, the police and NGOs, to seek services, and more importantly to disclose IPV, than before. This signifies a positive change in the perception of IPV as no longer a private matter. However, little is known about the outcomes of such help-seeking behaviour, especially in the context of negative attitudes, as well as limited knowledge and skills, among health care professionals who provide services to women experiencing IPV [27, 42]. Additionally, IPV related services at government hospitals are largely dependent on NGOs to provide shelter, legal aid, and social services. Yet, there is a lack of recognition of the NGOs' role by the government. In the post-conflict context, the state perception of all NGO efforts as 'anti-government,' created barriers for these organizations to continue their work [57].

The Women's and Children's Desks in police stations and the Prevention of Domestic Violence Act provide some support for women seeking recourse from IPV. However, women face numerous obstacles when trying to obtain an Interim Protection Order (IPO). For example, they must produce evidence of violence, and delays in the issue of an IPO after a complaint is made place their lives at risk [58]. Moreover, even when a court rules against a perpetrator and issues an IPO, the ruling is often inefficacious because the perpetrator is not sufficiently monitored and continues to threaten or abuse the woman and her family and friends. In some cases, the abusers

have threatened the (female) healthcare professionals who provide care to women experiencing IPV [18, 26].

Overall, there appears to be a positive change in the perception of IPV in Sri Lanka, which is no longer viewed as an entirely private matter, encouraging more women to seek outside services. However, in moving forward, there is a need to address many of the barriers that prevent women from seeking legal redress and recourse from IPV. These barriers include restrictive policies and practices that lower the status of women relative to men within the context of intimate relationships as well as their position in society.

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Conflicts of interests

There are no conflicts of interest.

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Short communication

Time to step-up: A review of the health sector response to intimate partner violence in Sri Lanka

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Intimate partner violence (IPV) is a major health concern for women worldwide, and health care professionals can play a significant role in providing services to women who have experienced IPV. This paper critically examines Sri Lanka's health sector response to IPV.

Introduction

IPV refers to a range of abusive and controlling acts and behaviors by a current or ex-intimate partner that causes physical, sexual and/or psychological harm (1). IPV occurs in epidemic proportions, (2) affecting 30% of all women worldwide. (3) Research conducted in different locations in Sri Lanka reports that 18–72% of all women experience IPV at some point in their lives, (4) with the higher rates emerging from research conducted in urban poor communities as well as in areas affected by the civil war. (5,6).

IPV has been linked to a range of short- and long-term physical and mental health consequences: (7) physical injuries (e.g., contusions, abrasions, lacerations, black eyes),(8-12) chronic physical health conditions (e.g., neck and back pain, arthritis, hypertension, ulcers and irritable bowel syndrome), psychological effects (e.g., depression, anxiety, PTSD, suicidal ideation and attempts), (11,13-15) and reproductive health problems (e.g., STIs, unwanted pregnancies, chronic pelvic pain, and pregnancy and labour complications) (16,17). In fact, literature indicates that IPV has a greater cumulative impact on morbidity and mortality of women than common public health problems (18). As such, it is very likely that women will come in contact with health care professionals in various hospital and community settings (more frequently than with other service providers). These health care visits present opportunities to provide care, support, and safety for women. It is, therefore, important that we look at health sector response to IPV in different contexts and settings.

Methods

Electronic bibliographic databases, websites, peer-reviewed journals, reference lists from articles/reports, as well as repositories/archives at universities and libraries were searched for published and grey literature about health sector response to IPV in Sri Lanka. A total of 23 relevant articles were reviewed using a classification system(19) based on the level and type of integration of IPV services within various health care settings. Level 1 involves selective provider/facility level integration where usually a doctor/nurse provides one or more IPV-related services for women who visit the hospital/clinic. Level 2 is a comprehensive provider/facility-level integration, offering more services by one or more doctors/nurses/counselors within the hospital/clinic. Level 3 is a system-wide comprehensive integration and offers many services at different sites with referrals and back-referrals across sites/settings. The following discussion applies this framework to Sri Lanka's health sector response to IPV.

Results

In Sri Lanka, as is the case in many other countries, health sector response to IPV has been slow. The first initiative to address IPV in Sri Lanka, the Gender Based Violence (GBV) Desk, was introduced in 2002. GBV Desks are service

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health education units, and staffed by doctors and nurses from the hospital and/or by counsellors from the local NGOs. Some GBV Desks were established in the north and the east after the tsunami (in 2004),(20-21) and as of 2011, there were 10 such service points in the country (22). GBV Desks fit with Level 1 selective provider/facility integration of services. However, the services provided go beyond typical Level 1 integration in that the counselors from NGOs managing GBV Desks often use their own networks and resources to offer women out-of-hospital referrals and services such as short-term housing, legal aid, and social services. This creates opportunities for wider multisite service integration, however, the potential to scale this up has not been recognized.

The second initiative began in 2007 with the *Mithuru Piyasa* program in emergency / outpatient departments. Under this program, doctors and nurses provide in-hospital care (such as, medical attention, counselling) and out-of-hospital referrals (such as, short-term housing, counseling, and legal aid) for women experiencing IPV. In 2014, there were 20 Mithuru Piyasa centers island-wide. The Mithuru Piyasa model shares some characteristics with the One-Stop Crisis Center model that has been in operation in many other countries, to provide a comprehensive package of services for women experiencing IPV (23). Similar to the One-Stop Crisis Center model, Mithuru Piyasa provides (Level 2) comprehensive facility-level integration, but also allows access to additional services at different sites because of the referral system set up by the hospital staff to connect women with police, legal aid, NGOs, and provincial social services. This is an excellent model, however, no published data evaluating these models are available, and our personal communications indicate that there is a lack of collaboration and coordination, both within and outside the hospitals.

One of the more recent attempts to expand IPV services within hospital settings in Sri Lanka is the appointment of a cadre of doctors (i.e., Medical Officers of Mental Health) trained to provide services to women experiencing IPV and their abusive male partners. However, at present, these doctors' main role is to conduct mental health clinics in hospitals where there are no psychiatrists. Even though they provide counseling to women referred by other clinics and hospitals, their contribution to IPV-related care and services remains unknown, and the level of service integration associated with this program is unclear.

In addition to the above-noted initiatives, some attempts have been made within the (separate) preventive health system in Sri Lanka to prevent IPV. Since 2009, public health midwives (PHMs) have been educating recently-married couples about relationships, family harmony, and conflict resolution. They also encourage both partners to attend information sessions at the local Medical Officer of Health clinic. This service is integrated with the routine domiciliary care provided by midwives (such as antenatal and postnatal care, and family planning services). While PHMs are also trained to refer women who self-identify as experiencing IPV and seek assistance to access services, their focus is not on providing care and services to women experiencing IPV, and as such, this program does not fall within the service integration framework discussed here.

The way forward

More than 20 years after the Women's Charter (1993) (24) outlining the commitment to women's rights was published, Sri Lanka's health sector response to IPV appears promising yet inadequate; there is only a small number of GBV Desks and Mithuru Piyasa centers in the country of 10 million women and girls (with high IPV prevalence rates). The curative and preventive health care systems together have the potential to facilitate a more effective, efficient, comprehensive system of care and service integration. Moving forward, the available services have to be carefully-evaluated to understand the best level of integration, the most suitable entry points into the health care system, and the optimal model of service provision. Furthermore, health care professionals' active engagement must be sought to improve their buy-in and support for the delivery of integrated IPV services. Lastly and most importantly, attention should be paid to the development and implementation of supportive policies and programs that would make IPV a priority within Sri Lanka's health sector.

Conflicting Interest

None declared

Acknowledgement

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NEW VISION

Publication of the Graduate Nurses' Foundation of Sri Lanka

Vol. 5 – Issue 1- May 2015

Inside….

Message from the President

S.S.P. Warnakulasuriya
President, GNFSL

Nurses' responsibility as a force for change in health care

Dear Nursing colleagues!

We commemorated the International Nurses' Day 12th of May with a number of activities at different places in the country during the entire week. We all focused special attention on this year's theme "Nurses a force for change: care effective, cost effective" and discussed within the context of its relevance to nursing in Sri Lanka. Having focused on that, we realized the importance of nursing force as a major determinant of any positive change made within the health care system. Nurses' involvement in health care reforms, policy development and improving the quality of care has a long history. Florence Nightingale, the founder of modern nursing, realized the importance of quality care and also acted on changes in health care reforms during the Crimean war. Her positive move of improving environmental conditions of patients to assist them for speedy recovery, auditing the effectiveness of services rendered for the sick and influencing health authorities for adequate supply of finances and resources were good examples in history of how pioneers in nursing acted as changing agents in health care.

Today we are experiencing significant changes in every aspect of health care delivery in terms of diagnosis of diseases, treatment strategies and care deliveries. We incorporate advanced sciences, information technology and research evidence in health care that we have not used ever before. And also we are experiencing various health problems that we have not seen ever before. All these changes in health care systems of the world have a great impact on nursing profession. In order to face the health challenges of the 21st century and ever increasing health care cost and rising concerns of quality of care, as nurses we should be equipped with adequate scientific knowledge, competencies and digital citizenship skills within ourselves. Nurses, we all are well positioned to drive efficiency and effectiveness improvements while providing quality care and attaining optimal patient care outcomes (ICN, 2015). However, as a changing agent in health care, are we (Sri Lankan nurses) equipped enough to contribute adequately with our existing knowledge and so called digital citizenship skills to face those challenges?. Other questions we have to answer would be; Do we generate evidence based knowledge consistently as professionals? Do we upgrade our knowledge to suit the rapid changes that are taken place in health care systems?. I think we have no clear answers for these questions. Therefore, it is our role and responsibility to explore new trends in health care and especially in the discipline of nursing and understand the present and future challenges in the health care systems locally and globally. For this to achieve, we need to be equipped further with scientific knowledge and competencies required in the 21st century. Today, all the health reforms demand systems that are evidence-based, cost-effective, and offer the highest quality of care for the patients. We, nurses as the largest occupational group in health care, our contribution for achieving quality and cost effective care and also our role in meeting millennium development goals have been highly emphasized by the WHO and ICN during the past years. As Sri Lankan nurses we should clearly understand this message and be prepared to be a unique force for a change in our health care system.

The Message from the Patron - Trixie Marthenesz

A patient speaks out..

Strikes!
Nurses! Doctors!
Oh heavens!
Haven't they had a formal professional learning
In that noble art of Patient-Care?
In a spirit worthy of their kind
Shouldn't they, their skills together blend,
To help us Patients,
Help ourselves?
Help us
Meet our daily needs?

For the rights they are empowered with,
For the mercies they are blessed with,
Aren't they obliged,
And shouldn't they be grateful
To the countless, generous people
Who till and toil and seat so sore
To make them
What they are?
Nurses and Doctors!

Aren't they by moral codes,
And the ethics of their calling,
Bound?
Aren't they accountable
To our near and dear ones?
And the State?
Aren't they answerable
To that great force that metes and doles,
Reactions sometimes good
And sometimes not so good
To actions here and now
Or in the land, Hereafter?

Their Most Important Persons
Are we, their Patients.
To those Nurses and Doctors
Dextrous in skills and committed
To care for the sick and feeble,
Don't we afford,
Their share of rice and curry,
Their clothing and shelter
In return for the time and energy
On us bestowed?
In return for their kindliness
And gracious service?

We, their Patients and individuals,
We belong to someone, somewhere,
Just as they do.
We were once within ourselves,
Well adjusted.
And to the world outside,
Well adapted.
Now symptoms mild and not so mild,
That change to a slow decline,
Do shatter us.

We, their Patients have needs and feelings
Just as they do.
A right to be well, haven't we?
An independence we would cherish
If we have a little more strength and will.
Aren't they duty bound
To help us again that "little more?"

To be ill and infirm we have a right.
To be shown the means
Whereby we can be fit and well,
To be rendered care,
To be offered the comfort and safety
Imbued with a spirit of love,
And be told
(In judicious tones of course)
That if nothing suffices
And life hangs on a perishing thread,
The inevitable end,
We have a right.
Don't we?

Patient care the world over
Is by nature altruistic.
'tis a genuine concern for us Patients
So sore, worn out and broken,
In spirit and body and mind,
For reasons sometimes known and sometimes not.
For reasons sometimes ours and sometimes not.

Patient care is a creed, unique.
It heeds no bars, no walls, non gaps
In man-made social rungs,
Power or wealth.
It is a creed, unique,
That treats
Man, woman, adolescent and child alike
And assures relief
In distress great or small.
Patient Care is gracious.
It is that smallest good deed done
In a spirit of love and service.
That lies entombed,
With so sweat a fragrance,
In our hearts, the Patients' hearts,
Humble and grateful,
And theirs',
Our Nurses' and Doctors',
So noble.

Care Effective, Cost Effective; Role of Nurses

This year's International Nurses' Day theme ; ***Nurses: A Force for Change, Care Effective, Cost Effective*** echoes, a clarion call for action for nurses to mobilize individually and collectively to tackle health system financing and achieve quality of care and patient safety in a cost effective way. So what can nurses do for more effective and sustainable healthcare financing?

Through your actions and interactions with policy makers and others nurses need to:

• **Use your experience** - Nurses have a wide range of experiences of working in the health system to build a case for effective financing of health systems. However, experiences should be informed by facts and figures to encourage intelligent lobbying and advocacy.

• **Pool your insights** - Nurses face similar problems. Pool your expertise and gather information on what has worked elsewhere rather than re-inventing the wheel. Apply the solutions within context and with knowledge, vigour and determination.

• **Learn the language of economists** and the type of arguments that convince policy makers of the need for additional funding. This includes an understanding of cost effectiveness, care-effectiveness, cost-benefit, and measuring outcomes of care so you can communicate well with policy makers.

• **Target your arguments** towards the Ministry of Finance as well as the Ministry of Health and do not forget the private sector.

• **Keep informed of developments**. It is important to know what is happening in healthcare financing, access to care, community concerns, and in the country generally. Nurses must keep up-to-date with public issues by engaging in dialogue with others, attending public meetings, reading newspapers and journals.

• **Develop an informed position** for your ideas so as to engage in smart dialogue with others using facts and figures. Emotional arguments on crucial topics such as need for more funds for healthcare, protective equipment or nurse-staffing levels do not make an impact.

• **Write and publish either alone or with colleagues**. Relevant and timely articles in journals, newspapers and magazines can help influence opinion. Keep an eye on current issues that would benefit from a nursing perspective. Collaborate with nurse researchers to obtain evidence to document ideas and discussions.

• **Mobilize public opinion** by participating in grass roots groups and use local radio to reach out citizens. Tell stories that people can relate to.

• **Join special interest organisations** such as patient or consumer groups that match your interests and share your positions. Your contribution might be more effective if presented through a larger group with an established reputation and credibility. Your NNA is a good source of information, support and consultation.

• **Know who the key players are**, such as politicians and officials in local, regional and national government. Visit them your colleagues, but prepare carefully. Develop an agenda and consider what you will present and how you will respond to difficult questions. To be persuasive, you need to be clear and concise in meetings. In addition, support your views with hard data or factual evidence to increase your credibility. Disseminate a brief summary of the issues. Remember to keep regular contact with key stakeholders and policy makers, not just when you need them.

• **Link with the key nurse leaders and networks** that you might work with, to have input into policy. For example, nurses in top positions in health ministries are valuable contacts. They are a key ally in getting your message across to the right audience.

• **Establish regular contact with nurses in influential positions**. They may be in policy or senior management positions in departments of health or other health organisations. Sometimes nurses are elected representatives in government at all levels or they may be members of parliament. Nurses are also found in public service organisations, voluntary organisations and non-governmental organisations. These groups can be useful resources to help you achieve your health policy goals.

• **Communicate your position** through ongoing representation in policy-making bodies, lobbying, written or oral submissions, and meetings with people in positions of influence. Remember to keep good relationship with the media.

Designing and implementing a sound health financing strategy involves continuous lobbying and advocacy rather than a one-off action towards a perfect system. The idea is to achieve a win-win situation so your efforts and contribution to health policy benefit health systems, patients and nurses. Building effective health and social policy requires that nurses collaborate with a wide range of stakeholders including patients' organisations, other health profession associations, other sectors such as human rights and women's groups, and others.

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Facing Challenges in Future Nursing – The Brainstorming Session

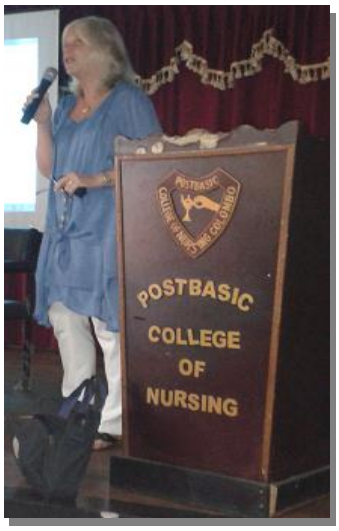
The GNFSL, as an organization that always in the forefront for the advancement of the Nursing profession, took initial steps to create a platform where the experts in Nursing in Sri Lanka gathered to discuss, in order to find solutions for the burning issues in nursing.
Experts from Nursing practice, Nursing education, Nursing administration and Community nursing participated in a brainstorming session launched on the 31.01.2015 at the Post Basic College of Nursing, Colombo. The theme and objectives of the session were as follows.
Theme – Facing the challenges in Future Nursing

General objective –
-To develop a five year strategic plan to improve nursing profession in Sri Lanka.

Specific Objectives –
-To identify strategies to congregate nursing professionals as a single force
-To identify strategies to further uplift nursing profession by developing and maintaining standards
-To establish an independent steering committee to direct future nursing.

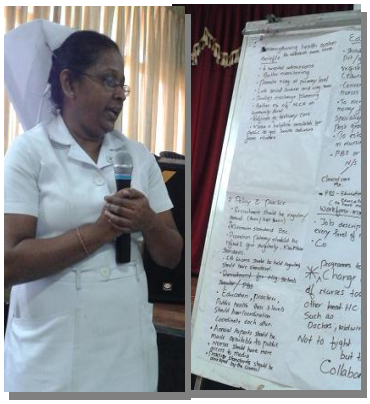
Many nursing leaders including Ms. Wimala Herath, Registrar, Sri Lanka Nursing Council, Office Bearers and members of GNFSL and Sri Lanka Nurses Association, Special Grade nursing staff, Nursing Sisters, Nursing Officers from various hospitals and Special Grade nursing staff from community health sector, nursing educators from Post Basic College of Nursing, Schools of Nursing, and Universities contributed to the session with their individual expertise. In addition, Dr. Kerstin Samarasinghe and Ms. Lena Larson, two Senior Lecturers from the Kristianstad University, Sweden participated in this session as resource persons.

All the participants actively involved in group discussions in developing objectives and strategies to improve different areas of nursing which were finally incorporated into the five year plan.








Organization of Professional Associations (OPA) -28th Annual Conference

The **28th Annual Conference** of the OPA will be held on the 18-19 August 2015, at Hotel Galadhari, Colombo. The Theme of this year will be "Innovation and technology for sustainable development".

Minimize the suffering and death in women due to cervical cancer

Women's cancers, including breast, cervical and ovarian cancers, lead to hundreds of thousands of premature deaths among women (WHO, 2013). Among those, cervical cancer is one of the leading causes of cancer death in women in the developing world. Cervical cancer is caused by the sexually transmitted Human Papilloma Virus (HPV), which is the most common viral infection of the reproductive tract. Additional risk factors that affect a woman's chance of developing cervical cancer include **sexual behaviours, smoking, having a weakened immune system, taking the oral contraceptive pills for more than five years, having more than five children (more the children greater the risk).**

Almost all sexually active individuals will be infected with HPV at some point in their lives and some may be repeatedly infected and the peak time for infection is shortly after becoming sexually active (WHO, 2013). Persistent infection with specific types of HPV (most frequently, types 16 and 18) may lead to precancerous lesions. If untreated, these lesions may progress to cervical cancer. Most of the time, early cervical cancer has no symptoms. Symptoms that may occur later include intermenstrual bleeding, postcoital bleeding and postmenopausal bleeding, vaginal discharge (watery, brown, bloody, or foul-smelling) and menorrhagia.

Cervical cancer can be prevented by early detection and treatment of precancerous lesions. The easiest way is to screen by Pap smear test which is used to detect cervical abnormalities caused by existing HPV infections. But that does not prevent the development of cervical cancer. Only primary prevention by vaccination will protect against future infections. Vaccine for HPV infection has been licensed in many countries including Sri Lanka. The optimal age of vaccination is preadolescent age and recommended to females aged 9-16 years before sexual debut. Catch up vaccination also has been recommended to females up to 26 years (Karunaratne, 2010).

Female population distribution in Sri Lanka is 52.6% and literacy rate of females is 90.8 % (Central Bank of Sri Lanka, 2013). Cervical cancer in Sri Lanka ranks as the 2nd most frequent cancer among women and the 3rd most frequent cancer among women between 15 and 44 years of age. Current estimates indicate that every year 1721 women are diagnosed with cervical cancer and 690 die from the disease in Sri Lanka (ICO, 2014). Although cervical cancer screening services are available at community level in Medical Officer of Health (MOH) clinics, especially in Well Women Clinics, participation to these preventive services is minimal. Health education on cancer prevention, including Pap smear is provided in these clinics.

Psychological and sociocultural factors contribute to nonparticipation in cervical cancer prevention, including limited knowledge about cervical cancer and screening; stigma, cultural beliefs, and perceptions related to the reproductive organs and symptoms; limited finances; lack of time; and not wanting to know more about cervical cancer status (Horo et al., 2012). Especially, traditional ways of thinking in Sri Lankan society, stigma and discriminations may discourage women from revealing health problems associated with their sexual activity and reproductive health. Importantly, women are anxious to get treatment for gynaecological problems and they are bound and restricted by their cultural milieu (Ross, et al., 2002). Even, availability, accessibility, confidentiality and even lack of publicity of available services were the main barriers for reproductive health services in Sri Lanka (Agampodi et al., 2008).

Unsatisfactory knowledge and low compliance with screening recommendations may lead to negative impact on community in undergoing a Pap smear. Healthcare providers are fundamental in relaying information to patients, particularly nurses who are able to reach a large and diverse population of females who may not normally have access to HPV and cervical cancer information or screening (Rogers and Cantu, 2009). Nurses attached to a variety of units, such as female wards and gaynaecological clinics, can educate women about the prevalence of HPV, methods to prevent infection, available screening facilities and importance of attending screening programmes.

By developing a good rapport between the nurse and the patient, varying the teaching style to match the needs of patients may help them to communicate information effectively to patients and families. This will result in improving participation in cervical cancer screening and to minimize suffering and death in women due to cervical cancer.

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Membership Activities

3rd General meeting - 2014

3rd General meeting of the GNFSL for year 2014 was held on **08th November 2014** (Saturday) at the Auditorium, Post Basic School of Nursing, Colombo.

As the special event, Ms. I.M.P.S. Ilankoon & Ms. M.W. Muthucumarana, members of GNFSL shared their experiences gained through the teacher exchange program in Sweden on Swedish Nursing Education and health care system.

Workshop for Nursing Officers....

Targeting the **EB examination of Grade I Nursing officers** of Ministry of Health, a workshop including lectures on Basic Research, Ward Management, Primary Health care and Communication Skills will be held **on 06th June 2015, 09.00am onwards** at the **Main Hall, School of Nursing Colombo**.
All are welcome!

Annual General meeting 2014/2015

The Annual General meeting of the GNFSL for year 2014/15 was held on 07th March 2015 at the Auditorium, Post Basic College of Nursing, Colombo.

Dr. Kosala Muthukumarana, a Medical Officer of the National Cancer Control Program delivered an informative lecture on **"Importance of Counselling and Communication in Cancer care"**.

Congratulations

We wish to congratulate the following members of the GNFSL for their following recent achievements.

HEDA UTTAMAABIMANI – 2015

Government Nursing Officers' Association awarded the "Heda Uttamaabimani 2015 Award" to following GNFSL members for their service contribution and the prestige brought to the Nursing profession.

1) **Ms. Karuna Saranguhewa,** Nursing Consultant, Faculty of Health Sciences, the Open University of Sri Lanka
2) **Dr. S.S.P. Warnakulasuriya,** Senior Lecturer, B.Sc. Nursing program, University of Sri Jayewardenepura.

FLORENCE NIGHTINGALE AWARD – 2015

Dr. S.S.P. Warnakulasuriya received the 'Florence Nightingale Award ' - 2015, from Sri Lanka Nurses' Association (SLNA) for being **the first Nursing personnel** (i) to receive President's Research Award in 2014 and (ii) to be awarded the Doctor of Philosophy (PhD) Degree from a Sri Lankan University (University of Sri Jayewardenepura)

With reference to job satisfaction Nightingale had this to say ...

" A good nurse has a professional pride in results of her nursing quite as much as a medical officer in the results of his treatment.
There are defective buildings, defective administration, defective appliances which make all good nursing impossible.
A good nurse does not like to waste herself and the better the nurse the stronger this feeling in her"

ශ්‍රී ලාංකික කාන්තාවන්ට ස්වාමිපුරුෂයන්ගෙන් / සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් සිදුවන ප්‍රචණ්ඩත්වය පිලිබඳ පර්යේෂණ වාර්තා විමර්ශනය

ආචාර්ය **සේපාලි ගුරුගේ[1], වෛද්‍ය චත්සලා ජයසූරිය[1], වෛද්‍ය.නාලිකා ගුණවර්ධන[2], සහ මෙලනි සෙල්වදුරේ[1]**

[1] හෙද පීඨය, රයර්සන් විශ්ව විද්‍යාලය, ටොරොන්ටො, කැනඩාව, [2]වෛද්‍ය විද්‍යාලය, කොළඹ විශ්වවිද්‍යාලය, ශ්‍රී ලංකාව

ලොව පුරා විවිධ රටවල කාන්තාවන් තම ස්වාමිපුරුෂයන්ගෙන්, සහකරුවන්ගෙන් හා පෙම්වතුන්ගෙන් ශාරීරික, මානසික, ලිංගික හා අනෙකුත් ප්‍රචණ්ඩත්වයන්ට භාජනය වන බව සුප්‍රකට කරුණකි. ආසියාතික රටවල වාසයකරන කාන්තාවන් මෙසේ ප්‍රචණ්ඩත්වයට ලක්වීමේ ප්‍රවණතාවය ඉහල බව මෑත කාලීන අධ්‍යයනයන් වලින් සොයාගෙන ඇත. ශ්‍රී ලාංකික කාන්තාවන්ගේ තත්වය අධ්‍යයනය කිරීම සඳහා ඒ පිලිබඳ පලවී ඇති පර්යේෂණ වාර්තා, ලිපි ලේඛන විමර්ශනය කිරීම මෙම ලිපියේ පරමාර්ථයයි.

ශ්‍රී ලාංකික කාන්තාවන් තිදෙනෙකුගෙන් එක අයෙක් මෙසේ ප්‍රචණ්ඩත්වයට භාජනය වීමේ ප්‍රවණතාවයක් ඇති බව දැනට පවතින පර්යේෂණ දත්ත අනුව පැහැදිලි වේ. සමහර පලාත්වල වසන කාන්තාවන්ගෙන් සියයට 80ක් පමණ මෙසේ ප්‍රචණ්ඩත්වයට ලක්වී ඇති බව සඳහන් වේ. යුද්ධයෙන් පීඩිත උතුරු, නැගෙනහිර පලාත්වල, මධ්‍යම පළාත් වතුකරයේ කාන්තාවන් හා නාගරික පලාත්වල අඩු ආදායම් පවුල්වල කාන්තාවන්ගේ ප්‍රචණ්ඩත්වයට ලක්වීමේ වැඩි ප්‍රවනතාව ගැන දත්ත පර්යේෂණ වලින් ප්‍රකාශ වන නමුත්, විවිධ තරාතිරම්වල හා විවිධ ජාති, ආගම්වල කාන්තාවන් හිංසනයට ලක්වීමේ අවධානම ගැන පැහැදිලි අවබෝධයක් නොමැති බව අනාවරණය වේ.

මෙසේ ප්‍රචණ්ඩත්වයට පත්වීමට බලපාන සාධක පිලිබඳ අධ්‍යයනයට සමහර පර්යේෂකයන් උත්සාහ ගෙන ඇත. ඔවුන් පෙන්වාදෙන අයුරින්, සමහර සාධක කාන්තාවන් ප්‍රචණ්ඩත්වයට භාජනය වීම කෙරේ බලපෑම් ඇති කරයි. උදාහරණ වශයෙන්, අඩු වයස්වල, අඩු ආදායම් ලබන හා අධ්‍යාපන මට්ටමෙන් පහල තල වල කාන්තාවන්ට වැඩි අවධානමක් ඇති බව පැවසේ. අනෙකුත් පර්යේෂණයන්ට අනුව ප්‍රචණ්ඩත්වයට ලක්වීමට බලපාන සාධක පැහැදිලිව වටහාගැනීමට නොහැකිවී ඇත. උදාහරණ වශයෙන් පුරුෂයන්ගේ අධික මත්පැන් හෝ මත්ද්‍රව්‍ය භාවිතය, අනියම් විවාහයන්, පිටස්තර අසම්මත ප්‍රේම/ ලිංගික සම්බන්ධතා හා ඔවුන් ළමා කාලයේ මුහුණදුන් අතවර හා කාන්තා හිංසනය අතර සම්බන්ධයක් ඇති බව සමහර පර්යේෂණයන් පෙන්වා දෙන නමුත්, අනෙකුත් දත්ත වලට අනුව මෙම සාධක පමණක් ප්‍රචණ්ඩත්වය ඇතිකිරීමට සෘජුවම දායක නොවන බව පැහැදිලිවේ.

ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ ස්ත්‍රී පුරුෂ සමාජ මට්ටම හා ඒ පිලිබඳ සමාජයේ ආකල්ප මෙම ප්‍රචණ්ඩත්වය ඇතිකිරීමට හා එහි ප්‍රවනතාවය ඇති කිරීමට හේතුවන බව පැහැදිලි කරුණකි.

තම ස්වාමිපුරුෂයන්ගෙන්/ සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් ප්‍රචණ්ඩත්වයට භාජනය වන බොහෝ ශ්‍රී ලාංකික කාන්තාවන් ඔවුන් මුහුණ දෙන අතවර පිළිබඳ පිටස්තරයන්, සෞඛ්‍ය සේවකයන් හා අනෙකුත් සේවා සපයන්නන්ට හෙළිකිරීමට මැලිවන බව පැහැදිලි වේ. බොහොමයක් කාන්තාවන් එසේ ප්‍රචණ්ඩත්වයට භාජනය වෙමින් දිගු කාලයක් එම සහකරුවා සමඟ ජීවත් වෙන බවත්, එයින් මිදීමට උත්සුක නොවන බවත් පෙන්වාදෙයි. උදව් සොයා යන කාන්තාවන් බොහොමයක් තම නෑදෑයන්, මිතුරන් හා අසල්වැසියන් වැනි සමීපතමයන් වෙත යොමුවන අතර, සමහරුන් ආගමික නායකයින් වැනි සමාජයේ පිළිගත් නායකයින්/ පුද්ගලයන් වෙත යොමුවේ. පොලිස් ස්ථාන, රෝහල් හා අනෙකුත් සේවා සපයන ආයතන වලට යොමුවන කාන්තා ප්‍රතිශතය ඉතා අල්ප බව බොහෝ පර්යේෂකයන් පෙන්වා දෙයි.

සේවා ලබා ගැනීමට සෞඛ්‍ය සේවා වෙත යොමුවන කාන්තාවන්ගෙන් බොහොමයක් එම සෞඛ්‍ය සේවකයන්ට තමා මුහුණදෙන අතවර පිලිබඳ අනාවරණය කිරීමට මැළි වේ. පොලිසියේ හෝ, නීතිමය ආධාර සෙවීමට යොමුවන කාන්තාවන් ප්‍රමාණය අල්පයක් බවත් පැහැදිලිවේ.

ප්‍රචණ්ඩත්වයන්ට මුහුණ දෙන කාන්තාවන්ට සේවා සැපයීමට කාන්තා සහන කාර්යාල/ මධ්‍යස්ථාන (මිතුරු පියස) රජයේ රෝහල්වල දැන් ස්ථාපිත කර ඇත. මෙම මධ්‍යස්ථාන වලින් වෛද්‍ය උපදේශන සේවා හා අනෙකුත් සේවාවන්, ප්‍රතිකාර, ලබාදෙන අතර, නීතිමය උපදේශන හා කෙටි කාලීන නේවාසික පහසුකම් සඳහා යොමුකිරීම්ද කරන බව ප්‍රකාශ වේ. මෙම මධ්‍යස්ථාන මගින් කාන්තාවන්ට අවශ්‍ය සේවාවන් පැහැදිලිවම ලබාදෙන බව නිශ්චය කිරීමට අවශ්‍ය අධ්‍යයනයන්/ දත්ත නොමැති බව පැහැදිලි කරුණකි. තවද, එම සේවා සපයන්නන්ට ඒ සඳහා අවශ්‍ය දැනුම, දක්ෂතාවය හා ආකල්ප ඇත්ද පිලිබඳ විශ්ලේෂණය කිරීම ඉතාම අල්ප වශයෙන් සිදුවී ඇති බව පැහැදිලි වේ. මෙම සේවාවන් ලබාදෙන සේවකයන්ගේ දැනුම හා ආකල්ප පිලිබඳ විශ්ලේෂණයක් මගින් ඔවුන්ට අවශ්‍ය දැනුම හා අත්දැකීම් හඳුනාගත යුතුබව පර්යේෂකයන් පෙන්වා දෙයි.

ශ්‍රී ලාංකික කාන්තාවන්ට ප්‍රචණ්ඩත්වයෙන් තාවකාලිකව මිදීමට අතුරු ආරක්ෂණ නියෝගයක් (Interim Protection Order) ලබාගැනීමේ අවස්ථාවක් ඇත. මෙසේ අතුරු ආරක්ෂණ නියෝගයක් ලබාගැනීම සඳහා කාන්තාවන් ප්‍රචණ්ඩත්වය පිලිබඳ සාක්ෂි ඉදිරිපත් කල යුතු බැවින් හා බොහෝ අවස්ථාවල එම නියෝග නිකුත්කිරීම ප්‍රමාද වන බැවින් අතුරු ආරක්ෂණ නියෝගයක් සඳහා ඉල්ලුම් කර ඇති කාන්තාවන් දිගටම ප්‍රචණ්ඩත්වයට භාජනය වීමේ අවධානමක් ඇත.

ශ්‍රී ලාංකික නීති පද්ධතියේ ඇති දුර්වලතා/ අඩුපාඩු නිසා නීතිමය ආධාර ලබාගැනීමද අපහසුය. උදාහරණයක් ලෙස විවාහය තුල සිදුවන ලිංගික අතවරයන්/ දූෂණ වලට නීතිමය ආධාර ලබා ගැනීමට අවශ්‍ය නීති නොමැති කමින් (සහකරුවන් නීතියෙන් වෙන්වී නොමැති අවස්ථාවල) මෙසේ ප්‍රචණ්ඩත්වයට පත්වන කාන්තාවන්ට සහනයක් ලබාගැනීමට අවස්ථාවක් නැත.

සමහර රෙගුලාසි නිසා පිරිමින්ගේ අධිකාරිය / ආධිපත්‍ය තවත් තහවුරු වේ. උදාහරණ ලෙස මැදපෙරදිග/ විදේශ රැකියා සඳහා යන කාන්තාවන් තම ස්වාමිපුරුෂයන්ගේ අනුමැතිය ලබාගත යුතු බවට ප්‍රතිපත්තියක් මෑත කාලයේ පනවා ඇත.

ලංකාවේ කාන්තාවන්ට තම ස්වාමිපුරුෂයන්ගෙන්, සහකරුවන්ගෙන් හා පෙම්වතුන්ගෙන් සිදුවන ප්‍රචණ්ඩත්වයට පිලිබඳ, (විශේෂයෙන්ම අවිවාහක සම්බන්දතා වල, විවිධ ප්‍රදේශ වල කාන්තාවන් අතර, හා විවිධ සමාජයීය, ජනවාර්ගික හා සංස්කෘතික කාන්තාවන් අතර සිදුවන හිංසනය පිලිබඳ) වැඩිදුරටත් පර්යේෂණ කල යුතුය. තිබෙන සේවාවන් ලබාගැනීමට කාන්තාවන් කෙසේ යොමු කල යුතුදැයි අපි නොදනිමු. එසේම සේවාදායකයින්ට අවශ්‍ය දැනුම, ආකල්ප හා දක්ෂතාවයන් තිබේදැයි අපි නොදනිමු. නීතිය, ප්‍රතිපත්ති හා වැඩසටහන් කාන්තා අයිතීන් රැක දී, ඔවුන්ට නිවසේ හා සමාජයේ සමතැන ලබාදීමට කටයුතු කලයුතුයි.

ස්ත්‍රී පුරුෂ සමාජභාවය, ඔවුන්ට අයත් භූමිකා හා කාන්තාවන්ගේ තරාතිරම පිලිබඳ සමාජයේ ඇති වැරදි මත වෙනස් කිරීමට පිළියම් ගැනීම සඳහා උත්සුක විය යුතුයි. දේශපාලන ක්‍රියාකාරකම් හා තීරණ ගැනීමේ කටයුතුවලදී කාන්තාවන්ගේ සහභාගීත්වය වැඩි කිරීමට අවශ්‍ය පියවර ගැනීමද ප්‍රමුඛතම අවශ්‍යතාවයකි.

පරිවර්තනය: මදාරා රන්මුතුගල මිය නැවත පරීක්ෂා කිරීම් : වෛද්‍ය චත්සලා ජයසූරිය. මෙහි සඳහන් කර අධ්‍යයන පිළිබඳ වැඩි විස්තර සඳහා contact@addressingipvsrilanka.ca email ලිපිනය හරහා අප සමග සම්බන්ධ වන්න.

ஸ்ரீ லங்காவில் பெண்களுக்கெத ிராக நெருங்கிய துணைவர் வன்முறை : சாராம்சம்

கலாநிதி: சேபாலி குருகே1 , கலாநிதி: வத்சலா ஜயசூரிய1 , கலாநிதி : நாலிக குணவர்தன2 , மெலனி செல்வதுரை
1 தாதியர் கல்லூரி . றையர்சன் பல்கலைக்கழகம், ரொறன்ரோ, கனடா 2 மருத்துவ பீடம், கொழும்பு பல்கலைக்கழகம் இலங்கை

நெருங்கிய துணைவர் வன்முறை என்பது தற்போது, கூட வாழ்ந்து கொண்டிருக்கும் அல்லது முன்னர் வாழ்ந்து கொண்டிருந்த நெருங்கிய துணைவர் ஒருவர் ஏற்படுத்துகின்ற உடல், பாலியல், உள ரீதியான துன்புறுத்தலாகும். ஒருவருக்கு இவற்றில் ஒன்றோ பலவோ நிகழலாம். .உலகளாவிய ரீதியில், நெருங்கிய துணைவரால் வன்முறைக்கு உள்ளாகுபவர்களில் பெரும்பாலானோர் பெண்களாவர். உலகில் ஏனைய பாகங்களில் உள்ள பெண்களை விட, நெருங்கிய துணைவரால் வன்முறைக்கு உள்ளாகுபவர்களில் அதிகமானோர் தென் ஆசியப் பெண்கள் என ஆய்வுகள் குறிப்பிடுகின்றன. இச் சாராம்சம் தென் ஆசிய நாடான ஸ்ரீ லங்காவில் உள்ள நிலைமையை விபரிக்கின்றது.

பொதுவான போக்கும் பாதிப்பு நிலவரமும்: இலங்கையில் 3 பெண்களில் ஒருவர் தமது வாழ்நாளில் எப்பொழுதோ நெருங்கிய துணைவருடைய வன்முறைக்கு ஆளாகின்றார் என அனேகமான ஆய்வுகள் மதிப்பிடுகின்றன. ஏனைய சில அறிக்கைகள் (சிறிய மற்றும் நடுத்தர அளவான மாதிரிகளை அடிப்படையாகக் கொண்டவை), இவ் வன்முறை அதிக அளவில் (80மூ) இடம் பெறுவதாகக் காட்டுகின்றன. உள்நாட்டு யுத்தத்தினால் பாதிக்கப்பட்ட வடக்கு, கிழக்கு மாகாணங்களில் உள்ள பெண்கள் , தேயிலைத் தோட்டங்களில் வாழும் பெண்கள் மற்றும் நகர்ப்பிரதேசங்களில் குறைந்த வருமானம் பெற்று வாழும் பகுதிகளில் வாழும் பெண்கள் மத்தியில் கூடிய வீதத்தில் இந்த வன்முறை நிகழ்கின்றது என ஆய்வுகள் குறிப்பிடுகின்றன.

ஆபத்து விளைவிக்கும் காரணிகள்: இளம் வயதுடைய, கல்வி நிலை குறைந்த மற்றும் குறைவான சமூகப்-பொருளாதார நிலைமையில் வாழும் பெண்களே நெருங்கிய துணைவர் வன்முறைக்கு அதிகமாக ஆளாகின்றனர் என சில ஆய்வுகள் கண்டறிந்துள்ளன. இக்காரணிகள் மாத்திரம் தனியாக பெண்களுக்கான ஆபத்தை அதிகரிப்பதில்லை எனவும் ஆண்களின் மதுப்பாவனை, போதைப்பொருள் பாவனை, திருமணத்துக்கு வெளியே உள்ள உறவுகள், சிறு பராயத்தில் வன்முறைக்கு ஆளாகியிருத்தல் போன்றவற்றுடன் இணையும்போது மாத்திரமே அவ்வாறு இடம் பெறுகின்றன எனச் சில அறிக்கைகள் குறிப்பிடுகின்றன. எனினும், கடுமையான சமூக ரீதியான பால்நிலை சார்ந்த கட்டுப்பாடுகள், பால் ரீதியாக வகிக்கும் நிலைகளும் இலங்கைப் பெண்கள் நெருங்கிய துணைவரின் வன்முறைக்கு ஆளாகுவதற்கான ஆபத்துக்களை அதிகரிக்கின்றன என்ற கருத்துடன் அனேகமான ஆய்வாளர்கள் உடன்படுகின்றனர்.

பெண்களின் பிரதிபலிப்புக்கள்: நெருங்கிய துணைவரால் வன்முறைக்கு ஆளாகின்ற அனேகமான பெண்கள் அது பற்றிப் பேசுவதில்லை. அத்துடன் தம்மை வன்முறைக்கு உட்படுத்தும் அதே துணைவருடனே தொடர்ந்தும் பல ஆண்டுகள் வாழ்கின்றனர். உதவி தேடுவோர் ஆரம்பத்தில் தமது குடும்பத்தினர், நண்பர்கள், அயல் வீட்டார், சமூக அங்கத்தவர்களான மதத்தலைவர்களை நாடுகின்றனர். சில பெண்கள் உதவிக்காக வைத்தியசாலைகள், பொலிஸ் மற்றும் நெருங்கிய துணைவர் வன்முறையுடன் தொடர்புபட்ட சேவைகளை வழங்கும் முகவர் நிலையங்களையும் நாடுகின்றனர். நெருங்கிய துணைவர் வன்முறையுடன் தொடர்புபட்ட காயங்களுக்காக வைத்திய சேவைகளைப் பயன்படுத்தும் பெண்கள், வன்முறை பற்றி வைத்திய சேவை வழங்குபவர்களுக்குத் தெரிவிப்பதில்லை. குறைந்த எண்ணிக்கையான பெண்களே வன்முறை பற்றி பொலிஸ் அலுவலர்களுக்கு அறிவிக்கின்றனர். அவ்வாறு செய்பவர்களின் அனேகமான பொலிஸ் அறிக்கைகள் கூட வன்முறை செய்தவர்களுக்கு எதிரான சட்ட நடவடிக்கை எடுப்பதற்கு இட்டுச்செல்வதில்லை. ஸ்ரீ லங்காவில் தற்கொலை செய்யும் வீதம் தொடர்ச் சியாக உயர்வாகவே காணப்படுகின்றது. எனினும் இதற்கும் நெருங்கிய துணைவர் வன்முறைக்கும் இடையிலான தொடர்பு பற்றிக் கவனமாக ஆய்வு செய்யப்படவில்லை.

சுகாதாரப் பகுதியினரின் நடவடிக்கை: (அரசாங்க வைத்தியசாலைகளில் உள்ள) பால்நிலை அடிப்படையாகக்கொண்ட வன்முறை முறைப்பாட்டு மேசை மற்றும் மித்துரு பியஸ (நட்பு இல்லம்) போன்ற நிலையங்கள் நெருங்கிய துணைவரது வன்முறைக்கு ஆளாகும் பெண்களுக்கு ‘‘சிகிச்சை’’ மற்றும் ஆலோசனை வழங்குகின்றன. இவை இரண்டும் சட்ட உதவி அல்லது குறுகிய கால வீட்டு வசதி போன்ற ஏனைய சேவைகளுக்கு வைத்தியசாலைகளுக்கு உள்ளும் அல்லது வெளியிலும் பரிந்துரைகளையும் வழங்குகின்றன. பால்நிலையை அடிப்படையாகக்கொண்ட வன்முறை முறைப்பாட்டு மேசை மற்றும் மித்துரு பியஸ நிலையங்கள் மதிப்பீடு செய்யப்படாததால், பெண்கள் தமக்குத் தேவையான சேவைகளைப்

பெற்றுக்கொள்கின்றனரா என்பது எமக்குத் தெரியாதுள்ளது. மேலும் இலங்கைச் சூழலில் நெருங்கிய துணைவரின் வன்முறைக்கு ஆளாகின்ற பெண்களுக்கு உதவி அளிக்கின்ற சுகாதார பராமரிப்பு மற்றும்

தொழில்சார் ஊழியர்களின் அறிவு, திறன், மனப்பாங்கு தொடர்பாக மட்டுப்படுத்தப்பட்ட ஆய்வுகளே காணப்படுகின்றன. சேவையினை நாடுகின்ற பெண்களைக் களங்கப்படுத்துகின்ற மனப்பாங்குடன் செயற்படுதல், வன்முறை நிகழ்ந்ததற்குப் பெண்களைக் குற்றம் கூறுதல், பெண்கள் கடுமையாக முயற்சித்தால் நிலமையைச் சீர் செய்ய முடியும் என அறிவுரை வழங்குதல் போன்ற நடவடிக்கைகளைச் சில சுகாதார பராமரிப்பு தொழில்சார் நிபுணர்கள் மேற்கொண்டதாகச் சில சான்றுகள் எடுத்துக்காட்டுகின்றன.

கொள்கைவகுப்பு, சட்ட / நீதி நடவடிக்கை: ஸ்ரீ லங்காவின் வீட்டு வன்முறை களைத் தடுக்கும் சட்டம், பெண்கள் தம்மீது வன்முறை மேற்கொள்ளும் துணைவர்களுக்கு எதிராக இடைக்கால பாதுகாப்பு கட்டளை ஒன்றினைப் பெற்றுக்கொள்வதற்கு அனுமதியளிக்கின்றது. அவ்வாறு செய்வதற்கு வன்முறை பற்றிய சாட்சியங்களை அவர்கள் வழங்க வேண்டும். அத்துடன் பல சமயங்களில் இடைக்காலப் பாதுகாப்புக் கட்டளை வழங்குவதில் தாமதங்களும் ஏற்படுகின்றன. இடைக்காலப் பாதுகாப்புக் கட்டளை ஒன்று வழங்கப்பட்டிருந்த போதிலும், இடைக்காலப ˙ பாதுகாப்புக் கட்டளை யை அமுல் செய்வதற்கான பொறிமுறைகள் இல்லாமையால், ஆண்கள் தொடர்ந்தும் வன்முறையை மேற்கொள்கின்றனர். ஸ்ரீ லங்காச் சட்ட முறையில் காணப்படுகின்ற இடைவெளிகளும், பெண்களையும் நெருங்கிய துணைவர்களால் நிகழ்த்தப்படும் வன்முறைக்கு எதிரான உதவி யினை நாடுவதற்கான அவர்களது ஆற்றலையும் பாதிக்கின்றன. உதாரணமாக துணைவர்கள் சட்ட ரீதியாகப் பிரிந்தாலன்றி, திருமணத்திற்குள் நிகழும் வன்புணர்ச்சி என்பது சட்டமுறையால் அங்கீகரிக்கப்படாத ஒன்றாகவே உள்ளது. ஏனைய கொள்கைகளும் ஒழுங்கு விதிகளும், பெண்களை நெருங்கிய துணைவர்களால் நிகழ்த்தப்படும் வன்முறைக்கு மேலும் உள்ளாகக்கூடியவர்களாக ஆக்கக்கூடியவையாக உள்ளன. உதாரணமாக அண்மையில் வெளிவந்த (2013) அரசாங்கக்கொள்கையானது, தொழிலுக்காக நாட்டை விட்டுச் செல்லும் பெண்கள் அவர்களது கணவரின் அனுமதியை ப் பெறவேண்டும் என்பதைக் கட்டாயப்படுத்துகின்றது. இக்கொள்கை பெண்கள் மீதான ஆண்களின் அதிகாரத்தையும் கட்டுப்பாட்டையும் அமுல்படுத்துகின்றது.

ஆய்வு, நடைமுறை மற்றும் கொள்கைவகுப்பு விளைவுகள்: ஸ்ரீ லங்காவின் வேறுபட்ட மாகாணங்கள் மற்றும் பல்வேறுபட்ட இன, பண்பாடு, சமயப்பின்னணியில் உள்ள பெண்கள் மத்தியில் குறிப்பாக திருமணமான உறவுகளில் நெருங்கிய துணைவர்களால் நிகழ்த்தப்படும் வன்முறை பற்றி ஆய்வு செய்ய வேண்டிய தேவை உள்ளது. கிடைக்கப்பெறுகின்ற சேவைகளைப் பெற்றுக்கொள்வதற்குப் பெண்கள் எவ்வாறு ஊக்குவிக்கப்பட முடியும் என்பதும் எமக்குத்தெரியாது. அல்லது நெரு ங்கிய துணைவரர்கள் நிகழ்த்தும் வன்முறைக்கு உள்ளான பெண்களுக்கான சேவைகளை வழங்குவதற்குத் தேவையான அறிவு, மனப்பாங்கு, மற்றும் திறன்கள் போன்றவற்றைச் சுகாதாரப் பராமரிப்பு, தொழில்சார் ஊழியர்கள் கொண்டுள்ளனரா என்பதும் எமக்குத்தெரியாது. சட்டங்க ளும் நிகழ்ச்சித்திட்டங்களும் பெண்களின் உரிமைகளைப் பாதுகாப்பதையும் குடும்பத்தினுள்ளும் சமூகத்திலு ம் அவர்களின் சமமான அந்தஸ்தினை உறுதி செய்வதனையும் குறிக்கோளாகக் கொண்டிருக்க வேண்டும். அரசியல் மற்றும் தீர்மானம் எடுக்கக்கூடிய பதவிநிலைகளில் பங்கேற்பதற்குத் தேவையான பெண்ணின் ஆற்றலை அதிகரிப்பதற்கு பால்நிலை பற்றிய சமூக ரீதியான தவறான எண்ணம், பால்நிலை வகிபாகங்கள் மற்றும் பெண்களின் அந்தஸ்து தொடர்பான பிரச்சினைகள் பற்றி எடுத்துரைப்பதற்கு முன்னுரிமை வேண்டும்.

இச் சாராம்சம் வெளியீட்டுக்காக தற்போது மீளாய்வு செய்ய ப்பட்டுவரும் கட்டுரை ஒன்றை அடிப்படையாகக்கொண்டது. மேலதிக தகவல்களுக்கு ஆசிரியர்களை contact@addressingipvsrilanka.ca என்ற மின்னஞ்சலில் தொடர்பு கொள்க.

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ශ්‍රී ලාංකික කාන්තාවන්ට ස්වාමිපුරුෂයන්ගෙන් / සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් වන ප්‍රචණ්ඩත්වය සඳහා පිළියම් යෙදීමට සලසා ඇති සෞඛ්‍ය සේවා පිලිබඳ විශ්ලේෂණය

ආචාර්යසේපාලි ගුරුගේ[1]වෛද්ය වත්සලා ජයසූරිය[1]වෛද්ය.නාලිකා ගුණවර්ධන[2], මෙලනි සෙල්වදුරේ[1]

[1] හෙද පීඨය, රයර්සන් විශ්ව විද්‍යාලය, ටොරොන්ටො [2] වෛද්‍ය විද්‍යාලය, කොළඹ විශ්වවිද්‍යාලය

ලොව පුරා කාන්තාවන් තිදෙනෙකුගෙන් එක අයෙක් තම ස්වාමිපුරුෂයන්ගෙන්/ සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් ප්‍රචණ්ඩත්වයට පත්වන බව ප්‍රකාශ වේ. ශ්‍රී ලංකාවේ විවිධ ප්‍රදේශයන්හි කල අධ්‍යයනයන් පෙන්වාදෙන අයුරින් සියයට 18-72 අතර ප්‍රමාණයක් කාන්තාවන් තම ජීවිත කාලය තුල යම් අවස්ථාවක මෙසේ ප්‍රචණ්ඩත්වයට පත්වී ඇත. නාගරික අඩු ආදායම් ලබන පවුල්වල කාන්තාවන් හා යුද්ධයෙන් පීඩිත උතුරු නැගෙනහිර ප්‍රදේශවල කාන්තාවන් මෙසේ සමීපතමයන්ගෙන් හිංසනයට ලක්වීමේ ප්‍රවණතාවය වැඩි බවත් පර්යේෂණ වලින් පෙන්වා දේ.මෙසේ ප්‍රචණ්ඩත්වයට පත්වන කාන්තාවන්ගේ අත්දැකීම ඒ සඳහා දක්වන ප්‍රතිචාර ඔවුන්ගේ පුද්ගලික ජීවිත භූමික මත වෙනස්වන බව සඳහන් වේ.
මෙම කාන්තාවන්ගෙන් බොහොමයක් ඒ පිලිබඳ අන්‍යන්ට හෙළි කිරීමට මැලිවන බවත්, එම හිංසනය/ පීඩනය ඇතිකරන සහකරුවා සමඟ වසර ගණනක් එකට වාසය කරන බවත් පැහැදිලි වේ. උදව් සොයා යන කාන්තාවන් බොහෝ දෙනෙක් තම නෑදෑයන්, මිතුරියන් හා අසල්වැසියන් වෙත යොමුවන බවත්, තවත් සමහර කාන්තාවන් ආගමික නායකයින්, ග්‍රාමසේවක වැනි සමාජයේ පිළිගත් පුද්ගලයින් වෙත යොමුවන බවත් ප්‍රකාශවේ.

පොලිසියේ, සෞඛ්‍ය සේවාවන් වල හා මේ සඳහා විශේෂිත සේවාවන් සපයන ආයතන වලින් සේවා ලබාගන්නා කාන්තාවන්ගේ ප්‍රතිශතය අල්ප බවත් පර්යේෂණ පෙන්වාදේ. තවද, මේ සඳහා විධිමත් සේවාවන් සපයන ආයතන වලින් සේවා ලබාගෙන එම තත්වයෙන් මිදීමට උත්සුකවන කාන්තාවන්ගේ ප්‍රමාණය ඊටත් අඩු බව පෙන්වා දෙයි. වෙනත් රටවල පර්යේෂණ පෙන්වාදෙන අයුරින්, සමීපතමයන්ගෙන් හිංසනයට, පීඩනයට පත්වන කාන්තාවන් ඔවුන්ට ඇතිවන ශාරීරික හා මානසික ආතතියන්ට පිළියම් සෙවීමට සෞඛ්‍ය සේවාවන් වෙත යොමුවීමේ ප්‍රවණතාවයක් ඇති අතර, ඔවුන් එම සේවකයන්ට තමා මුහුණපාන හිංසනය/ පීඩනය පිලිබඳ හෙළි නොකලත්. එම අවස්ථාවන් ඔවුන්ට සේවා ගැන දැනුවත් කිරීමට සුදුසු අවස්ථාවක් වේ.

මෙම සාරාංශයේ අරමුණ වන්නේ, ශ්‍රී ලාංකික කාන්තාවන්ට සමීපතමයන්ගෙන් (ස්වාමිපුරුෂයන්ගෙන්/ සහායකයන්ගෙන්/ පෙම්වතුන්ගෙන්) සිදුවන හිංසා/ පීඩා පිලිබඳ සේවා සැපයීම සෞඛ්‍ය සේවාවේ ප්‍රතිචාර පිලිබඳ විශ්ලේෂණය කිරීමයි.

ලොව පුරා විවිධ රටවල ස්ථාපිත කර ඇති (ආසියාතික රටවල් ඇතුළුව) මෙවැනි සේවාවන් අධ්‍යයනයකර එම සේවාවන් දැනට පවතින සෞඛ්‍ය සේවාවන් හා යාබද්ධිත කර ඇති අයුරු වර්ගීකරණය කර ඇත. එම වර්ගීකරණයට අනුව පළවෙනි මට්ටමේ (අඩුම මට්ටමේ) සේවාවන් වලින් රෝහලට පැමිණෙන කාන්තාවන්ට හිංසනයට සම්බන්ධ උපදෙස් දීම, උපදේශනය වැනි සේවාවන් අල්පයක් (එකක් හෝ දෙකක්) වෛද්‍යවරුන් හා හෙදියන් විසින් ලබාදෙයි. දෙවන මට්ටමේ සේවාවන් තුල වඩා පුළුල් සේවාවක් සපයන අතර, වඩා වැඩි වෛද්‍යවරුන් රෝහල්/ සෞඛ්‍ය සේවා ආයතන තුල හා හෙදියන් ප්‍රමාණයක් මේ සඳහා දායක වෙයි. ඊට අමතරව රෝහල තුලම ඇති වෙනත් සේවාවන් සායන වෙත කාන්තාවන් යොමු කිරීමත් සිදුවේ. තුන්වන මට්ටමේ සේවාවන් වර්ගීකරණයට අනුව මුළු සෞඛ්‍ය පද්ධතිය පුරා ව්‍යාප්තවූ පුළුල්තම සේවාවන් විවිධ ආයතනයන් හා එකාබද්ධව සපයනු ලැබේ.

අන් රටවල මෙන්ම ශ්‍රී ලංකාවේද කාන්තාවන්ට විශේෂිත වූ සේවාවන් රාජ්‍ය සෞඛ්‍ය සේවාවන් තුල ස්ථාපිත වීම මෑත කාලීන ප්‍රවණතාවයකි. මේ සඳහා මුල් පියවර වශයෙන් කාන්තා හිංසන වැළැක්වීමමට සේවාවන් (GBV desks) ස්ථාපිත වූයේ 2002 වසරේය. එය හදිසිඅනතුරු අංශ/ බාහිර රෝගී අංශ ආශ්‍රිතව වෛද්‍යවරුන්/ හෙදියන් විසින් ලබාදෙන උපදෙස් සේවාවකට පමණක් විය. එම සේවා වර්ගීකරණයට අනුව පලවෙනි මට්ටමට අයත් වන සේවාවක් විය.

බොහොමයක් රෝහල්වල ස්ථාපිත කර ඇති GBV Desks වල උපදේශන සේවා සැපයීමට රාජ්‍ය නොවන ආයතනවල (NGO) උපදේශකයන්ගේ සේවාවන් ලබාගෙන ඇති බව ප්‍රකාශ වේ. මෙම උපදේශකයන්ගේ

රෝහලෙන් පිටස්තර ආයතන සමඟ ඇති සම්බන්ධතා උදව් කරගෙන කාන්තාවන්ට උපදේශනයට අමතර සේවාවන් ලබාදීමට (නීතිමය උපදෙස්, කෙටිකාලීන නවාතැන්) උත්සුක වී ඇති බව පර්යේෂණ පෙන්වා දෙයි. එම නිසා මෙම සේවාව වර්ගීකරණය පළවෙනි මට්ටමට වඩා පුළුල් සේවාවක් ලබාදීමට අවස්ථාවන් සලසා දී ඇති බව පෙනේ. 2011 වන විට මෙවැනි කාර්යාල 10ක් ලංකාවේ විවිධ පලාත්වල පැවතුනි.

මීට අමතර දෙවැනි සෞඛ්‍ය සේවා පියවරක් වශයෙන් මිතුරු පියස කාර්යාලයක් 2007 වසරේදී ස්ථාපිත විය. හදිසි අනතුරු./ බාහිර රෝගී අංශය ආශ්‍රිතව පිහිටවූ මෙම කාර්යාල වල ඒ සඳහා විශේෂිත පුහුණුවක්ලද වෛද්‍යවරුන්/ හෙදියන් රෝහල තුල විවිධ වූ පුළුල් සේවාවන් ලබා දීමට සේවයේ යොදවන ලදී. රෝහල තුල පිහිටි සෞඛ්‍ය සේවා හා උපදේශනයට යොමු කිරීමට අමතරව රෝහල් වලින් පිටස්තර වූ සේවාවන් වෙත (නීතිමය උපදෙස්, කෙටි කාලීන නේවාසික පහසුකම් වැනි) යොමු කිරීමක්ද සිදු වේ. 2014 වන විට මිතුරු පියස කාර්යාල 20ක් ලංකාවේ ස්ථාපිත කර තිබූ බවට ප්‍රකාශ වේ.

මිතුරු පියස කාර්යාල මගින් වර්ගීකරණයට අනුව දෙවන මට්ටමේ සේවා ව්‍යාප්තියක් (විවිධ ආයතන තුල විවිධ සේවාවන් සමඟ යාබද්ධව ලබාදෙන සේවාවන්) සපයාදීමේ පහසුකම් ඇතිකරයි. මිතුරු පියස කාර්යාල සේවකයන් මගින් රෝහලින් පිටස්තර වූ ආයතන (පොලිසිය, නීති ආධාර වෙනත් රාජ්‍ය නොවන ආයතන, සමාජ සේවා සංවිධාන) සමඟ සම්බන්ධතා ඇතිකරගෙන සේවා සඳහා කාන්තාවන් මෙම ආයතනවලට යොමු කිරීමට දිරිමත් කරයි.

මෙම සේවා පද්ධතිය ඉතා පුළුල් සේවාවන් සැපයීමට සුදුසු පසුබිම සැකසීමේ හැකියාව ඇති නමුත්, ප්‍රායෝගික දුෂ්කරතා හා අඩුපාඩු නිසා එය ක්‍රියාත්මක කිරීමේ දුෂ්කරතා ඇති බව ප්‍රකාශ වේ. මෙම සේවා පද්ධතිය අධ්‍යයනය කිරීමට අවශ්‍ය පර්යේෂණ/ දත්ත නොමැති වුවද, විවිධ වාර්තා හා පුද්ගලයන්ගේ අදහසට අනුව මෙම සේවා පුළුල්ව ව්‍යාප්තවීමට අවශ්‍ය අන්තර් සම්බන්ධතා විවිධ ආයතන අතර හොඳින් ස්ථාපිත වී ඇති බව ප්‍රකාශ වේ. උදාහරණ වශයෙන් රෝහල හා ඊට බාහිර වූ රාජ්‍ය ආයතන (පොලිසිය, සමාජ සේවා ආයතන, රාජ්‍ය නොවන ආයතන) අතර අන්‍යොන්‍ය සම්බන්ධතා හොඳින් දියුණු වී නැති බව පෙන්වා දෙයි.

ඉදිරි ක්‍රියාමාර්ග: ප්‍රචණ්ඩත්වයට භාජනය වූ කාන්තාවන් වෙනුවෙන් ස්ථාපිත කර ඇති සෞඛ්‍ය අංශයේ සේවාවන් පිලිබඳ පුළුල් අධ්‍යයනයක් කිරීමේ අවශ්‍යතාවය මෙම පිලිබඳ දැනට පලවී ඇති ලිපිලේඛන, වාර්තා විශ්ලේෂණයන්ගෙන් පැහැදිලිවේ. සෞඛ්‍ය සේවකයන් මෙම සේවාවන් සැපයීම දක්වා උනන්දුව හා ඔවුන් මේ සඳහා ලබා ඇති දැනුම්, ආකල්ප හා පුහුණුව පිළිබඳව අධ්‍යයනයන් අවශ්‍යව ඇත.

මිලියන 10ටවැඩි ශ්‍රී ලාංකික කාන්තාවන් වෙනුවෙන් ස්ථාපිත කර ඇති කාන්තා සහන කාර්යාල හා මිතුරු පියස සේවා මධ්‍යස්ථාන අල්පයක් බැවින් සෞඛ්‍ය පද්ධතිය තුල ස්ථාපිත කර ඇති සේවාවන් වඩාත් පුළුල්ව ව්‍යාප්තකිරීමේ අවශ්‍යතාවයක් ඇත. ඒ සඳහා අවශ්‍ය පසුබිම හා දත්ත ලබාගැනීමට දැනට පවතින සේවාවන් විශ්ලේෂණයක් කිරීමත්, එම සේවාවන් වඩාත් පුළුල් කිරීමට (වර්ගීකරණයට අනුව තුන්වන මට්ටමේ සේවා පද්ධතියක් ලෙස) අවශ්‍ය පියවර ගැනීමත් ප්‍රමුඛතම කාලීන අවශ්‍යතාවයකි.

රෝහල් වලින් පිටස්තරව, කාන්තාවන්ට අවශ්‍යතම වූ සමාජ සේවා, තාවකාලික නවාතැන්, නීති ආධාර ලබාදෙන රාජ්‍ය නොවන ආයතන වල දායකත්වය වඩාත් හොඳින් ඇගයීමට ලක්කිරීමක් සිදුවිය යුතුය. තවද, ප්‍රචණ්ඩත්වයට ලක්වූ කාන්තාවන්ට සෞඛ්‍ය සේවාවන් තුල සෞඛ්‍ය සේවාවන් සැපයීම අවශ්‍ය ජාතික ප්‍රතිපත්ති හා වැඩසටහන් දියත් කිරීමේ දැඩි අවශ්‍යතාවයක් ඇති බවද අවධාරණය වේ.

පරිවර්තනය: මදාරා රන්මුතුගල මිය නැවත පරීක්ෂාකිරීම් : වෛද්ය චත්සලා ජයසූරිය. මෙහි සඳහන්කර අධ්‍යයන පිළිබඳ වැඩි විස්තර සඳහා contact@addressingipvsrilanka.ca email ලිපිනය හරහා අප සමග සම්බන්ධවන්න.

இலங்கையில் நெருங்கிய துணைவர் வன்முறையும் சுகாதாரத்துறை புதில் நடவடிக்கைகளும்

கலாநிதி. சேபாலி குருகே, கலாநிதி. வத்சலா ஜயசூரிய, கலாநிதி நாலிகா குணவர்த்தனா மற்றும் மெலனி செல்வதுரை. தாதிமார் கல்லூரி, ரெயர்சன் பல்கலைக்கழகம், டொரன்டோ, கனடா. மருத்துவ பீடம், கொழும்பு பல்கலைக்கழகம், ஸ்ரீ லங்கா.

பெண்களுக்கெதிரான நெருங்கிய துணைவர் வன்முறை (IPV) என்பது, தற்போது உடன வாழ்ந்து கொண்டிருக்கும் அல்லது முன்னால் வாழ்ந்து கொண்டிருந்த துணைவரினால் (ஆண் துணை, கணவர், துணைவர், இணை பங்குதாரர்) இழைக்கப்படும் உடல், பாலியல், வாய்மூல, மற்றும் உள ரீதியான துஷ்பிரயோகங்கள், பல்வேறு முறைகளினாலான கட்டுப்பாட்டு நடத்தைகள் போன்றவற்றைக் குறிக்கும். உலகளாவிய ரீதியில் மூன்று பெண்களில் ஒருவர் நெருங்கிய துணைவர் வன்முறைகள (IPV) அனுபவத்திற்கு உள்ளாகி இருக்கின்றனர். இலங்கையில் பல பிதேசங்களில் மேற்கொள்ளப்பட்ட ஆய்வுகளின் படி 18–72% வீதமான பெண்கள் அவர்களது வாழ்க்கையில் சில சமயங்களில் நெருங்கிய துணைவர் வன்முறைகளுக்கு(IPV) உள்ளாகியுள்ளனர். ˙ நகர்ப்புறங்களில் வாழும் வறுமையான குடும்பங்களைச் சார்ந்த பெண்களும் யுத்தத்தினால் பாதிக்கப்பட்ட பகுதிகளில் வசிக்கும் பெண்களுமே இத்தகைய நெருங்கிய துணைவர் வன்முறை ஆபத்துகளுக்கு அதிகம் முகங் கொடுத்துள்ளனர்.

நெருங்கிய துணைவர் வன்முறைகள் தொடர்பாக பெண்களின் பதில் நடவடிக்கைகள், தனிப்பட்ட ரீதியில் அவர்கள் வாழும் சூழல் மற்றும் நெருங்கிய தணைவர் வன்முறைகள் தொடர்பான அவர்கள் அனுபவம் அடிப்படையில் வேறுபடும். நெருங்கிய தணைவர் வன்முறைகளுக்கு முகங்கொடுத்துள்ள பெரும்பாலான பெண்கள் அது பற்றி பேசுவதில்லை. அவர்கள் தொடர்ந்தம் பல வருடங்களாக தம்மைத் துஷ்பிரயோக்துக்கு உட்படுத்திய துணைவரோடு வாழ்ந்து வருகின்றனர். அப்படி அது தொடர்பாக முதன்மை நிலையான உதவிகளைப் பெற விரும்புவோர் அவர்களது குடும்பம், நண்பர்கள், அயல் வீட்டார், மதத் தலைவர்கள் போன்ற சமூக தலைவர்கயே நாடுகின்றனர். நெருங்கிய துணைவர் வன்முறைகளுக்குள்ளான மிகக் குறைந்த விதத்தினரே மருத்துவமனை, பொலீஸ் நிலையம், நலன் விரும்பும் சேவைகளை மேற் கொள்ளும் முகவர் நிலையங்களுக்குச் சென்றுள்ளனர். நாட்டில் காணப்படும் மட்டுப்படுத்தப்பட்ட ஆதரவு மற்றும் சேவைகளுடன் பார்க்கும் போது பெரும்பாலான பெண்களுக்கு அவர்களை துஷ்பிரயேகத்துக்குள்ளாக்கிய துணைவரை விட்டு விலகுவது ஒரு தேர்வாக அமைவதில்லை. ஏனெனில் துஷ்பிரயோகத்திற்கு உள்ளான பெண்களின் உடல், உள ரீதியான விளைவுகள், துஷ்பிரயோகம் மற்றும் வன்முறைகள் முடிவடைந்ததன் பின்னரும் பல காலம் நிலைத்திருக்கலாம். அதனால் சுகாதார, பராமரிப்பு தொழிற்றுறை நிபுணர்களுடன் அவர்கள் தொடர்பு கொள்வதற்கான சாத்தியமுண்டு. ஏனைய சேவை வழங்குனரோடு ஒப்பிட்டால் மிக அதிகம்.) எனவே இலங்கையின் பிண்ணணியில் நெருங்கிய துணைவர் வன்முறைகளை கையாள்வதற்கு சுகாதாரத் துறையில் கவனம் செலுத்துவது

சேவைகளுக்குள் காணப்படும் நெருங்கிய துணைவர் வன்முறைகள் தொடர்பான வகைப்பாட்டு முறை ஒனறைப் பிரயோகித்தோம்:

படிநிலை 1 (ஆகக்குறைந்த படிநிலை) இது தேர்ந்தெடுக்கப்பட்ட சேவை வழங்குனர்/வசதிகளின் ஒருங்கிணைப்பாகும். பொதுவாக ஒரு மருத்துவர்/தாதி மருத்துவமனைக்கு/கிளினிக்கு வரும் பெண்களுக்கு நெருங்கிய துணைவர் வன்முறைகளோடு தொடர்புடைய ஒன்று அல்லது அதற்கு மேற்பட்ட சேவைகளை வழங்கல். படிநிலை 2 என்பது பல்வேறு சேவைகளை உள்ளடக்கிய சேவை வழங்குனர்/வசதிகளின் ஒருங்கிணைப்பாகும். மருத்துவமனையில் அல்லது கிளினிக்கில் இருக்கும் ஒரு மருத்துவர் அல்லது அதற்கு மேற்பட்ட மருத்துவர்கள்/ தாதிமார்கள் மற்றும் ஆலோசகர்களால் வழங்கப்படும் அதிகமான சேவைகளைக் குறிக்கும். படிநிலை 3 என்பது துறை விரிவு படுத்தப்பட்ட பல்வேறு சேவைகள் கொண்ட ஒரு ஒருங்கிணைப்பு முறையாகும். பல்வேறு இடங்களில், பலவித சேவைகளை வழங்குவதுடன் மீண்டும் மீண்டும் சேவைகளுக்கு உள்ளக விதப்புரை செயகின்ற நிலையையும் கொண்டிருக்கும்.

அநேக நாடுகளில் காணப்படுவது போல இலங்கையிலும் சுகாதாரத்துறை பதில் நடவடிக்கைகள் மிக மெதுவாகவே இடம் பெற்று வருகின்றது. முதற் நடபடிக்கையாக பால்நிலை சார்ந்த வன்முறை மேசை ஒன்று 2002 ஆம் ஆண்டு முதன் முதலில் அறிமுகப்படுத்தப்பட்டது. இவை அவசர அல்லது வெளி நோயாளர் திணைக்களங்கள் அல்லது சுகாதாரக் கல்வி பிரிவுகளிலுள்ள .அவசர சேவை மையங்களாகும். இவைகளில் மருத்துவமனை மருத்துவர்களும், தாதிமார்களும் இருப்பார்கள் அல்லது உள்ளுர் அரச சார்பற்ற நிறுவங்களின்

ஆலோசகர்கள் இருப்பார்கள். பால்நிலை தொடர்பான வன்முறை மேசையானது படிநிலை 1 க்குரிய தேர்ந்தெடுக்கப்பட்ட வழங்குனர்/வசதி ஒருங்கிணைப்பு சேவைகளோடு பொருந்துகின்றது. எனினும் படிநிலை

ஒன்றுடன் தொடர்புபட்டால் பால்நிலை வன்முறை மேசையை நிருவகிக்கும் அரச சார்பற்ற நிறுவனங்களின் ஆலோசகர்கள், அவர்களின் சொந்த

வலைப்பின்னல்களை பாவிக்கலாம். அவர்கள் மாதிகையான படிநிலை 1 சேவைகளுக்கு அப்பால், மருத்துவ நிலையங்களைத் தவிர குறுகிய காலம் தங்கும் வீடுகள், சட்ட உதவிகள், மற்றும் சமூக சேவைகள் தொடர்பான வளங்களையும் விதப்புரை சேவைகளையும் வழங்கலாம். 2011 ஆம் ஆண்டில் நாடு முழுதும் 10 பால்நிலை வன்முறை மேசைகள் இருந்தன. இரண்டாவது முயற்சியாக 2007 ஆம் ஆண்டு, வெளி நோயாளிகளின் மற்றும் அவசர திணைக்களங்களுடன் தொடர்பாக மித்துரு பியச (நட்புறவு இல்லம்) ஆரம்பமானது. இந்நிகழ்ச்சித் திட்டத்தின் கீழ் தாதிமாரும், மருத்துவர்களும் மருத்துவமனைகளில் சேவைகளை வழங்குவர் (மருத்துவ ரீதியான கவனிப்பு, ஆலோசனைச் சேவைகள்). அத்தோடு மருத்துவ மனைகளுக்கு வெளியே (குறுகிய காலம் தங்கும் வீடுகள், சட்டஉதவிகள்) சேவை பெறுவதற்கான விதப்புரைகளையும் நெருங்கிய துணைவர் வன்முறைகளுக்கு உள்ளான பெண்களுக்கு வழங்குவர். 2014 ஆம் ஆண்டு, நாடு முழுதும் ஏறக்குறைய 20 மித்துரு பியச நிலையங்கள் இருந்தன. (என். மாபிட்டிகம, பபால்நிலை கவனக்குவியப் புள்ளி, சுகாதார அமைச்சு, தனிப்பட்ட தொடர்பாடல்). ஏனைய நாடுகளிலுள்ள ஓரிட நெருக்கடி மைய மாதிரியை ஒத்த, மித்துரு பியச (படிநிலை 2) க்குரிய, விரிவான வசதிகளின் ஒருங்கிணைப்பாகும், இது வெவ்வேறு இடங்களிலுள்ள வெவ்வேறு துறைகளுக்கான மேலதிக சேவைகளை அடைவதற்கான வாய்ப்புக்களை உள்ளடக்கியது ஏனென்றால் பெண்களை பொலீஸ், சட்ட உதவிகள், அரச சார்பற்ற நிறுவனங்கள், மாகாண மட்டத்திலான சமூக சேவை நிலையங்கள் மற்றும் பொலிசுடன் இணைப்பதற்கு விரிவான விதப்புரைக்குறிப்பு முறையை மருத்துவ ஊழியர்கள் உருவாக்கியுள்ளனர்.. இது ஒரு சிறப்பான மாதிரியாகக் காணப்படுகின்றது. எனினும் பலவிதமான நடைமுறை சவால்கள், வரையறைகளும் இருக்கின்றன. இம்மாதிரி தற்போதும் காணப்படுகின்றதா என்பது பற்றி எவ்வித தகவல் மதிப்பீடும் இல்லை. எமது தனிபபட்ட தொடர்புகள் குறிப்பிடுவது என்னவெனில் மருத்துவ மனைக்கு உள்ளேயும் வெளியேயும் காணப்படும் ஒத்துழைப்பின் அளவு (பொலீசுடன், சமூக சேவைகள், மற்றும் அரச சார்பற்ற நிறுவனங்கள்) குறைவான மட்டத்திலேயே உளளது.

முன்னேற்றத்திறகான முறை: இலங்கையில் நெருங்கிய துணைவர் வன்முறை உள்ளான பெண்களுக்குரிய சேவைகளின் வினைத்திறன் தொடர்பான விடயங்கள் அறியக்கூடியதாக இல்லை. அத்துடன் சுகாதார பாரமரிப்பு தொழில் நிபுணர்களின் ஆர்வம், ஈடுபடுவதற்கான உள்ள ஆயத்தநிலை, நெருங்கிய துணைவர் வன்முறை சேவை மாதிரிகளை மிக விரிவான வவ்வாறு கொண்டு நடத்துவது என்பது தொடர்பாக எவ்வித தகவல்களும் இல்லை. ஏனெனில் 10 மில்லியன் பெண்களும், பெண் பிள்ளைகளும் வாழும் (அதிக நோய்த்தாக்க வீதங்கள்) இந்நாட்டில், மட்டுப்படுத்தப்பட்ட எண்ணிக்கையிலான பால்நிலை வன்முறை மேசைகளும் மித்துரு பியச நிலையங்களுமே உள்ளன. இலங்கையின் கூட்டு மொத்த சுகாதார சேவைகளின் பதில் நடவடிக்கைகளும் எல்லைப்படுத்தபட்ட அளவிலோயே காணப்படுகின்றன. அதேபோல் மேற்குறிப்பிட்ட இரண்டு மாதிரிகளையும் மதிப்பீடு செய்வதும், தேவையான மாற்றங்களைச் செய்வதும் மிக அவசியமாகும் அத்தோடு தேசியமட்டத்தில் அவை கணிக்கப்படவும் வேண்டும் (படிநிலை 3). அத்துடன், தேவையானவற்றை வழங்கும் அரச சார்பற்ற நிறுவனங்களின் தொழிற்பாடுகளை அடையாளம் கண்டு மதிப்பளிப்பதும், மருத்துவ மனைக்கு உள்ளேயும் வெளியிலும் நெருங்கிய துணைவர் வன்முறை தொடர்பான சேவைகளை அடையாளம் காண்பதும் முக்கியமானதாகும். இறுதியாக, நெருங்கிய துணைவர் வன்முறையை சுகாதார துறையில் ஒரு முன்னுரிமைக்கு உரியதாக்கூடிய ஆதரவான கொள்கைகைளையும் நிகழ்ச்சி நிரல்களையும் உருவாக்குதல் ஒரு முக்கியஅவசர தேவையாக உள்ளது.

இக்சுருக்கக் குறிப்பானது தற்போது பிரசுரிக்கப்படுவதற்கு மீளாய்வு யெய்யப்பட்டுக் கொண்டிருக்கும் கட்டுரை ஒன்றின் அடிப்படையில் அமைந்ததாகும் உங்களுக்கு மேலதிக விபரங்கள் அறிய வேண்டுமானால் தயவு செய்து ஆசிரியருடன் தொடர்பு கொள்ளவும்.

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Intimate partner violence against women in Sri Lanka: A summary

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Intimate partner violence (IPV) is the physical, sexual and/or emotional abuse by a current or former intimate partner. Worldwide, the majority of victims of IPV are women. Research suggests that women in South Asia are at a greater risk for IPV than women in other parts of the world. This summary describes the situation in one South Asian country - Sri Lanka.

Patterns and prevalence: Most research estimates that 1 in 3 women in Sri Lanka have experienced IPV at some time during their life. A few other reports (based on small to moderate sample sizes) suggest a higher prevalence rate (up to 80%). Research also suggests that prevalence rates are higher among women living in areas affected by civil war in the Northern and Eastern provinces, those in the tea estates, and women residing in urban low-income areas.

Risk factors: Some studies have found that women experiencing IPV are younger, have less education, and live in lower socio-economic conditions. Other reports suggest that these factors alone do not increase women's risk and will only do so when combined with men's alcohol/ drug abuse, extra marital affairs, and experiences of abuse in childhood. However, most researchers agree that strict societal gender roles/relations increase Sri Lankan women's risk of experiencing IPV.

Women's responses: Most women facing IPV do not talk about it and continue to live with their abusive partners for years. Those who seek help primarily turn to their family, friends, neighbors, and community members such as religious leaders. Few women seek help from hospitals, police, and agencies providing IPV related services. Women who use health care services for IPV related injuries often do not tell health care providers about the abuse. Even fewer women report abuse to police officers; among those who do, most reports do not lead to legal action against their abuser. The rates of suicide in Sri Lanka remain high but the relationship between these and IPV has not been examined carefully.

Health sector response: Gender based violence (GBV) Desks and *Mithuru Piyasa* (Friendly Abode) centers (located in government hospitals) provide 'treatment' and counseling for women experiencing IPV. Both also provide some in- and/or out-of-hospital referrals to other services, such as legal aid or short-term housing. Because GBV Desks and Mithuru Piyasa centers have not been evaluated, we do not know if women receive the services they need. Furthermore, there is limited research about the knowledge, skills, and attitudes of health care professionals in helping women dealing with IPV in the Sri Lankan context. Evidence suggests that some health care professionals have stigmatizing attitudes towards women who seek services, blame women for abuse, and advise that the women can fix the situation if they try harder.

Policy and legal/justice response: Sri Lanka's Prevention of Domestic Violence Act allows women to obtain an Interim Protection Order (IPO) against their abusive partner. To do so, they have to provide evidence of abuse, and often there are delays in issuing IPOs. Even when an

IPO is issued, men can continue the abuse as there are no IPO enforcement mechanisms. Gaps in the Sri Lankan legal system also affect women and their ability to seek help for IPV. For example, marital rape is not recognized by the legal system unless the partners are legally separated. Other policies and regulations can also make women further vulnerable to IPV. For example, a recent (2013) government policy requires women leaving the country for employment to seek permission from their husband; this enforces men's authority and control over women.

Research, practice and policy implications: Research is particularly needed about IPV in non-marital relationships, among women in different parts of Sri Lanka, and from various ethno-cultural and religious groups. We do not know how women can be encouraged to seek available services or if health care professionals have the required knowledge, attitudes, and skills to provide services for women who have experienced IPV. Laws, policies, and programs should aim to protect women's rights and ensure an equal status for them within the home and the community. Addressing societal misperceptions about gender, gender roles, and the status of women so as to increase women's ability to participate in politics and decision making positions should be a priority.

This summary is based on a paper currently under review for publication. If you need more details please contact the authors: contact@addressingipvsrilanka.ca

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ஸ்ரீ லங்காவில் பெண்களுக்கெதிராக நெருங்கிய துணைவர் வன்முறை : சாராம்சம்

கலாநிதி: சேபாலி குருகே[1], கலாநிதி: வத்சலா ஜயசூரிய[1] , கலாநிதி : நாலிக குணவர்தன[2] , மெலனி செல்வதுரை

1 தாதியர் கல்லூரி . றையர்சன் பல்கலைக்கழகம், ரொறன்ரோ, கனடா 2 மருத்துவ பீடம், கொழும்பு பல்கலைக்கழகம் இலங்கை

நெருங்கிய துணைவர் வன்முறை என்பது தற்போது, கூட வாழ்ந்து கொண்டிருக்கும் அல்லது முன்னர் வாழ்ந்து கொண்டிருந்த நெருங்கிய துணைவர் ஒருவர் ஏற்படுத்துகின்ற உடல், பாலியல், உள ரீதியான துன்புறுத்தலாகும். ஒருவருக்கு இவற்றில் ஒன்றோ பலவோ நிகழலாம். .உலகளாவிய ரீதியில், நெருங்கிய துணைவரால் வன்முறைக்கு உள்ளாகுபவர்களில் பெரும்பாலானோர் பெண்களாவர். உலகில் ஏனைய பாகங்களில் உள்ள பெண்களை விட, நெருங்கிய துணைவரால் வன்முறைக்கு உள்ளாகுபவர்களில் அதிகமானோர் தென் ஆசியப் பெண்கள் என ஆய்வுகள் குறிப்பிடுகின்றன. இச் சாராம்சம் தென் ஆசிய நாடான ஸ்ரீ லங்காவில் உள்ள நிலைமையை விபரிக்கின்றது.

பொதுவான போக்கும் பாதிப்பு நிலவரமும்: இலங்கையில் 3 பெண்களில் ஒருவர் தமது வாழ்நாளில் எப்பொழுதோ நெருங்கிய துணைவருடைய வன்முறைக்கு ஆளாகின்றார் என அனேகமான ஆய்வுகள் மதிப்பிடுகின்றன. ஏனைய சில அறிக்கைகள் (சிறிய மற்றும் நடுத்தர அளவான மாதிரிகளை அடிப்படையாகக் கொண்டவை), இவ் வன்முறை அதிக அளவில் (80%) இடம் பெறுவதாகக் காட்டுகின்றன. உள்நாட்டு யுத்தத்தினால் பாதிக்கப்பட்ட வடக்கு, கிழக்கு மாகாணங்களில் உள்ள பெண்கள், தேயிலைத் தோட்டங்களில் வாழும் பெண்கள் மற்றும் நகர்ப்பிரதேசங்களில் குறைந்த வருமானம் பெற்று வாழும் பகுதிகளில் வாழும் பெண்கள் மத்தியில் கூடிய வீதத்தில் இந்த வன்முறை நிகழ்கின்றது என ஆய்வுகள் குறிப்பிடுகின்றன.

ஆபத்து விளைவிக்கும் காரணிகள்: இளம் வயதுடைய, கல்வி நிலை குறைந்த மற்றும் குறைவான சமூகப்-பொருளாதார நிலைமையில் வாழும் பெண்களே நெருங்கிய துணைவர் வன்முறைக்கு அதிகமாக ஆளாகின்றனர் என சில ஆய்வுகள் கண்டறிந்துள்ளன. இக்காரணிகள் மாத்திரம் தனியாக பெண்களுக்கான ஆபத்தை அதிகரிப்பதில்லை எனவும் ஆண்களின் மதுப்பாவனை, போதைப்பொருள் பாவனை, திருமணத்துக்கு வெளியே உள்ள உறவுகள், சிறு பராயத்தில் வன்முறைக்கு ஆளாகியிருத்தல் போன்றவற்றுடன் இணையும்போது மாத்திரமே அவ்வாறு இடம் பெறுகின்றன எனச் சில அறிக்கைகள் குறிப்பிடுகின்றன. எனினும், கடுமையான சமூக ரீதியான பால்நிலை சார்ந்த கட்டுப்பாடுகள், பால் ரீதியாக வகிக்கும் நிலைகளும் இலங்கைப் பெண்கள் நெருங்கிய துணைவரின் வன்முறைக்கு ஆளாகுவதற்கான ஆபத்துக்களை அதிகரிக்கின்றன என்ற கருத்துடன் அனேகமான ஆய்வாளர்கள் உடன்படுகின்றனர்.

பெண்களின் பிரதிபலிப்புக்கள்: நெருங்கிய துணைவரால் வன்முறைக்கு ஆளாகின்ற அனேகமான பெண்கள் அது பற்றிப் பேசுவதில்லை. அத்துடன் தம்மை வன்முறைக்கு உட்படுத்தும் அதே துணைவருடனே தொடர்ந்தும் பல ஆண்டுகள் வாழ்கின்றனர். உதவி

தேடுவோர் ஆரம்பத்தில் தமது குடும்பத்தினர், நண்பர்கள், அயல் வீட்டார், சமூக அங்கத்தவர்களான மதத்தலைவர்களை நாடுகின்றனர். சில பெண்கள் உதவிக்காக வைத்தியசாலைகள், பொலிஸ் மற்றும் நெருங்கிய துணைவர் வன்முறையுடன் தொடர்புபட்ட சேவைகளை வழங்கும் முகவர் நிலையங்களையும் நாடுகின்றனர். நெருங்கிய துணைவர் வன்முறையுடன் தொடர்புபட்ட காயங்களுக்காக வைத்திய சேவைகளைப் பயன்படுத்தும் பெண்கள், வன்முறை பற்றி வைத்திய சேவை வழங்குபவர்களுக்குத் தெரிவிப்பதில்லை. குறைந்த எண்ணிக்கையான பெண்களே வன்முறை பற்றி பொலிஸ் அலுவலர்களுக்கு அறிவிக்கின்றனர். அவ்வாறு செய்பவர்களின் அனேகமான பொலிஸ் அறிக்கைகள் கூட வன்முறை செய்தவர்களுக்கு எதிரான சட்ட நடவடிக்கை எடுப்பதற்கு இட்டுச்செல்வதில்லை. ஸ்ரீ லங்காவில் தற்கொலை செய்யும் வீதம் தொடர்ச்சியாக உயர்வாகவே காணப்படுகின்றது. எனினும் இதற்கும் நெருங்கிய துணைவர் வன்முறைக்கும் இடையிலான தொடர்பு பற்றிக் கவனமாக ஆய்வு செய்யப்படவில்லை.

<u>சுகாதாரப் பகுதியினரின் நடவடிக்கை</u>: (அரசாங்க வைத்தியசாலைகளில் உள்ள) பால்நிலை அடிப்படையாகக்கொண்ட வன்முறை முறைப்பாட்டு மேசை மற்றும் *மித்துரு பியஸ* (நட்பு இல்லம்) போன்ற நிலையங்கள் நெருங்கிய துணைவரது வன்முறைக்கு ஆளாகும் பெண்களுக்கு ''சிகிச்சை'' மற்றும் ஆலோசனை வழங்குகின்றன. இவை இரண்டும் சட்ட உதவி அல்லது குறுகிய கால வீட்டு வசதி போன்ற ஏனைய சேவைகளுக்கு வைத்தியசாலைகளுக்கு உள்ளும் அல்லது வெளியிலும் பரிந்துரைகளையும் வழங்குகின்றன. பால்நிலையை அடிப்படையாகக்கொண்ட வன்முறை முறைப்பாட்டு மேசை மற்றும் மித்துரு பியஸ நிலையங்கள் மதிப்பீடு செய்யப்படாததால், பெண்கள் தமக்குத் தேவையான சேவைகளைப் பெற்றுக்கொள்கின்றனரா என்பது எமக்குத் தெரியாதுள்ளது. மேலும் இலங்கைச் சூழலில் நெருங்கிய துணைவரின் வன்முறைக்கு ஆளாகின்ற பெண்களுக்கு உதவி அளிக்கின்ற சுகாதார பராமரிப்பு மற்றும் தொழில்சார் ஊழியர்களின் அறிவு, திறன், மனப்பாங்கு தொடர்பாக மட்டுப்படுத்தப்பட்ட ஆய்வுகளே காணப்படுகின்றன. சேவையினை நாடுகின்ற பெண்களைக் களங்கப்படுத்துகின்ற மனப்பாங்குடன் செயற்படுதல், வன்முறை நிகழ்ந்ததற்குப் பெண்களைக் குற்றம் கூறுதல், பெண்கள் கடுமையாக முயற்சித்தால் நிலமையைச் சீர் செய்ய முடியும் என அறிவுரை வழங்குதல் போன்ற நடவடிக்கைகளைச் சில சுகாதார பராமரிப்பு தொழில்சார் நிபுணர்கள் மேற்கொண்டதாகச் சில சான்றுகள் எடுத்துக்காட்டுகின்றன.

<u>கொள்கைவகுப்பு, சட்ட / நீதி நடவடிக்கை</u>: ஸ்ரீ லங்காவின் வீட்டு வன்முறைகளைத் தடுக்கும் சட்டம், பெண்கள் தம்மீது வன்முறை மேற்கொள்ளும் துணைவர்களுக்கு எதிராக இடைக்கால பாதுகாப்பு கட்டளை ஒன்றினைப் பெற்றுக்கொள்வதற்கு அனுமதியளிக்கின்றது. அவ்வாறு செய்வதற்கு வன்முறை பற்றிய சாட்சியங்களை அவர்கள் வழங்க வேண்டும். அத்துடன் பல சமயங்களில் இடைக்காலப் பாதுகாப்புக் கட்டளை வழங்குவதில் தாமதங்களும் ஏற்படுகின்றன. இடைக்காலப் பாதுகாப்புக் கட்டளை ஒன்று வழங்கப்பட்டிருந்த போதிலும், இடைக்காலப் பாதுகாப்புக் கட்டளையை அமுல் செய்வதற்கான பொறிமுறைகள் இல்லாமையால், ஆண்கள் தொடர்ந்தும் வன்முறையை மேற்கொள்கின்றனர். ஸ்ரீ லங்காச் சட்ட

முறையில் காணப்படுகின்ற இடைவெளிகளும், பெண்களையும் நெருங்கிய துணைவர்களால் நிகழ்த்தப்படும் வன்முறைக்கு எதிரான உதவியினை நாடுவதற்கான அவர்களது ஆற்றலையும் பாதிக்கின்றன. உதாரணமாக துணைவர்கள் சட்ட ரீதியாகப் பிரிந்தாலன்றி, திருமணத்திற்குள் நிகழும் வன்புணர்ச்சி என்பது சட்டமுறையால் அங்கீகரிக்கப்படாத ஒன்றாகவே உள்ளது. ஏனைய கொள்கைகளும் ஒழுங்கு விதிகளும், பெண்களை நெருங்கிய துணைவர்களால் நிகழ்த்தப்படும் வன்முறைக்கு மேலும் உள்ளாகக்கூடியவர்களாக ஆக்கக்கூடியவையாக உள்ளன. உதாரணமாக அண்மையில் வெளிவந்த (2013) அரசாங்கக்கொள்கையானது, தொழிலுக்காக நாட்டை விட்டுச் செல்லும் பெண்கள் அவர்களது கணவரின் அனுமதியைப் பெறவேண்டும் என்பதைக் கட்டாயப்படுத்துகின்றது. இக்கொள்கை பெண்கள் மீதான ஆண்களின் அதிகாரத்தையும் கட்டுப்பாட்டையும் அமுல்படுத்துகின்றது.

ஆய்வு, நடைமுறை மற்றும் கொள்கைவகுப்பு விளைவுகள்: ஸ்ரீ லங்காவின் வேறுபட்ட மாகாணங்கள் மற்றும் பல்வேறுபட்ட இன, பண்பாடு, சமயப்பின்னணியில் உள்ள பெண்கள் மத்தியில் குறிப்பாக திருமணமான உறவுகளில் நெருங்கிய துணைவர்களால் நிகழ்த்தப்படும் வன்முறை பற்றி ஆய்வு செய்ய வேண்டிய தேவை உள்ளது. கிடைக்கப்பெறுகின்ற சேவைகளைப் பெற்றுக்கொள்வதற்குப் பெண்கள் எவ்வாறு ஊக்குவிக்கப்பட முடியும் என்பதும் எமக்குத்தெரியாது. அல்லது நெருங்கிய துணைவரர்கள் நிகழ்த்தும் வன்முறைக்கு உள்ளான பெண்களுக்கான சேவைகளை வழங்குவதற்குத் தேவையான அறிவு, மனப்பாங்கு, மற்றும் திறன்கள் போன்றவற்றைச் சுகாதாரப் பராமரிப்பு, தொழில்சார் ஊழியர்கள் கொண்டுள்ளனரா என்பதும் எமக்குத்தெரியாது. சட்டங்களும் நிகழ்ச்சித்திட்டங்களும் பெண்களின் உரிமைகளைப் பாதுகாப்பதையும் குடும்பத்தினுள்ளும் சமூகத்திலும் அவர்களின் சமமான அந்தஸ்தினை உறுதி செய்வதனையும் குறிக்கோளாகக் கொண்டிருக்க வேண்டும். அரசியல் மற்றும் தீர்மானம் எடுக்கக்கூடிய பதவிநிலைகளில் பங்கேற்பதற்குத் தேவையான பெண்ணின் ஆற்றலை அதிகரிப்பதற்கு பால்நிலை பற்றிய சமூக ரீதியான தவறான எண்ணம், பால்நிலை வகிபாகங்கள் மற்றும் பெண்களின் அந்தஸ்து தொடர்பான பிரச்சினைகள் பற்றி எடுத்துரைப்பதற்கு முன்னுரிமை வேண்டும்.

இச் சாராம்சம் வெளியீட்டுக்காக தற்போது மீளாய்வு செய்யப்பட்டுவரும் கட்டுரை ஒன்றை அடிப்படையாகக்கொண்டது. மேலதிக தகவல்களுக்கு ஆசிரியர்களை contact@addressingipvsrilanka.ca என்ற மின்னஞ்சலில் தொடர்பு கொள்க.

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ශ්‍රී ලාංකික කාන්තාවන්ට ස්වාමිපුරුෂයන්ගෙන් / සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් සිදුවන ප්‍රචණ්ඩත්වය පිලිබඳ පර්යේෂණ වාර්තා විමර්ශනය

මහාචාර්ය සේපාලි ගුරුගේ[1], වෛද්‍ය වත්සලා ජයසූරිය[1], වෛද්‍ය.නාලිකා ගුණවර්ධන[2], මෙලනි සෙල්වදුරේ[1]

[1] හෙද පීඨය, රයර්සන් විශ්ව විද්‍යාලය, ටොරොන්ටො, කැනඩාව, [2]වෛද්‍ය විද්‍යාලය, කොළඹ විශ්වවිද්‍යාලය, ශ්‍රී ලංකාව

ලොව පුරා විවිධ රටවල කාන්තාවන් තම ස්වාමිපුරුෂයන්ගෙන්, සහකරුවන්ගෙන් හා පෙම්වතුන්ගෙන් ශාරීරික, මානසික, ලිංගික හා අනෙකුත් ප්‍රචණ්ඩත්වයන්ට භාජනය වන බව සුප්‍රකට කරුණකි. ආසියාතික රටවල වාසයකරන කාන්තාවන් මෙසේ ප්‍රචණ්ඩත්වයට ලක්වීමේ ප්‍රවණතාවය ඉහල බව මෑත කාලීන අධ්‍යයනයන් වලින් සොයාගෙන ඇත. ශ්‍රී ලාංකික කාන්තාවන්ගේ තත්වය අධ්‍යයනය කිරීම සඳහා ඒ පිලිබඳ පලවී ඇති පර්යේෂණ වාර්තා, ලිපි ලේඛන විමර්ශනය කිරීම මෙම ලිපියේ පරමාර්ථයයි.

ශ්‍රී ලාංකික කාන්තාවන් තිදෙනෙකුගෙන් එක අයෙක් මෙසේ ප්‍රචණ්ඩත්වයට භාජනය වීමේ ප්‍රවණතාවයක් ඇති බව දැනට පවතින පර්යේෂණ දත්ත අනුව පැහැදිලි වේ. සමහර පලාත්වල වසන කාන්තාවන්ගෙන් සියයට 80ක් පමණ මෙසේ ප්‍රචණ්ඩත්වයට ලක්වී ඇති බව සඳහන් වේ. යුද්ධයෙන් පීඩිත උතුරු, නැගෙනහිර පලාත්වල, මධ්‍යම පළාත් වතුකරයේ කාන්තාවන් හා නාගරික පලාත්වල අඩු ආදායම් පවුල්වල කාන්තාවන්ගේ ප්‍රචණ්ඩත්වයට ලක්වීමේ වැඩි ප්‍රවනතාව ගැන දත්ත පර්යේෂණ වලින් ප්‍රකාශ වන නමුත්, විවිධ තරාතිරම්වල හා විවිධ ජාති, ආගම්වල කාන්තාවන් හිංසනයට ලක්වීමේ අවධානම ගැන පැහැදිලි අවබෝධයක් නොමැති බව අනාවරණය වේ.

මෙසේ ප්‍රචණ්ඩත්වයට පත්වීමට බලපාන සාධක පිලිබඳ අධ්‍යයනයට සමහර පර්යේෂකයන් උත්සාහ ගෙන ඇත. ඔවුන් පෙන්වාදෙන අයුරින්, සමහර සාධක කාන්තාවන් ප්‍රචණ්ඩත්වයට භාජනය වීම කෙරේ බලපෑම් ඇති කරයි. උදාහරණ වශයෙන්, අඩු වයස්වල, අඩු ආදායම් ලබන හා අධ්‍යාපන මට්ටමෙන් පහල තල වල කාන්තාවන්ට වැඩි අවධානමක් ඇති බව පැවසේ. අනෙකුත් පර්යේෂණයන්ට අනුව ප්‍රචණ්ඩත්වයට ලක්වීමට බලපාන සාධක පැහැදිලිව වටහාගැනීමට නොහැකිවී ඇත. උදාහරණ වශයෙන් පුරුෂයන්ගේ අධික මත්පැන් හෝ මත්ද්‍රව්‍ය භාවිතය, අනියම් විවාහයන්, පිටස්තර අසම්මත ප්‍රේම/ ලිංගික සම්බන්ධතා හා ඔවුන් ළමා කාලයේ මුහුණදුන් අතවර හා කාන්තා හිංසනය අතර සම්බන්ධයක් ඇති බව සමහර පර්යේෂණයන් පෙන්වා දෙන නමුත්, අනෙකුත් දත්ත වලට අනුව මෙම සාධක පමණක් ප්‍රචණ්ඩත්වය ඇතිකිරීමට සෘජුවම දායක නොවන බව පැහැදිලිවේ.

ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ ස්ත්‍රී පුරුෂ සමාජ මට්ටම හා ඒ පිලිබඳ සමාජයේ ආකල්ප මෙම ප්‍රචණ්ඩත්වය ඇතිකිරීමට හා එහි ප්‍රවනතාවය ඇති කිරීමට හේතුවන බව පැහැදිලි කරුණකි.

තම ස්වාමිපුරුෂයන්ගෙන්/ සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් ප්‍රචණ්ඩත්වයට භාජනය වන බොහෝ ශ්‍රී ලාංකික කාන්තාවන් ඔවුන් මුහුණ දෙන අතවර පිළිබඳ පිටස්තරයන්, සෞඛ්‍ය සේවකයන් හා අනෙකුත් සේවා සපයන්නන්ට හෙළිකිරීමට මැලිවන බව පැහැදිලි වේ. බොහොමයක් කාන්තාවන් එසේ ප්‍රචණ්ඩත්වයට භාජනය වෙමින් දිගු කාලයක් එම සහකරුවා සමඟ ජීවත් වෙන බවත්, එයින් මිදීමට උත්සුක නොවන බවත් පෙන්වාදෙයි. උදව් සොයා යන කාන්තාවන් බොහොමයක් තම නෑදෑයන්, මිතුරන් හා අසල්වැසියන් වැනි සමීපතමයන් වෙත යොමුවන අතර, සමහරුන් ආගමික නායකයින් වැනි සමාජයේ පිළිගත් නායකයින්/ පුද්ගලයන් වෙත යොමුවේ. පොලිස් ස්ථාන, රෝහල් හා අනෙකුත් සේවා සපයන ආයතන වලට යොමුවන කාන්තා ප්‍රතිශතය ඉතා අල්ප බව බොහෝ පර්යේෂකයන් පෙන්වා දෙයි.

සේවා ලබා ගැනීමට සෞඛ්‍ය සේවා වෙත යොමුවන කාන්තාවන්ගෙන් බොහොමයක් එම සෞඛ්‍ය සේවකයන්ට තමා මුහුණදෙන අතවර පිලිබඳ අනාවරණය කිරීමට මැළි වේ. පොලිසියේ හෝ, නීතිමය ආධාර සෙවීමට යොමුවන කාන්තාවන් ප්‍රමාණය අල්පයක් බවත් පැහැදිලිවේ.

ප්‍රචණ්ඩත්වයන්ට මුහුණ දෙන කාන්තාවන්ට සේවා සැපයීමට කාන්තා සහන කාර්යාල/ මධ්‍යස්ථාන (මිතුරු පියස) රජයේ රෝහල්වල දැන් ස්ථාපිත කර ඇත. මෙම මධ්‍යස්ථාන වලින් වෛද්‍ය උපදේශන සේවා හා අනෙකුත් සේවාවන්, ප්‍රතිකාර, ලබාදෙන අතර, නීතිමය උපදේශන හා කෙටි කාලීන නේවාසික පහසුකම් සඳහා යොමුකිරීම්ද කරන බව ප්‍රකාශ වේ. මෙම මධ්‍යස්ථාන මගින් කාන්තාවන්ට අවශ්‍ය සේවාවන් පැහැදිලිවම ලබාදෙන බව නිශ්චය කිරීමට අවශ්‍ය අධ්‍යයනයන්/ දත්ත නොමැති බව පැහැදිලි කරුණකි. තවද, එම සේවා සපයන්නන්ට ඒ සඳහා අවශ්‍ය දැනුම, දක්ෂතාවය හා ආකල්ප ඇත්ද පිලිබඳ විශ්ලේෂණය කිරීම ඉතාම අල්ප වශයෙන් සිදුවී ඇති බව පැහැදිලි වේ. මෙම සේවාවන් ලබාදෙන සේවකයන්ගේ දැනුම හා ආකල්ප පිලිබඳ විශ්ලේෂණයක් මගින් ඔවුන්ට අවශ්‍ය දැනුම හා අත්දැකීම් හඳුනාගත යුතුබව පර්යේෂකයන් පෙන්වා දෙයි.

ශ්‍රී ලාංකික කාන්තාවන්ට ප්‍රචණ්ඩත්වයෙන් තාවකාලිකව මිදීමට අතුරු ආරක්ෂණ නියෝගයක් (Interim Protection Order) ලබාගැනීමේ අවස්ථාවක් ඇත. මෙසේ අතුරු ආරක්ෂණ නියෝගයක් ලබාගැනීම සඳහා කාන්තාවන් ප්‍රචණ්ඩත්වය පිලිබඳ සාක්ෂි ඉදිරිපත් කල යුතු බැවින් හා බොහෝ අවස්ථාවල එම නියෝග නිකුත්කිරීම ප්‍රමාද වන බැවින් අතුරු ආරක්ෂණ නියෝගයක් සඳහා ඉල්ලුම් කර ඇති කාන්තාවන් දිගටම ප්‍රචණ්ඩත්වයට භාජනය වීමේ අවධානමක් ඇත.

ශ්‍රී ලාංකික නීති පද්ධතියේ ඇති දුර්වලතා/ අඩුපාඩු නිසා නීතිමය ආධාර ලබාගැනීමද අපහසුය. උදාහරණයක් ලෙස විවාහය තුල සිදුවන ලිංගික අතවරයන්/ දූෂණ වලට නීතිමය ආධාර ලබා ගැනීමට අවශ්‍ය නීති නොමැති කමින් (සහකරුවන් නීතියෙන් වෙන්වී නොමැති අවස්ථාවල) මෙසේ ප්‍රචණ්ඩත්වයට පත්වන කාන්තාවන්ට සහනයක් ලබාගැනීමට අවස්ථාවක් නැත.

සමහර රෙගුලාසි නිසා පිරිමින්ගේ අධිකාරිය / ආධිපත්‍ය තවත් තහවුරු වේ. උදාහරණ ලෙස මැදපෙරදිග/ විදේශ රැකියා සඳහා යන කාන්තාවන් තම ස්වාමිපුරුෂයන්ගේ අනුමැතිය ලබාගත යුතු බවට ප්‍රතිපත්තියක් මෑත කාලයේ පනවා ඇත.

ලංකාවේ කාන්තාවන්ට තම ස්වාමිපුරුෂයන්ගෙන්, සහකරුවන්ගෙන් හා පෙම්වතුන්ගෙන් සිදුවන ප්‍රචණ්ඩත්වය පිලිබඳ, (විශේෂයෙන්ම අවිවාහක සම්බන්දතා වල, විවිධ ප්‍රදේශ වල කාන්තාවන් අතර, හා විවිධ සමාජයීය, ජනවාර්ගික හා සංස්කෘතික කාන්තාවන් අතර සිදුවන හිංසනය පිලිබඳ) වැඩිදුරටත් පර්යේෂණ කල යුතුය. තිබෙන සේවාවන් ලබාගැනීමට කාන්තාවන් කෙසේ යොමු කල යුතුදැයි අපි නොදනිමු. එසේම සේවාදායකයින්ට අවශ්‍ය දැනුම, ආකල්ප හා දක්ෂතාවයන් තිබේදැයි අපි නොදනිමු. නීතිය, ප්‍රතිපත්ති හා වැඩසටහන් කාන්තා අයිතීන් රැක දී, ඔවුන්ට නිවසේ හා සමාජයේ සමතැන ලබාදීමට කටයුතු කලයුතුයි.

ස්ත්‍රී පුරුෂ සමාජභාවය, ඔවුන්ට අයත් භූමිකා හා කාන්තාවන්ගේ තරාතිරම පිලිබඳ සමාජයේ ඇති වැරදි මත වෙනස් කිරීමට පිළියම් ගැනීම සඳහා උත්සුක විය යුතුයි. දේශපාලන ක්‍රියාකාරකම් හා තීරණ ගැනීමේ කටයුතුවලදී කාන්තාවන්ගේ සහභාගීත්වය වැඩි කිරීමට අවශ්‍ය පියවර ගැනීමද ප්‍රමුඛතම අවශ්‍යතාවයකි.

මෙහි සඳහන් අධ්‍යයන පිළිබඳ වැඩි විස්තර සඳහා contact@addressingipvsrilanka.ca email ලිපිනය හරහා අප සමග සම්බන්ධ වන්න.

Intimate partner violence and the health sector response in Sri Lanka

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Intimate partner violence against women (IPV) refers to physical, sexual, verbal and psychological abuse, and various controlling behaviors by a current or former male partner (boyfriend/husband/spouse/co-habiting partner). One in three women worldwide experiences IPV. Research conducted in different locations in Sri Lanka reports that 18–72% of women experience IPV at some point in their lives. Women from urban poor communities as well as women living in areas affected by the civil war are at a higher risk of IPV.

Women's responses to IPV can be different depending on the individual context within which they live and experience IPV. Most women facing IPV do not talk about it and continue to live with their abusive partners for years. Those who seek help primarily turn to their family, friends, neighbors, and community members such as religious leaders. Only a small proportion of women experiencing IPV visit hospitals, police stations, and agencies for related care and services. For most women, leaving an abusive partner is not an option given the limited formal support and services available in the country. Because women experience various physical and mental health consequences that may last long after the abuse/violence has ended, it is very likely that women will come in contact with health care professionals (more frequently than with other service providers). It is, therefore, important that we look at health sector response to IPV in the Sri Lankan context.

We reviewed available literature about health sector response to IPV in Sri Lanka and applied a classification system based on the level and type of integration of IPV services within various health care services: Level 1 (lowest level) involves selective provider/facility level integration where usually a doctor/nurse provides one or more IPV-related services for women who visit the hospital/clinic. Level 2 is a comprehensive provider/ facility-level integration, offering more services by one or more doctors/nurses/counselors within the hospital/clinic. Level 3 is a system-wide comprehensive integration, offering many services at different sites with referral and back-referrals across sites/settings.

In Sri Lanka, as is the case in many other countries, health sector response has been slow. The first initiative, the Gender Based Violence (GBV) Desk, was first introduced in 2002. These are service points in emergency/outpatients departments or health education units, and are staffed by nurses and doctors from the hospital and/or by counsellors from the local NGOs. GBV Desks fit with Level 1 selective provider/facility integration of services. The services provided, however, go beyond typical Level 1 integration in that the counselors from NGOs managing GBV Desks could use their own networks and resources to offer women out-of-hospital referral and services such as short-stay homes, legal aid, and social services. In 2011 there were 10 GBV Desks across the country. The second initiative began in 2007 with the *Mithuru Piyasa* (Friendly Abode) program in outpatient/emergency departments. Under this program, nurses and doctors provide in-hospital care (medical attention, counselling) and out-of-hospital referrals (short-term housing, counseling, and legal aid) for women experiencing IPV. In 2014 there were 20 Mithuru Piyasa centers island-wide (N. Mapitigama, Gender Focal Point, Ministry of Health, personal communication). Similar to the One-Stop Crisis Center model in other countries, Mithuru Piyasa involves (Level 2) comprehensive facility-level integration,

with additional access to services at different sites because of the extensive referral system set up by the hospital staff to connect women with police, legal aid, NGOs, and provincial social services. This appears to be an excellent model; however, several practical challenges and limitations exist. While no data evaluating these models is available, our personal communications indicate that the level of collaboration both within and outside the hospitals (with the police, social services, and NGOs etc) is suboptimal.

The way forward: Little is known about the effectiveness of the available services for women experiencing IPV in Sri Lanka. There is also no information about health care professionals' interest and readiness to be involved in or take up these models of IPV services more widely. Because there is a limited number of GBV Desks and Mithuru Piyasa centres available in the country of 10 million women and girls (with high IPV prevalence rates), Sri Lanka's overall health sector response is marginal. As such, there is an urgent need to evaluate and make necessary modifications to improve the two models, and to scale them up to the national level (Level 3). Along with this, it is important to recognize the work of NGOs who provide essential, within and out-of-hospital services for women experiencing IPV. Finally, there is a critical need to develop supportive policies and programs that would make IPV a health sector priority.

This summary is based on a paper currently under review for publication. If you need more details please contact the authors: contact@addressingipvsrilanka.ca

இலங்கையில் நெருங்கிய துணைவர் வன்முறையும் சுகாதாரத்துறை புதில் நடவடிக்கைகளும்

கலாநிதி. சேபாலி குருகே, கலாநிதி. வத்சலா ஜயசூரிய, கலாநிதி நாலிகா குணவர்த்தனா மற்றும் மெலனி செல்வதுரை.
தாதிமார் கல்லூரி, ரெயர்சன் பல்கலைக்கழகம், டொரன்டோ, கனடா. மருத்துவ பீடம், கொழும்பு பல்கலைக்கழகம், ஸ்ரீ லங்கா.

பெண்களுக்கெதிரான நெருங்கிய துணைவர் வன்முறை (IPV) என்பது, தற்போது உடன வாழ்ந்து கொண்டிருக்கும் அல்லது முன்னால் வாழ்ந்து கொண்டிருந்த துணைவரினால் (ஆண் துணை, கணவர், துணைவர், இணை பங்குதாரர்) இழைக்கப்படும் உடல், பாலியல், வாய்மூல, மற்றும் உள ரீதியான துஷ்பிரயோகங்கள், பல்வேறு முறைகளினாலான கட்டுப்பாட்டு நடத்தைகள் போன்றவற்றைக் குறிக்கும். உலகளாவிய ரீதியில் மூன்று பெண்களில் ஒருவர் நெருங்கிய துணைவர் வன்முறைகள (IPV) அனுபவத்திற்கு உள்ளாகி இருக்கின்றனர். இலங்கையில் பல பிதேசங்களில் மேற்கொள்ளப்பட்ட ஆய்வுகளின் படி 18–72% வீதமான பெண்கள் அவர்களது வாழ்க்கையில் சில சமயங்களில் நெருங்கிய துணைவர் வன்முறைகளுக்கு(IPV) உள்ளாகியுள்ளனர். ˙ நகர்ப்புறங்களில் வாழும் வறுமையான குடும்பங்களைச் சார்ந்த பெண்களும் யுத்தத்தினால் பாதிக்கப்பட்ட பகுதிகளில் வசிக்கும் பெண்களுமே இத்தகைய நெருங்கிய துணைவர் வன்முறை ஆபத்துகளுக்கு அதிகம் முகங் கொடுத்துள்ளனர்.

நெருங்கிய துணைவர் வன்முறைகள் தொடர்பாக பெண்களின் பதில் நடவடிக்கைகள், தனிப்பட்ட ரீதியில் அவர்கள் வாழும் சூழல் மற்றும் நெருங்கிய தணைவர் வன்முறைகள் தொடர்பான அவர்கள் அனுபவம் அடிப்படையில் வேறுபடும். நெருங்கிய தணைவர் வன்முறைகளுக்கு முகங்கொடுத்துள்ள பெரும்பாலான பெண்கள் அது பற்றி பேசுவதில்லை. அவர்கள் தொடர்ந்தம் பல வருடங்களாக தம்மைத் துஷ்பிரயோக்துக்கு உட்படுத்திய துணைவரோடு வாழ்ந்து வருகின்றனர். அப்படி அது தொடர்பாக முதன்மை நிலையான உதவிகளைப் பெற விரும்புவோர் அவர்களது குடும்பம், நண்பர்கள், அயல் வீட்டார், மதத் தலைவர்கள் போன்ற சமூக தலைவர்கயே நாடுகின்றனர். நெருங்கிய துணைவர் வன்முறைகளுக்குள்ளான மிகக் குறைந்த விதத்தினரே மருத்துவமனை, பொலீஸ் நிலையம், நலன் விரும்பும் சேவைகளை மேற் கொள்ளும் முகவர் நிலையங்களுக்குச் சென்றுள்ளனர். நாட்டில் காணப்படும் மட்டுப்படுத்தப்பட்ட ஆதரவு மற்றும் சேவைகளுடன் பார்க்கும் போது பெரும்பாலான பெண்களுக்கு அவர்களை துஷ்பிரயோகத்துக்குள்ளாக்கிய துணைவரை விட்டு விலகுவது ஒரு தேர்வாக அமைவதில்லை. ஏனெனில் துஷ்பிரயோகத்திற்கு உள்ளான பெண்களின் உடல், உள ரீதியான விளைவுகள், துஷ்பிரயோகம் மற்றும் வன்முறைகள் முடிவடைந்ததன் பின்னரும் பல காலம் நிலைத்திருக்கலாம். அதனால் சுகாதார, பராமரிப்பு தொழிற்றுறை நிபுணர்களுடன் அவர்கள் தொடர்பு கொள்வதற்கான சாத்தியமுண்டு. ஏனைய சேவை வழங்குனரோடு ஒப்பிட்டால் மிக அதிகம்.) எனவே இலங்கையின் பிண்ணணியில் நெருங்கிய துணைவர் வன்முறைகளை கையாள்வதற்கு சுகாதாரத் துறையில் கவனம் செலுத்துவது மிக முக்கியமானது. இலங்கையின் நெருங்கிய தணைவர் வன்முறைகள் தொடர்பாக தற்போது இருக்கின்ற தகவல்களை மீளாய்வு செய்தோம். நெருங்கிய துணைவர் வன்முறையின் வகை மற்றும் தரம் போன்றவற்றின அடிப்படையில், பல்வேறு சுகாதார பராமரிப்பு

சேவைகளுக்குள் காணப்படும் நெருங்கிய துணைவர் வன்முறைகள் தொடர்பான வகைப்பாட்டு முறை ஒனறைப் பிரயோகித்தோம்:

படிநிலை 1 (ஆகக்குறைந்த படிநிலை) இது தேர்ந்தெடுக்கப்பட்ட சேவை வழங்குனர்/வசதிகளின் ஒருங்கிணைப்பாகும். பொதுவாக ஒரு மருத்துவர்/தாதி மருத்துவமனைக்கு/கிளினிக்கு வரும் பெண்களுக்கு நெருங்கிய துணைவர் வன்முறைகளோடு தொடர்புடைய ஒன்று அல்லது அதற்கு மேற்பட்ட சேவைகளை வழங்கல். படிநிலை 2 என்பது பல்வேறு சேவைகளை உள்ளடக்கிய சேவை வழங்குனர்/வசதிகளின் ஒருங்கிணைப்பாகும். மருத்துவமனையில் அல்லது கிளினிக்கில் இருக்கும் ஒரு மருத்துவர் அல்லது அதற்கு மேற்பட்ட மருத்துவர்கள்/ தாதிமார்கள் மற்றும் ஆலோசகர்களால் வழங்கப்படும் அதிகமான சேவைகளைக் குறிக்கும். படிநிலை 3 என்பது துறை விரிவு படுத்தப்பட்ட பல்வேறு சேவைகள் கொண்ட ஒரு ஒருங்கிணைப்பு முறையாகும். பல்வேறு இடங்களில், பலவித சேவைகளை வழங்குவதுடன் மீண்டும் மீண்டும் சேவைகளுக்கு உள்ளக விதப்புரை செயகின்ற நிலையையும் கொண்டிருக்கும்.

அநேக நாடுகளில் காணப்படுவது போல இலங்கையிலும் சுகாதாரத்துறை பதில் நடவடிக்கைகள் மிக மெதுவாகவே இடம் பெற்று வருகின்றது. முதற் நடபடிக்கையாக பால்நிலை சார்ந்த வன்முறை மேசை ஒன்று 2002 ஆம் ஆண்டு முதன் முதலில் அறிமுகப்படுத்தப்பட்டது. இவை அவசர அல்லது வெளி நோயாளர் திணைக்களங்கள் அல்லது சுகாதாரக் கல்வி பிரிவுகளிலுள்ள .அவசர சேவை மையங்களாகும். இவைகளில் மருத்துவமனை மருத்துவர்களும், தாதிமார்களும் இருப்பார்கள் அல்லது உள்ளூர் அரச சார்பற்ற நிறுவங்களின் ஆலோசகர்கள் இருப்பார்கள். பால்நிலை தொடர்பான வன்முறை மேசையானது படிநிலை 1 க்குரிய தேர்ந்தெடுக்கப்பட்ட வழங்குனர்/வசதி ஒருங்கிணைப்பு சேவைகளோடு பொருந்துகின்றது. எனினும் படிநிலை ஒன்றுடன் தொடர்புபட்டால் பால்நிலை வன்முறை மேசையை நிருவகிக்கும் அரச சார்பற்ற நிறுவனங்களின் ஆலோசகர்கள், அவர்களின் சொந்த வலைப்பின்னல்களை பாவிக்கலாம். அவர்கள் மாதிகையான படிநிலை 1 சேவைகளுக்கு அப்பால், மருத்துவ நிலையங்களைத் தவிர குறுகிய காலம் தங்கும் வீடுகள், சட்ட உதவிகள், மற்றும் சமூக சேவைகள் தொடர்பான வளங்களையும் விதப்புரை சேவைகளையும் வழங்கலாம். 2011 ஆம் ஆண்டில் நாடு முழுதும் 10 பால்நிலை வன்முறை மேசைகள் இருந்தன. இரண்டாவது முயற்சியாக 2007 ஆம் ஆண்டு, வெளி நோயாளிகளின் மற்றும் அவசர திணைக்களங்களுடன் தொடர்பாக மித்துரு பியச (நட்புறவு இல்லம்) ஆரம்பமானது. இந்நிகழ்ச்சித் திட்டத்தின் கீழ் தாதிமாரும், மருத்துவர்களும் மருத்துவமனைகளில் சேவைகளை வழங்குவர் (மருத்துவ ரீதியான கவனிப்பு, ஆலோசனைச் சேவைகள்). அத்தோடு மருத்துவ மனைகளுக்கு வெளியே (குறுகிய காலம் தங்கும் வீடுகள், சட்டஉதவிகள்) சேவை பெறுவதற்கான விதப்புரைகளையும் நெருங்கிய துணைவர் வன்முறைகளுக்கு உள்ளான பெண்களுக்கு வழங்குவர். 2014 ஆம் ஆண்டு, நாடு முழுதும் ஏறக்குறைய 20 மித்துரு பியச நிலையங்கள் இருந்தன. (என். மாபிட்டிகம, பபால்நிலை கவனக்குவியப் புள்ளி, சுகாதார அமைச்சு, தனிப்பட்ட தொடர்பாடல்). ஏனைய நாடுகளிலுள்ள ஓரிட நெருக்கடி மைய மாதிரியை ஒத்த, மித்துரு பியச (படிநிலை 2) க்குரிய, விரிவான வசதிகளின் ஒருங்கிணைப்பாகும், இது வெவ்வேறு இடங்களிலுள்ள வெவ்வேறு துறைகளுக்கான மேலதிக சேவைகளை அடைவதற்கான வாய்ப்புக்களை

உள்ளடக்கியது ஏனென்றால் பெண்களை பொலீஸ், சட்ட உதவிகள், அரச சார்பற்ற நிறுவனங்கள், மாகாண மட்டத்திலான சமூக சேவை நிலையங்கள் மற்றும் பொலிசுடன் இணைப்பதற்கு விரிவான விதப்புரைக்குறிப்பு முறையை மருத்துவ ஊழியர்கள் உருவாக்கியுள்ளனர்.. இது ஒரு சிறப்பான மாதிரியாகக் காணப்படுகின்றது. எனினும் பலவிதமான நடைமுறை சவால்கள், வரையறைகளும் இருக்கின்றன. இம்மாதிரி தற்போதும் காணப்படுகின்றதா என்பது பற்றி எவ்வித தகவல் மதிப்பீடும் இல்லை. எமது தனிபபட்ட தொடர்புகள் குறிப்பிடுவது என்னவெனில் மருத்துவ மனைக்கு உள்ளேயும் வெளியேயும் காணப்படும் ஒத்துழைப்பின் அளவு (பொலீசுடன், சமூக சேவைகள், மற்றும் அரச சார்பற்ற நிறுவனங்கள்) குறைவான மட்டத்திலேயே உளளது.

முன்னேற்றத்திறகான முறை: இலங்கையில் நெருங்கிய துணைவர் வன்முறை உள்ளான பெண்களுக்குரிய சேவைகளின் வினைத்திறன் தொடர்பான விடயங்கள் அறியக்கூடியதாக இல்லை. அத்துடன் சுகாதார பாரமரிப்பு தொழில் நிபுணர்களின் ஆர்வம், ஈடுபடுவதற்கான உள்ள ஆயத்தநிலை, நெருங்கிய துணைவர் வன்முறை சேவை மாதிரிகளை மிக விரிவான வவ்வாறு கொண்டு நடத்துவது என்பது தொடர்பாக எவ்வித தகவல்களும் இல்லை. ஏனெனில் 10 மில்லியன் பெண்களும், பெண் பிள்ளைகளும் வாழும் (அதிக நோய்த்தாக்க வீதங்கள்) இந்நாட்டில், மட்டுப்படுத்தப்பட்ட எண்ணிக்கையிலான பால்நிலை வன்முறை மேசைகளும் மித்துரு பியச நிலையங்களுமே உள்ளன. இலங்கையின் கூட்டு மொத்த சுகாதார சேவைகளின் பதில் நடவடிக்கைகளும் எல்லைப்படுத்தபட்ட அளவிலோயே காணப்படுகின்றன. அதேபோல் மேற்குறிப்பிட்ட இரண்டு மாதிரிகளையும் மதிப்பீடு செய்வதும், தேவையான மாற்றங்களைச் செய்வதும் மிக அவசியமாகும் அத்தோடு தேசியமட்டத்தில் அவை கணிக்கப்படவும் வேண்டும் (படிநிலை 3). அத்துடன், தேவையானவற்றை வழங்கும் அரச சார்பற்ற நிறுவனங்களின் தொழிற்பாடுகளை அடையாளம் கண்டு மதிப்பளிப்பதும், மருத்துவ மனைக்கு உள்ளேயும் வெளியிலும் நெருங்கிய துணைவர் வன்முறை தொடர்பான சேவைகளை அடையாளம் காண்பதும் முக்கியமானதாகும். இறுதியாக, நெருங்கிய துணைவர் வன்முறையை சுகாதார துறையில் ஒரு முன்னுரிமைக்கு உரியதாக்க்கூடிய ஆதரவான கொள்கைகளையும் நிகழ்ச்சி நிரல்களையும் உருவாக்குதல் ஒரு முக்கியஅவசர தேவையாக உள்ளது.

இக்சுருக்கக் குறிப்பானது தற்போது பிரசுரிக்கப்படுவதற்கு மீளாய்வு செய்யப்பட்டுக் கொண்டிருக்கும் கட்டுரை ஒன்றின் அடிப்படையில் அமைந்ததாகும் உங்களுக்கு மேலதிக விபரங்கள் அறிய வேண்டுமானால் தயவு செய்து ஆசிரியருடன் தொடர்பு கொள்ளவும்.
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ශ්‍රී ලාංකික කාන්තාවන්ට ස්වාමිපුරුෂයන්ගෙන් / සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් වන ප්‍රචණ්ඩත්වය සඳහා පිළියම් යෙදීමට සලසා ඇති සෞඛ්‍ය සේවා පිලිබඳ විශ්ලේෂණය.

ආචාර්ය **සේපාලි ගුරුගේ[1] වෛද්‍ය වත්සලා ජයසූරිය[1] වෛද්‍ය.නාලිකා ගුණවර්ධන[2], මෙලනි සෙල්වදුරේ[1]**

[1] හෙද පීඨය, රයර්සන් විශ්ව විද්‍යාලය, ටොරොන්ටෝ [2]වෛද්‍ය විද්‍යාලය, කොළඹ විශ්වවිද්‍යාලය

ලොවේ පුරා කාන්තාවන් තිදෙනෙකුගෙන් එක අයෙක් තම ස්වාමිපුරුෂයන්ගෙන්/ සහකරුවන්ගෙන්/ පෙම්වතුන්ගෙන් ප්‍රචණ්ඩත්වයට පත්වන බව ප්‍රකාශ වේ. ශ්‍රී ලංකාවේ විවිධ ප්‍රදේශයන්හි කල අධ්‍යයනයන් පෙන්වාදෙන අයුරින් සියයට 18-72 අතර ප්‍රමාණයක් කාන්තාවන් තම ජීවිත කාලය තුල යම් අවස්තාවක මෙසේ ප්‍රචණ්ඩත්වයට පත්වී ඇත. නාගරික අඩු ආදායම් ලබන පවුල්වල කාන්තාවන් හා යුද්ධයෙන් පීඩිත උතුරු නැගෙනහිර ප්‍රදේශවල කාන්තාවන් මෙසේ සමීපතමයන්ගෙන් හිංසනයට ලක්වීමේ ප්‍රවනතාවය වැඩි බවත් පර්යේෂණ වලින් පෙන්වා දේ. මෙසේ ප්‍රචණ්ඩත්වයට පත්වන කාන්තාවන්ගේ අත්දැකීම ඒ සඳහා දක්වන ප්‍රතිචාර ඔවුන්ගේ පුද්ගලික ජීවිත භූමික මත වෙනස්වන බව සඳහන් වේ.

මෙම කාන්තාවන්ගෙන් බොහොමයක් ඒ පිලිබඳ අන්‍යන්ට හෙළි කිරීමට මැලිවන බවත්, එම හිංසනය/ පීඩනය ඇතිකරන සහකරුවා සමඟ වසර ගණනක් එකට වාසය කරන බවත් පැහැදිලි වේ. උදව් සොයා යන කාන්තාවන් බොහෝ දෙනෙක් තම නාදයන්, මිතුරියන් හා අසල්වැසියන් වෙත යොමුවන බවත්, තවත් සමහර කාන්තාවන් ආගමික නායකයින්, ග්‍රාමසේවක වැනි සමාජයේ පිළිගත් පුද්ගලයින් වෙත යොමුවන බවත් ප්‍රකාශවේ.

පොලිසියේ, සෞඛ්‍ය සේවාවන් වල හා මේ සඳහා විශේෂිත සේවාවන් සපයන ආයතන වලින් සේවා ලබාගන්නා කාන්තාවන්ගේ ප්‍රතිශතය අල්ප බවත් පර්යේෂණ පෙන්වාදේ. තවද, මේ සඳහා විධිමත් සේවාවන් සපයන ආයතන වලින් සේවා ලබාගෙන එම තත්වයෙන් මිදීමට උත්සුකවන කාන්තාවන්ගේ ප්‍රමාණය ඊටත් අඩු බව පෙන්වා දෙයි. වෙනත් රටවල පර්යේෂණ පෙන්වාදෙන අයුරින්, සමීපතමයන්ගෙන් හිංසනයට, පීඩනයට පත්වන කාන්තාවන් ඔවුන්ට ඇතිවන ශාරීරික හා මානසික ආතතියන්ට පිළියම් සෙවීමට සෞඛ්‍ය සේවාවන් වෙත යොමුවීමේ ප්‍රවනතාවයක් ඇති අතර, ඔවුන් එම සේවකයන්ට තමා මුහුණපාන හිංසනය/ පීඩනය පිලිබඳ හෙළි නොකලත්. එම අවස්තාවන් ඔවුන්ට සේවා ගැන දැනුවත් කිරීමට සුදුසු අවස්තාවක් වේ.

මෙම සාරාංශයේ අරමුණ වන්නේ, ශ්‍රී ලාංකික කාන්තාවන්ට සමීපතමයන්ගෙන් (ස්වාමිපුරුශයන්ගෙන්/ සහායකයන්ගෙන්/ පෙම්වතුන්ගෙන්) සිදුවන හිංසා/ පීඩා පිලිබඳ සේවා සැපයීම සෞඛ්‍ය සේවාවේ ප්‍රතිචාර පිලිබඳ විශ්ලේෂණය කිරීමයි.

ලොව පුරා විවිධ රටවල ස්ථාපිත කර ඇති (ආසියාතික රටවල් ඇතුළුව) මෙවැනි සේවාවන් අධ්‍යයනය කර එම සේවාවන් දැනට පවතින සෞඛ්‍ය සේවාවන් හා යාබද්ධිත කර ඇති අයුරු වර්ගීකරණය කර ඇත. එම වර්ගීකරණයට අනුව පලවෙනි මට්ටමේ (අඩුම මට්ටමේ) සේවාවන් වලින් රෝහලට පැමිණෙන කාන්තාවන්ට හිංසනයට සම්බන්ධ උපදෙස් දීම , උපදේශනය වැනි සේවාවන් අල්පයක් (එකක් හෝ දෙකක්) වෛද්‍යවරුන් හා හෙදියන් විසින් ලබාදෙයි. දෙවන මට්ටමේ සේවාවන් තුල වඩා පුළුල් සේවාවක් සපයන අතර, වඩා වැඩි වෛද්‍යවරුන් රෝහල්/ සෞඛ්‍ය සේවා ආයතන තුල හා හෙදියන් ප්‍රමාණයක් මේ සඳහා දායක වෙයි. ඊට අමතරව රෝහල තුලම ඇති වෙනත් සේවාවන් සායන වෙත කාන්තාවන් යොමු කිරීමත් සිදුවේ. තුන්වන මට්ටමේ සේවාවන් වර්ගීකරණයට අනුව මුළු සෞඛ්‍ය පද්ධතිය පුරා ව්‍යාප්ත වූ පුළුල්තම සේවාවන් විවිධ ආයතනයන් හා එකාබද්ධව සපයනු ලැබේ.

අන් රටවල මෙන්ම ශ්‍රී ලංකාවේද කාන්තාවන්ට විශේෂිත වූ සේවාවන් රාජ්‍ය සෞඛ්‍ය සේවාවන් තුල ස්ථාපිත බීම මෑත කාලීන ප්‍රවණතාවයකි. මේ සඳහා මුල් පියවර වශයෙන් කාන්තා හිංසන වැළැක්වීමමට සේවාවන් (G BV desks) ස්ථාපිත වූයේ 2002 වසරේය. එය හදිසි අනතුරු අංශ/ බාහිර රෝගී අංශ ආශ්‍රිතව වෛද්‍යවරුන්/ හෙදියන් විසින් ලබාදෙන උපදෙස් සේවාවකට පමණක් විය. එම සේවා වර්ගීකරණයට අනුව පලවෙනි මට්ටමට අයත් වන සේවාවක් විය.

බොහොමයක් රෝහල්වල ස්ථාපිත කර ඇති GBV Desks වල උපදේශන සේවා සැපයීමට රාජ්‍ය නොවන ආයතනවල (NGO) උපදේශකයන්ගේ සේවාවන් ලබාගෙන ඇති බව ප්‍රකාශ වේ. මෙම උපදේශකයන්ගේ රෝහලෙන් පිටස්තර ආයතන සමඟ ඇති සම්බන්දතා උදව් කරගෙන කාන්තාවන්ට උපදේශනයට අමතර සේවාවන් ලබාදීමට (නීතිමය උපදෙස්, කෙටිකාලීන නවාතැන්) උත්සුක වී ඇති බව පර්යේෂණ පෙන්වා දෙයි.

එම නිසා මෙම සේවාව වර්ගීකරණය පලවෙනි මට්ටමට වඩා පුළුල් සේවාවක් ලබාදීමට අවස්තාවන් සලසා දී ඇති බව පෙනේ. 2011 වන විට මෙවැනි කාර්යාල 10ක් ලංකාවේ විවිධ පලාත්වල පැවතුනි.

මීට අමතර දෙවැනි සෞඛ්‍ය සේවා පියවරක් වශයෙන් මිතුරු පියස කාර්යාලයක් 2007 වසරේදී ස්ථාපිත විය. හදිසි අනතුරු./ බාහිර රෝගී අංශය ආශ්‍රිතව පිහිටවූ මෙම කාර්යාල වල ඒ සඳහා විශේෂිත පුහුණුවක් ලද වෛද්‍යවරුන්/ හෙදියන් රෝහල තුල විවිධ වූ පුළුල් සේවාවන් ලබා දීමට සේවයේ යොදවන ලදී. රෝහල තුල පිහිටි සෞඛ්‍ය සේවා හා උපදේශනයට යොමු කිරීමට අමතරව රෝහල් වලින් පිටස්තර වූ සේවාවන් වෙත (නීතිමය උපදෙස්, කෙටි කාලීන නේවාසික පහසුකම් වැනි) යොමු කිරීමක්ද සිදු වේ. 2014 වන විට මිතුරු පියස කාර්යාල 20ක් ලංකාවේ ස්ථාපිත කර තිබූ බවට ප්‍රකාශ වේ.

මිතුරු පියස කාර්යාල මගින් වර්ගීකරණයට අනුව දෙවන මට්ටමේ සේවා ව්‍යාප්තියක් (විවිධ ආයතන තුල විවිධ සේවාවන් සමඟ යාබද්ධව ලබාදෙන සේවාවන්) සපයාදීමේ පහසුකම් ඇතිකරයි. මිතුරු පියස කාර්යාල සේවකයන් මගින් රෝහලින් පිටස්තර වූ ආයතන (පොලිසිය, නීති ආධාර වෙනත් රාජ්‍ය නොවන ආයතන, සමාජ සේවා සංවිධාන) සමඟ සම්බන්ධතා ඇතිකරගෙන සේවා සඳහා කාන්තාවන් මෙම ආයතනවලට යොමු කිරීමට දිරිමත් කරයි.

මෙම සේවා පද්ධතිය ඉතා පුළුල් සේවාවන් සැපයීමට සුදුසු පසුබිම සැකසීමේ හැකියාව ඇති නමුත්, ප්‍රායෝගික දුෂ්කරතා හා අඩුපාඩු නිසා එය ක්‍රියාත්මක කිරීමේ දුෂ්කරතා ඇති බව ප්‍රකාශ වේ. මෙම සේවා පද්ධතිය අධ්‍යයනය කිරීමට අවශ්‍ය පර්යේෂණ/ දත්ත නොමැති වුවද, විවිධවාර්තා හා පුද්ගලයන්ගේ අදහසට අනුව මෙම සේවා පුළුල්ව ව්‍යාප්ත වීමට අවශ්‍ය අන්තර් සම්බන්ධතා විවිධ ආයතන අතර හොඳින් ස්ථාපිත වී ඇති බව ප්‍රකාශ වේ. උදාහරණ වශයෙන් රෝහල හා ඊට බාහිර වූ රාජ්‍ය ආයතන (පොලිසිය, සමාජ සේවා ආයතන, රාජ්‍ය නොවන ආයතන) අතර අන්‍යොන්‍ය සම්බන්ධතා හොඳින් දියුණු වී නැති බව පෙන්වා දෙයි.

ඉදිරි ක්‍රියාමාර්ග: ප්‍රචණ්ඩත්වයට භාජනය වූ කාන්තාවන් වෙනුවෙන් ස්ථාපිත කර ඇති සෞඛ්‍ය අංශයේ සේවාවන් පිලිබඳ පුළුල් අධ්‍යයනයක් කිරීමේ අවශ්‍යතාවය මෙම පිලිබඳ දැනට පලවී ඇති ලිපිලේඛන, වාර්තා විශ්ලේෂණයන්ගෙන් පැහැදිලිවේ. සෞඛ්‍ය සේවකයන් මෙම සේවාවන් සැපයීම දක්වා උනන්දුව හා ඔවුන් මේ සඳහා ලබා ඇති දැනුම්, ආකල්ප හා පුහුණුව පිළිබඳව අධ්‍යයනයන් අවශ්‍යව ඇත.

මිලියන 10ට වැඩි ශ්‍රී ලාංකික කාන්තාවන් වෙනුවෙන් ස්ථාපිත කර ඇති කාන්තා සහන කාර්යාල හා මිතුරු පියස සේවා මධ්‍යස්ථාන අල්පයක් බැවින් සෞඛ්‍ය පද්ධතිය තුල ස්ථාපිත කර ඇති සේවාවන් වඩාත් පුළුල්ව ව්‍යාප්ත කිරීමේ අවශ්‍යතාවයක් ඇත. ඒ සඳහා අවශ පසුබිම හා දත්ත ලබාගැනීමට දැනට පවතින සේවාවන් විශ්ලේෂණයක් කිරීමත්, එම සේවාවන් වඩාත් පුළුල් කිරීමට (වර්ගීකරණයට අනුව තුන්වන මට්ටමේ සේවා පද්ධතියක් ලෙස) අවශ්‍ය පියවර ගැනීමත් ප්‍රමුඛතම කාලීන අවශ්‍යතාවයකි.

රෝහල් වලින් පිටස්තරව, කාන්තාවන්ට අවශ්‍යතම වූ සමාජ සේවා, තාවකාලික නවාතැන්, නීති ආධාර ලබාදෙන රාජ්‍ය නොවන ආයතන වල දායකත්වය වඩාත් හොඳින් ඇගයීමට ලක්කිරීමක් සිදුවිය යුතුය. තවද, ප්‍රචණ්ඩත්වයට ලක්වූ කාන්තාවන්ට සෞඛ්‍ය සේවාවන් තුල අවශ්‍ය සේවාවන් සැපයීම අවශ්‍ය ජාතික ප්‍රතිපත්ති හා වැඩසටහන් දියත් කිරීමේ දැඩි අවශ්‍යතාවයක් ඇති බවද අවධාරණය වේ.

පරිවර්තනය: මදාරා රන්මුතුගල මිය නැවත පරීක්ෂා කිරීම් : වෛද්‍ය වත්සලා ජයසූරිය. මෙහි සඳහන් කර අධ්‍යයන පිළිබඳ වැඩි විස්තර සඳහා contact@addressingipvsrilanka.ca email ලිපිනය හරහා අප සමඟ සම්බන්ධ වන්න.

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International Development Research Centre
Centre de recherches pour le développement international

RYERSON UNIVERSITY

Strengthening Health Policy Response to Address IPV in Sri Lanka
Research Staff Training Workshop I

Location: Department of Community Medicine, University of Colombo, Sri Lanka

Date: March 21st, 2015

Time Slot	Description
9:00 AM – 9:30 AM	Welcome and Introductions
	Overview of the project/collaboration **Prof. Nalika Gunawardena** *University of Colombo*
9.30 AM – 10:15 AM	Fieldwork in Sri Lanka: phase I **Dr. Vathsala Jayasuriya-Illesinghe** *Ryerson University*
10:15 PM – 10:30 PM	Tea Break
10:30 AM – 11:30 PM	Interview methods and techniques **Prof. S Sivayogan** *University of Sri Jayewardenepura*
11.30 AM– 12.00 PM	Discussion
12:00 AM – 1:30 PM	Lunch break
1:30 PM – 2:30 PM	Research in post-conflict areas **Dr. Mahesan Ganesan** *National Institute of Mental Health*
2:30 PM – 3:30 PM	Role play exercise : Interviews guides and methods **Dr. Vathsala Jayasuriya-Illesinghe** *Ryerson University*

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RYERSON UNIVERSITY

Strengthening Health Policy Response to Address IPV in Sri Lanka
Research Staff Training Workshop ll

Location: University of Colombo, Sri Lanka

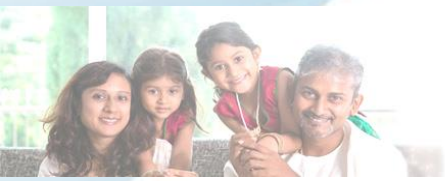
Date: March 22ndt, 2015

Time Slot	Description
9:00 AM – 9:15 AM	Welcome
9:15 AM – 10:00 AM	Overview of field work in Sri Lanka: phase II **Dr. Vathsala Jayasuriya-Illesinghe** *Ryerson University*
10:00 AM – 11:00 AM	Ethno-cultural considerations in researching IPV **Prof. Gameela Samarasinghe** *University of Colombo*
11:00 AM – 12:00 PM	Discussion and clarifications
12:00 AM – 1:30 PM	Lunch break
1:30 PM – 2:30 PM	Research involving health care staff – Nurses & Midwives **Ms. Sujatha Seneviratne** *University of Sri Jayewardenepura* **Mrs. W.M. Ariyaseeli** *National School of Nursing*
2:30 PM – 3:30 PM	Discussion
3.30 PM	Tea and closing

KNOWLEDGE SHARING FORUM

Addressing Intimate Partner Violence in Sri Lanka

Looking back: Moving forward



Purpose of the Project

Through a Canada-Sri Lanka research partnership, this project aims to identify and address gaps in knowledge, skills, resources, practices, and policies to address intimate partner violence (IPV) against women in Sri Lanka.

The project will help raise awareness about IPV among healthcare, community, and policy stakeholders, and develop a strong IPV prevention and treatment network.

It will also improve research capacity and knowledge-sharing/dissemination between stakeholders in order to create a knowledge-base to support future research, practice, and policy initiatives.

Purpose of the Knowledge Sharing Forum

The forum is aimed at strengthening existing networks and building sustainable, mutually-beneficial, **collaborative relationships** with community, academic, and policymaker partners at national and international levels. It is to **generate new knowledge** that can inform practice and policy changes in order to improve care and services to women experiencing IPV in Sri Lanka.

What is Intimate Partner Violence?

Intimate partner violence (IPV), is defined as any physical, sexual, or psychological harm that is perpetrated by a current (or former) partner or spouse.

> "Worldwide, almost **one third (30%)** of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partners. In some regions, **38% of women** have experienced intimate partner violence."
>
> World Health Organization, 2013

Intimate Partner Violence in Sri Lanka

Evidence from Sri Lanka highlights **up to 60%** of women in different locations have experienced IPV at some time during their life. Knowledge of IPV in Sri Lanka is based on limited research drawn mainly from the Sinhalese community due to a 25-year long civil war, limiting access to the Tamil community in the North and East. Previous work among the Sri Lankan Tamil diaspora in Canada and Tamils in eastern Sri Lanka, as well as recent studies in the Sinhalese communities in Sri Lanka and Canada show that **IPV is often overlooked, under-reported, and poorly managed.**

Date : 13th October 2015
Venue: BMICH, Colombo, Sri Lanka

www.addressingipvsrilanka.ca

Ryerson University

Sri Lanka Medical Association
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INVITED SPEAKERS

Henrica A.F.M. (Henriette) Jansen
International Researcher Violence Against Women (Independent)

Henrica A.F.M. (Henriette) Jansen

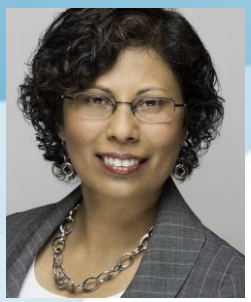
is an internationally renowned expert on violence against women (VAW) research, with special interest in measurement, ethical and safety issues. Currently she is mainly involved with UNFPA Asia and the Pacific Regional office supporting national VAW studies and strengthening regional research capacity. She led VAW studies in the Pacific Region (2009-2013, UNFPA and NGOs), Viet Nam (2009-2010, WHO/GSO) and Turkey (2008-2009, HUIPS/KSGM/EU) and was Core Research Team member on the WHO Multi-country Study on Women's Health and Domestic Violence (1999-2007). She wrote "Swimming against the Tide: Lessons Learned from Field Research on Violence against Women in Solomon Islands and Kiribati" (2010, UNFPA), and is (co-) author on multiple journal articles.

Dr. Nishi Mitra
Social Cultural Anthropologist & Researcher

Nishi Mitra

is a trained Social Cultural Anthropologist. She is presently an Associate Professor at the Advanced Centre for Women's Studies, Tata Institute of Social Sciences in Mumbai, India and the Project Director of a UNFPA study on child marriage and early pregnancy at the TISS-UNFPA Centre of Excellence on Adolescents and Youth.
She is currently exploring the 'Vulnerability Approach to Violence Against Women' and is involved in Cost Action IS1206 research initiative on femicide across Europe. She has led several international research partnerships to strengthen cross-cultural teaching and research in areas of women's issues, gender studies, and issues of power and powerlessness with academics from Brazil, South Africa, Sri Lanka, USA, UK, and Sweden. Dr. Nishi's areas of interest and research include intimate partner violence, sexual violence against women, femicide, feminist theorizing in India, feminist research methodologies, and feminist peace and justice studies.

FORUM ORGANIZERS



Prof. Sepali Guruge is Professor and Research Chair in Urban Health Research in the School of Nursing at Ryerson University, Toronto, Canada. Her program of research focuses on immigrant health, with a particular focus on violence against women and children. Within this area, she has collaborated on more than 45 research projects in various local, national, and international settings. Her work on violence against women goes beyond Canada, and the findings of her projects have been disseminated in over 10 languages. Dr. Guruge has received numerous awards in recognition of her work, and in 2014, she was selected to be part of the inaugural cohort of the College of the New Scholars, Artists, and Scientists of the Royal Society of Canada. www.immigranthealthresearch.ca

Prof. Nalika Gunawardane is a Professor in Community Medicine at the Faculty of Medicine at the University of Colombo, Sri Lanka. She has a keen interest in promoting women's health and is the current Chairperson of the Expert Committee on Women's Health at the Sri Lanka Medical Association. She is also an honorary member of the Centre for Women's research (CENWOR). Her research interests range from gender based violence against women, sexual coercion experienced by female university undergraduates to nutritional issues among women and girls in the plantation sector. She has co-edited a publication on review of research on gender based violence in Sri Lanka and have several publications in peer reviewed journals on issues related to women in Sri Lanka.

Dr. Vathsala Jayasuriya-Illesinghe is a Consultant Community Physician in Sri Lanka and a former senior lecturer in Community Medicine at University of Sri Jaewardenepura. She is currently executing a multi-site intervention research project addressing the stigma of mental illness among Asian communities in Canada at the School of Nursing, Ryerson University. Dr. Illesinghe has led numerous research projects focussed on intimate partner violence against women and has received several awards for her work in Sri Lanka. She has served as the Chairperson of the Expert Committee on Women's Health at the Sri Lanka Medical Association, and is a member of the WHO international network of Violence against Women (VAW) researchers.

Future Events and Venues

http://www.addressingipvsrilanka.ca/events

Policy Makers Meeting
December 16, 2015
The Cinnamon Grand Hotel,
Colombo, Sri Lanka

Stakeholders Forum
January 15, 2016
Sears Atrium, Ryerson university
Toronto, Canada

For information about the project: contact@addressingipvsrilanka.ca

A Project Funded by:

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International Development Research Centre
Centre de recherches pour le développement international

Knowledge Sharing Forum: Addressing IPV in Sri Lanka

October 13th, 2015 BMICH, Colombo

Participant Feedback

What is your overall impression about the forum?

Excellent ☐ Very good ☐ Good ☐ Average ☐ Poor ☐

What were the most useful aspects of the forum ?

……

……

What were the least useful aspects of the forum ?

……

……

What could be done differently in future similar forums?

……

……

Thank you !

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Strengthening Health Policy Response to Address Intimate Partner Violence in the Sri Lankan Context

FINDINGS & CONFERENCE PROCEEDINGS

www.addressingipvsrilanka.ca

Ryerson University

Sri Lanka Medical Association
Serving the Profession - Serving the Nation

ABOUT THE PROJECT

Purpose of the Project
Through a Canada-Sri Lanka research partnership, this project aims to identify and address gaps in knowledge, skills, resources, practices, and policies to address intimate partner violence (IPV) against women in Sri Lanka.

The project will help raise awareness about IPV among healthcare, community, and policy stakeholders, and develop a strong IPV prevention and treatment network.

It will also improve research capacity, knowledge-sharing, and knowledge dissemination between stakeholders in order to create a knowledge-base to support future research, practice, and policy initiatives.

Project Activities

1. Comprehensive review of existing information about:
   - IPV in Sri Lanka
   - Health sector responses to IPV in low-middle income settings
   - Best practices in Canada and other settings

2. Research into the pathways through which women seek recourse from IPV in Sri Lanka as well as the perceptions of and responses to IPV among nurses, midwives, and doctors in Sri Lanka.

3. Knowledge-sharing and partnership-building events in Sri Lanka and Canada.

"Worldwide, almost **one third (30%)** of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partners. In some regions, **38% of women** have experienced intimate partner violence."

World Health Organization, 2013

Intimate Partner Violence in Sri Lanka:
Evidence from Sri Lanka highlights **up to 60%** of women in different locations have experienced IPV at some time during their life. Knowledge of IPV in Sri Lanka is based on limited research drawn mainly from the Sinhalese community due to a 25-year long civil war, limiting access to the Tamil community in the North and East.

Previous work among the Sri Lankan Tamil diaspora in Canada and Tamils in eastern Sri Lanka, as well as recent studies in the Sinhalese communities in Sri Lanka and Canada show that **IPV is often overlooked, under-reported, and poorly managed.**

Addressing Intimate Partner Violence in Sri Lanka

Looking Back: Moving Forward

Knowledge sharing forum proceedings
October 13th, BMICH, Colombo

"It was an opportunity to meet different speakers from different backgrounds, that made the forum very interesting and diverse."

" We could see the situation in the different regions in the country and Indian and global perspective about these issues."

"One of the few occasions that simultaneous translations were given at a conference everyone can equally participate – this is very important."

"This was an opportunity for those from outside the medical professions to meet those working in healthcare on similar topics."



AGENDA

8:30 AM – 9:00 AM	Registration, Networking, and Breakfast
9:00 AM – 9:30 AM	Opening Remarks Prof. Jennifer Perera, President SLMA
9:30 AM – 10:30 AM	Plenary and Discussion: Looking back The Integrated Health Sector Response to IPV in Sri Lanka 1. Dr. Nethanjali Mapitigama, Gender Focal Point, Family Health Bureau 2. Ms. Sumithra Fernando, Women In Need 3. Ms. Udhayani Navaratnam, Women Development Officer, Jaffna District
10:30 AM – 12:00 PM	Working Groups: Sharing Knowledge All forum participants into small groups to discuss and identify key issues and gaps that are relevant for the Sri Lankan context • Practice and policy gaps • Women's access to services • Services in post-conflict areas • Engaging and working with men
12:00 PM – 1:00 PM	Lunch & Poster Viewing
1:00 PM – 2:15 PM	Leveraging Research for Practice and Policy Change 1. Dr. Henrica A.F.M. (Henriette) Jansen, International Researcher Violence Against Women 2. Prof. Nishi Mitra, Advanced Centre for Women's Studies, Tata Institute of Social Sciences, India
2:15 PM – 3:15 PM	Open Discussion: Addressing IPV Among Underserved Communities in Sri Lanka
3:15 PM – 4:00 PM	Closing Remarks: Research, Practice and Policy Implications 1. Dr. Ganesan Mahesan, Consultant Psychiatrist, NIMH, Sri Lanka 2. Prof. Sepali Guruge, Ryerson University, Toronto, Canada 3. Prof. Nalika Gunawardena, Sri Lanka Medical Association, Sri Lanka

OPENING REMARKS

Prof. Jennifer Perera
President, Sri Lanka Medical Association

Intimate Partner Violence is a significant public health problem in Sri Lanka

Prof. Jennifer Perera highlighted the magnitude of the problem of Intimate partner violence (IPV) in Sri Lanka and the significant role that can be played by the health care sector in addressing this problem.

She also spoke about the key role played by the Sri Lanka Medical Association in promoting education and capacity building with regards to addressing Gender Based Violence within the Universities and higher education institutions was also highlighted. Prof. Perera was confident that the forum would provide an opportunity for relevant stakeholders to engage in mutually beneficial knowledge sharing activities.

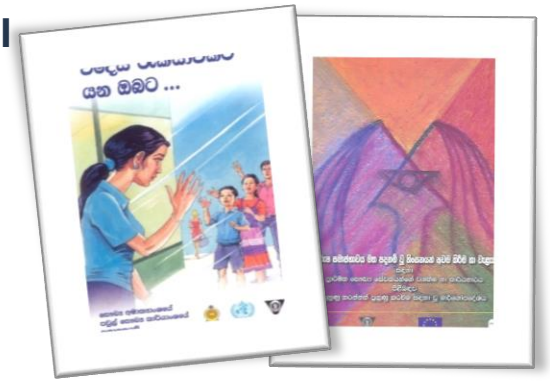
Dr Vathsala Jayasuriya-Illesinghe,
Co-Principal Investigator of the Project

Dr. Vathsala Jayasuriya-Illesinghe described the background to the project highlighting the progress made within and beyond the health sector in recognizing IPV as a significant health problem in Sri Lanka.

Looking back to a time when IPV was not recognized a public health problem in Sri Lanka, and tracing the steps over time it was evident that many researchers, advocates, and service providers had played a hug role towards the present day achievement in bringing this important issues to the forefront of the health sector agenda.

Intimate Partner Violence is defined as any physical, sexual, or psychological harm that is perpetrated by a current (or former) partner or spouse.

HEALTH SECTOR RESPONSE TO GENDER BASED VIOLENCE IN SRI LANKA



Dr. Nethanjali Mapitigama,
Program Manager Gender and Women's Health
Family Health Bureau, Ministry of Health, Sri Lanka

The Family Health Bureau is the directorate responsible for women's health inclusive of gender-based violence (GBV) issues in the Ministry of Health.

The national policies that guide this work include:

- Reproductive Health Policy (1998)
- Health Master Plan (2007 – 2016)
- Maternal and Child Health Policy (2009)

A **multi-pronged approach** is used to respond to the needs of those experiencing IPV as well as to prevent such violence. This includes capacity building among primary health care staff about prevention and management of GBV, developing resource material to raise community awareness, and setting up hospital based centers to offer befriender services, emotional support, counselling, and referrals for required services

A **Gender Based Violence** framework is used by the Ministry of Health in Sri Lanka to address Intimate Partner Violence (IPV) against women.

Special Focus: Staff Training

- Training of health staff, welfare officers, and sensitization of estate managers about GBV
- Guideline to address sexual harassment among staff in workplaces in health sector
- Package for migrant workers and their families to create awareness regarding IPV

MITHURU PIYASA is a free support center operated by hospital staff offering counseling, support, and referrals.

New Initiative *Facilitators' Guide for Trainers of Medical Undergraduate on Responding to GBV is* being developed in collaboration with expert committee on women's health of the Sri Lanka Medical Association.

Way Forward

We need to improve and increase access to services and resources. A **service providers' directory** and facilitators' guides to sensitize health care professionals to the issue of IPV are also needed. Health care professionals should know how to make appropriate **referrals** for victims of IPV.

WOMEN IN NEED

"Break the silence, WIN against violence"

"IPV has always been widespread in Sri Lanka, patriarchal norms, gender stereotyping, and attitudes have influenced and reinforced IPV perpetration."

Ms. Sumithra Fernando
Executive Director, Women In Need

Women in Need (WIN) provides **comprehensive services** to victims of intimate partner violence (IPV). These services include counselling, legal, temporary shelter provision, a confidential 24 hour hotline, crisis centers, and resource centers.

Many incidences of IPV may go unreported due to shame, fear, feeling powerless, lack of knowledge, male control of movement outside the home, perceiving the legal system as inaccessible and impersonal, and law enforcement authorities and the judiciary trivializing issues of abuse and violence.

> *"There is a lack of adequate support services and the legal system has not effectively dealt with grave incidents of IPV. Some of the provisions in the Domestic Violence Act (for example counselling and shelters for victims of domestic abuse) have yet to be implemented."*

WIN also undertakes **preventive efforts towards addressing IPV** which includes awareness campaigns, lobbying and advocacy, sensitization of stakeholders, capacity building, enhancing coping skills, networking with like-minded organizations such as enforcement agencies or the health sector, and working with men and boys to become advocates for the issue of intimate partner violence.

The organization **faces many challenges**, especially when addressing gendered and stereotypical attitudes and beliefs towards IPV. There is a general lack of support for victims and their children, a lack of funding and state support, and a lack of recognition of IPV as a human rights violation

Active and coordinated participation of all service providers and state support is urgently needed for the service providers.
The community should have access to information about available services.

INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE NORTHERN PROVINCE

"Ground reality is that implementation of the Domestic Violence Act is ineffective because women are subordinated, stigmatized by society, and men control and hold positions of power."

Ms. Udhayani Navaratnam,
Women Development Officer, Jaffna District

Based on the reports from Women Development Officers and social workers from the Northern province, an increase in number of cases of intimate partner violence (IPV) against women that are reported appears to be increasing. One of the reasons for this could be better reporting mechanisms now being in place. Most women report to agencies and/or seek services as a last resort.

"There is a lack of male participation in overcoming these issues."

Some of the root causes for IPV are poverty, alcohol and substance abuse, weakened family and social structures due to the war and post-war conditions, and the changes in values, attitudes, and behaviors in the post-war context.

The media plays a role in perpetuating these values and attitudes.

"Most cases referred from the GBV desk at the Jaffna Teaching Hospital is related to IPV. Domestic violence, non-partner sexual violence, and sexual harassment are also reported."

Challenges in addressing intimate partner violence include lack of a collective response, poor implementation of the laws, and lack of knowledge about reproductive health issues.

Filling the vacancies in health care institutions and social service sectors must be an urgent priority in the war-affected areas.

Way Forward
An expansion of the hospital-based centers (Mithuru Piyasa) to all peripheral areas is needed.
Spaces must be created to provide a safe and private environment for women to talk about their experiences with counsellors and social service officers.
Multisectoral networks must be strengthened; attention must be focused on preventing IPV.

WORKING GROUPS: SHARING KNOWLEDGE

*What are the **challenges faced by healthcare workers** in providing services for women experiencing IPV in hospital settings?*

> *"What do we ask and what do we look for?" Identifying women's IPV-related healthcare needs is a challenge. Clear protocols about when to suspect IPV among women who seek services is lacking.*

Healthcare workers have curative and preventive roles in providing IPV-related services. Treatment and referral, counselling, case discussion, and shared care were identified as **curative services.** Identifying victims and those at risk, providing referrals, advocacy, inter-sectoral collaboration, empowerment, social mobilization, shared care, and follow-up care were categorized as **preventative services**.

Healthcare workers remain hesitant to get involved in IPV-related care. Healthcare workers lack knowledge and skills about how to identify victims when to ask about IPV and/or when to suspect IPV with women who seek services.
There is also a **"fear around getting involved in such issues"** because they may lack the tools and resources to provide services "if a woman says she has experienced IPV". Male healthcare workers find this especially challenging.

Maintenance of confidentiality, lack of guidance on management, and unavailability of facilities continue to present gaps in service provision.

> *"Providing IPV-related care is still not a priority among the healthcare workers"*

*What are the **most urgent resource and training needs** in providing services within hospitals?*

- Training and developing human resources
- Improving infrastructure
- Developing guidelines for case management

The summaries presented here are based on the overall discussions and are not views expressed by the persons depicted in the photographs.

*What are the **challenges in providing IPV-related services** to women from post-conflict areas in Sri Lanka?*

Post-conflict, there is a prioritization of economic development efforts in the region with low emphasis on other areas. Defence regulations and militarization of civil life can be barriers to engaging with communities and to improving community awareness about issues such as IPV.

A **general societal impunity towards violence** is felt and enacted throughout this region as well as the rest of the country. Political influences prevent implementation of laws and legal redress for victims of violence.

Women-headed families and their struggles are particularly specific in post-conflict areas. Language barriers, and poor access to and shortage of resources are main limitations in providing services.

Women and child desks should be in place all police stations.

> *"Care providers lack the tools and capacity necessary to provide effective services to women experiencing IPV in the North."*

*What are the **most urgent resource needs** in providing services to women experiencing IPV in a post-conflict situation?*

Improving transportation and infrastructure will address some barriers to access. However, access is also contingent upon healthcare workers' **ability to communicate in Tamil**, and **willingness to work with other categories of staff.**

Coordination and collaboration with front line service providers such as public health workers, women development officers, and social service officers, is necessary for building relationships in the north. Having a political will for change is imperative in achieving these goals.

*What are the **challenges faced by NGOs, social services and other non-health service partners** in providing IPV-related care ?*

There is a lack of policies or guidelines on how non-government organizations (NGOs) and other sectors should work collaboratively with the health sector in providing services for women experiencing IPV. The Domestic Violence Act does not provide the necessary framework.

As a result there is a lack of defined roles for providers and no service model or system for providing services.
We need responsible media reporting.
We also need to consider the role of academia in addressing IPV.

Duplication of and gaps in services decrease the efficiency and effectiveness of available services.

There is also a lack of integration within the NGO Civil Society Organization (CSO) sector and between different sectors. CSO works are often “project oriented” and with a lack of human resources, its sustainability is called into question.

*What are the ways in which we can **overcome these barriers** and provide a coordinated multi-sector response to IPV?*

Attitudinal change within and between different sectors can help overcome these barriers. If we can identify (and define) roles within an overall policy framework as well as obtain funding and state support for CSO work, we can start to establish a coordinated effort in response to IPV.

> *Providing safe houses/shelters – “whose responsibility is it ?”*

*What are the **prevention efforts** in place to address IPV against women in Sri Lanka?*

> *"Even though international convents are ratified and adopted to address violence against women (VAW), no national level strategy or policy exists to guide prevention of VAW."*

The Family Health Bureau (FHB) has developed several resources with the aim of preventing gender based violence including preconception packages for recently married couples, resource packages for migrant workers, and training manuals for health care workers.

A conducive environment has been created with a separate ministry for women and youth, a focal point at FHB and DS offices, police desk and a help line (119).

NGOs and others, such as the National Institute of NIMH, carry out ad hoc programs focusing on prevention.

*What are the **challenges in advocating** for and in the implementation of preventive programs?*

Cultural barriers, attitudes, beliefs, and stigma (stereotyping) mean that there is a lack of sensitivity among men regarding IPV. Lack of economic and educational opportunities for women limits them to holding subordinate positions. Lack of focus on youth programs mean that children will grow up with similar barriers, attitudes, and beliefs surrounding IPV.

> *"There are no formal programs focused on engaging or working with men as a preventive effort."*

Research for Policy & Change

15 YEARS OF PREVALENCE STUDIES ON VIOLENCE

Dr. Henrica A.F.M. (Henriette) Jansen
International Researcher Violence Against Women

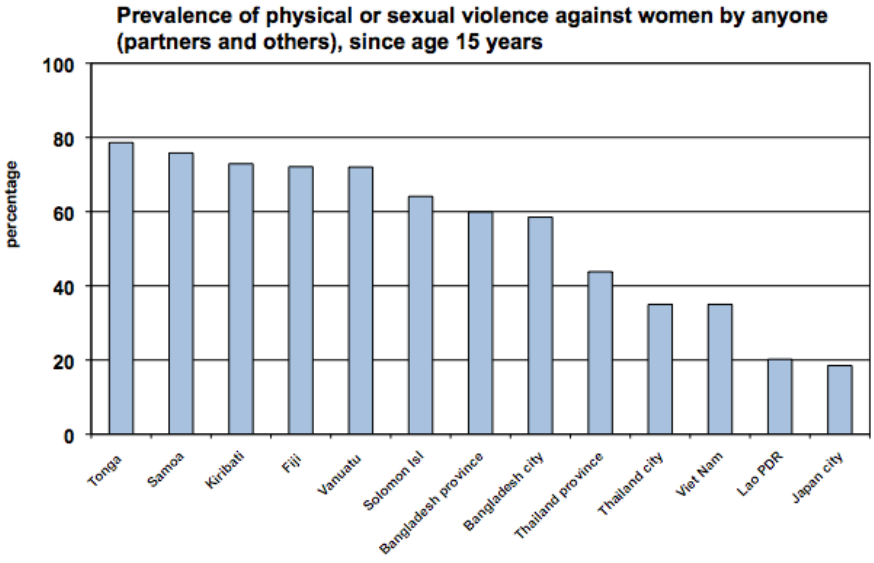
"In many countries, there have been different levels of transformative processes taking place within and around a survey. Many women start thinking for the first time about what is happening to them; their awareness is being changed. Half of the women speak for the first time the burden of their abusive experiences."

Prevalence data is an important first step for awareness creation and later for policy development and practice changes. Service based statistics only show the tip of the iceberg. Summaries and generalizations can hide huge differences in incidence, severity, and risk; context is key to understanding the numbers.

"Know the story behind the data and only collect data if it gets used."

There are many types of violence against women (VAW). Not all types of VAW can be measured in surveys (for example, trafficking of women and femicide). Most existing surveys have a special emphasis on domestic violence. They measure violence by intimate partners (current of former husbands and/or men with whom women lived together); in particular on physical violence, sexual violence, acts of emotional abuse, and controlling behaviors by these partners (economic violence in some countries).

Prevalence Rates, Asia & the Pacific Region (2000-2015)



Some governments can use the term gender based violence (GBV) to "sweep violence against women issues under the carpet".

AGAINST WOMEN IN ASIA & THE PACIFIC REGION

How do we make sure research data gets used?

- Engaging stakeholders **from the beginning** of the research process to create ownership and commitment.
- Involving stakeholders in interpretation and formulation of recommendations.
- Simplifying the findings, relating a story, and being able to visualize/humanize data have been useful to engage with policy makers.

> *"Interviewers everywhere relate how their involvement was a transformative process personally and/or professionally. Interviewers become agents of change."*

DATA FOR ACTION: EXAMPLES FROM THE REGION

Vietnam

- A series of advocacy events with parliamentarians, political parties, relevant ministries, (Ministry of Public Security and National Assembly, Ministry of Health, Ministry of Justice), and NGOs, with the technical assistance from UN agencies
- Advocacy & lobbying using a range of communication materials and involving the media to disseminate results of the study
- Visualizing data: real case stories developed into films, bringing the voice of survivors to policy dialogues

Solomon Islands

- Data owned and presented by the Government and approval from the Cabinet
- Wide dissemination reducing the stigma and silence around the issue
- Large media campaign

Engage the **media** - **prepare** visual material
Behavior change is challenging and takes time

Impact in Vietnam

- Increased attention from parliamentarians, communist party/government leaders and local authorities, development partners and donors
- Violence against women (VAW) and domestic violence (DV) included in the Government Program of Actions
- Government reviewing five years of DV law implementation
- VAW indicator included in health information systems

Impact in the Solomon Islands

New national policies on gender equality and ending violence against women

- Increased reporting of cases to police
- Increased police attention to GBV
- Increased donor funds and improved services
- New legislation to address family violence

SEXUAL VIOLENCE & THE CULTURE OF SILENCE:

Prof. Nishi Mitra
Advanced Centre for Women's Studies
Tata Institute of Social Sciences

Sexual violence is the primary mode of social control exercised over female sexuality and women's participation in the economy and society in general. It remains a difficult question to address as, in most societies in the world, it is associated with the private sphere of marriage and family.

Moreover, studies have shown that domestic violence (DV) is not to be dismissed as unimportant conflict between loving couples. Injuries resulting from DV are serious and pervasive across class and women report health consequences of such violence despite social censure and taboos.

Women have little power negotiating safe relationships:

- Early marriages of adolescent girls are consummated with force
- Difficulty obtaining contraception especially in the early years of marriage until after the birth of two or three children
- Difficulty convincing their husbands for safe sex puts her at substantial risk of contracting sexually transmitted infections
- Women cannot refuse sex to their partners even when they have genuine medical reasons to do so, as dictated by cultural norms

> *"Sexual violence not studied much; studies throwing light on its existence in marriage are rare."*

Studies on sexual and reproductive health reveal that pregnancy is not experienced by women as safe. There are studies that point to high incidence of domestic violence during pregnancy and higher rates of maternal mortality related to complications associated with DV.

Fetal and infant death due to domestic violence at the time of pregnancy have also been noted in studies and have direct implications for women's physical and mental health.

Institutions like heath care, Police, or the judiciary largely adhere to patriarchal expectations of masculine and feminine behaviour which makes it difficult for women to report incidences of DV and for their reports to be taken seriously.

A critical appraisal of the role of health services for IPV

'I have handled many cases of miscarriages and post-partum bleeding but I am not sure whether these were cases of sexual violence. Sometimes I may suspect violence, but then it is not for me as a doctor to look into that. Professional ethics demand that I remain focused on what I can do to treat the wound or injury." – Health care workers in India

Doctors often lack education regarding DV and an understanding of the barriers faced by women that prevent them from openly communicating about abuse. Some physicians:

- Justify wife beating
- Are indifferent to the issue of wife beating since indifference is seen as objective, professional, and ethical behaviour
- See sexual violence as masculine behaviour and assertiveness in sex
- Do not understand the significance and links between physical injuries and different forms of violence

Health care professionals can play a pivotal role in recognizing victims of sexual violence who otherwise remain hidden due to stigma and taboo on sexuality.

Medical health professionals enjoy moral authority and respect and may, through their scrutiny, send a clear public signal of such violence being condemned. They may also help in alerting other agencies like social care professionals and police in situations which demand such attention.

"We have to attend so many cases in a day that we are unable to devote sufficient time to each and every case." – Health care workers in India

A multi-sectoral approach to address the problems of service seekers is required so that health professionals can be enabled to make appropriate referrals to agencies which may be required to provide social and legal support to women seeking intervention.

Possible Strategies to Help Address DV

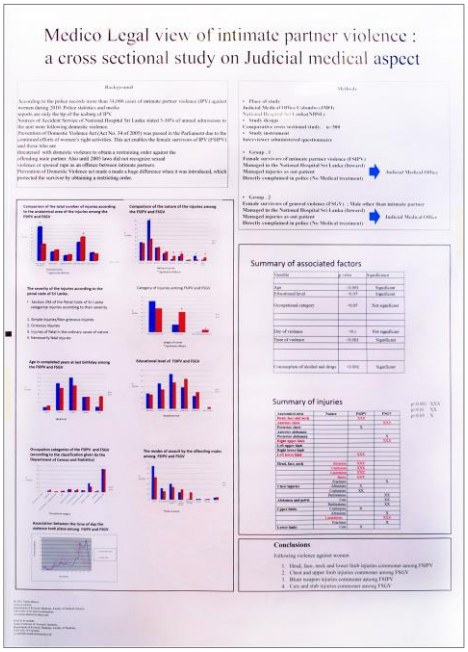
- Multi-sectoral approach – referrals by health care professionals and legal aid
- Advise health professionals on feminist perspectives so that health issues are addressed within an empowerment model
- Use of a non-judgmental and sympathetic attitude on the part of health practitioners may facilitate disclosure

The Accredited Social Health Activists (ASHA) are currently engaged as a part of a rural health mission to be the interface between community and public health care system in India.
They are women activists belonging to the same community and have become the first contact for addressing health needs.

With continuing and advanced training, ASHA workers are seen to play critical preventive and corrective roles in cases of violence against women, child marriages, teen pregnancies and dowry-related violence.

CONFERENCE POSTER PRESENTATIONS

Forum attendees were invited to showcase their work in posters. They presented work covering a wide range of topics from medico-legal, nursing, and mental health aspects of IPV-related care, reproductive health providers' experiences in providing care for women experiencing IPV, as well as papers focusing on researching and working with men, and those capturing researchers' experiences in this area of work. For more information about these presentations, please contact the author(s). Their email addresses are given below.



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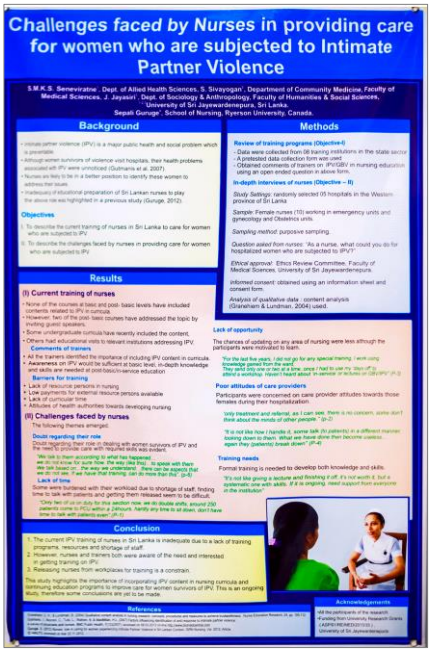

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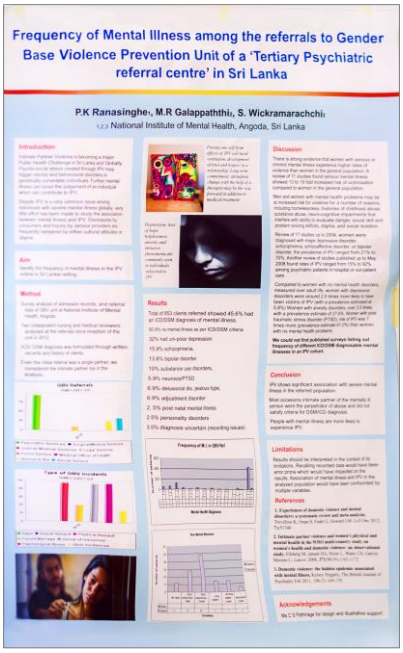

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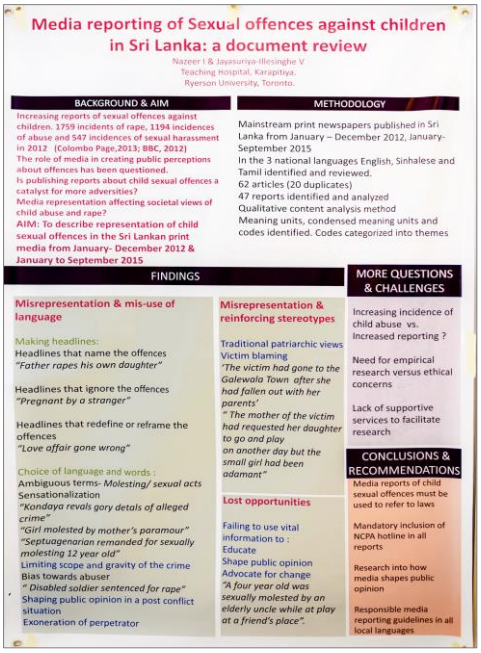

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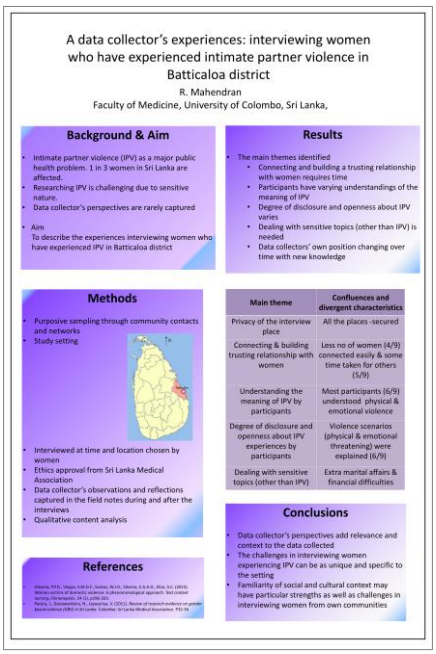

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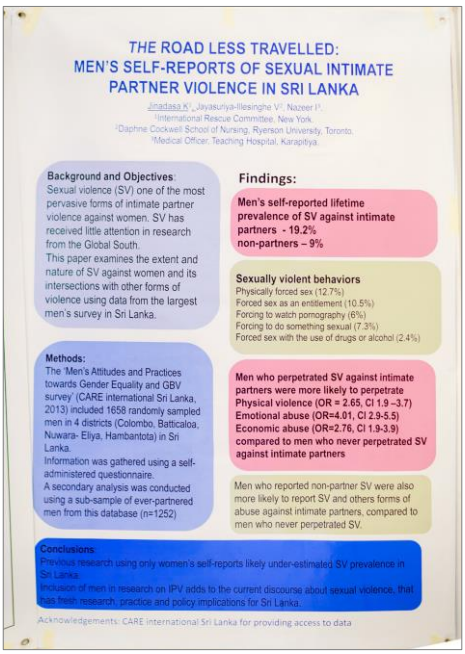

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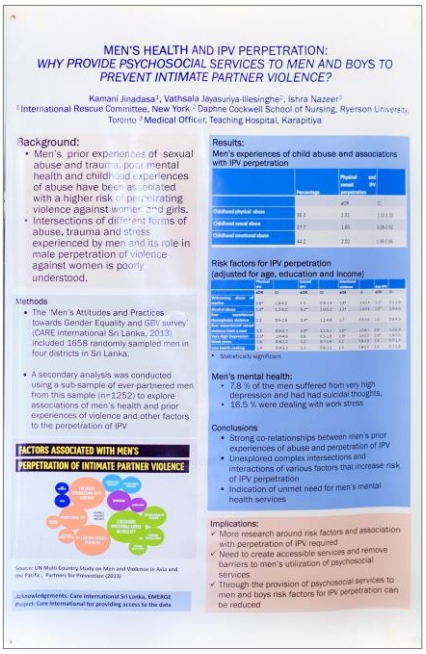

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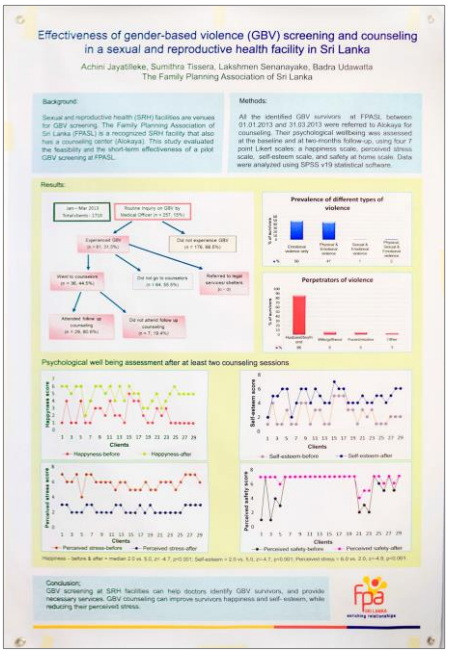

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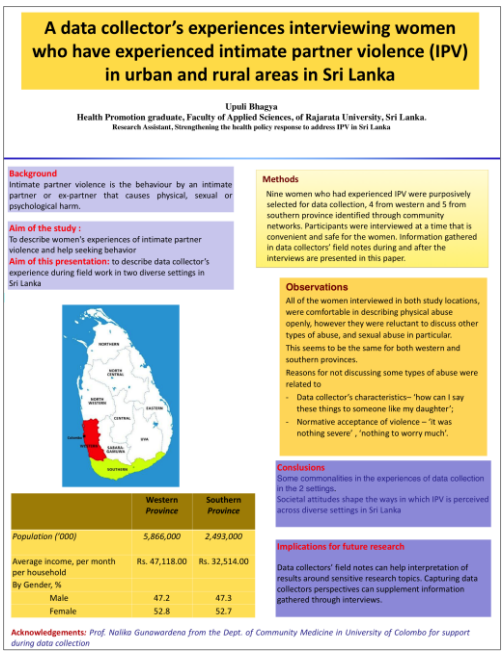

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CLOSING REMARKS: PRACTICE AND POLICY IMPLICATIONS

Dr. Ganesan Mahesan, Prof. Sepali Guruge, Prof. Nalika Gunawardena

Addressing intimate partner violence (IPV) against women falls under the Violence Against Women framework of the Ministry of Women's Affairs and Child Development. The health sector response requires an alignment with this overarching framework. Working towards and calling for separate policies and frameworks may not be the most progressive step towards a multi-sectoral response. Social services, legal services, and other sectors working to address IPV must also align their mandates with this framework for an integrated and collaborative approach.

The health sector could provide a useful entry point for provision of services, however, addressing this complex problem and the underlying root causes of violence could be beyond the scope of one agency or ministry.

The bio-medical model may not be the most suitable approach to guide our response to address IPV against women. Our understanding of IPV could be too narrowly defined, out of context, and lack relevance to the diverse communities in various parts of Sri Lanka.

Within the health sector there is a lack of technical capacity among the caregivers.

Health workers can disempower survivors and those who seek services if they themselves perpetuate gendered stereotypical attitudes.

> *"Women often wait to see someone accessing services and the outcome before reaching out to these agencies herself."*
> *"Do we have information about outcomes ?"*

"Numbers help, but does not tell the full story"

> "*There are windows of opportunity to move forward. The question is, have we missed them ?"*

A woman's decision to seek services is a critical point for intervention. Women who decide to seek services for abuse do so after much suffering and deliberation.
If they do not receive the support they need, they go back and they may not want to seek help or may be prevented from doing so ever again

Even though more women are now reporting to agencies and seeking services, there is very little evaluation of outcomes at the individual and/or the program level. Therefore there is a lack of awareness about what works in different contexts.

Most programs offer short term support but hardly any address long term health and social needs of affected women

If services are limited to immediate care, women are unlikely to benefit from the efforts and the resources allocated to IPV-related services in Sri Lanka may not be optimally used.

Short training programs targeting healthcare workers fail to address and/or challenge societal norms and perceptions about IPV. Addressing these are key issues in developing healthcare workers' capacity to provide service to women experiencing IPV

> *"There is a lack of women's voices in decision-making processes. Have we asked women who experience IPV what kind of services they need or what they have received so far ?"*

The research team

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Future Events and Venues

Policy Makers Meeting
December 16, 2015
The Cinnamon Grand Hotel,
Colombo, Sri Lanka

Stakeholders Forum
January 20, 2016
Ryerson university
Toronto, Canada

Ryerson University

Sri Lanka Medical Association
Serving the Profession - Serving the Nation

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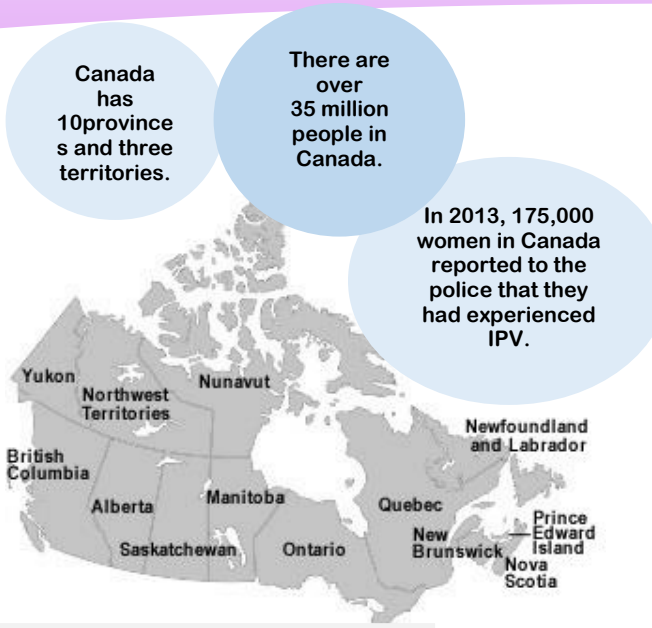
To find out more about the project and more updates please visit our website at www.addressingipvsrilanka.ca

Intimate Partner Violence (IPV) Initiatives in Canada
A summary

Prof. Sepali Guruge, Dr. Vathsala Jayasuriya-Illesinghe, Laura Zahreddine, MN(s)

In Canada,

- IPV related annual health, social, and economic costs are about $7.4 billion.
- The federal government's Family Violence Initiative directs IPV-related programs and services across Canada.
- The Canadian Network of Women's Shelters and Transition Houses provides a national forum for agencies to work together collaboratively.
- Canada has many great strides towards improving care and services to women experiencing IPV.
- Women in marginalized communities continue to face many systemic barriers in accessing IPV related services.



There are inconsistencies in the terminology used in Federal and Provincial policy documents. Domestic violence, IPV, and Family violence are used interchangeably to refer to violence instigated by current or former partner or spouse. Only some of the provinces have specific policies focusing on IPV. Details about some of the provincial initiatives are given below.

Ontario (ON)

- The Domestic Violence (DV) Action Plan directs programs and services that respond to survivor
- *Neighbours, Friends and Families* campaign provides education resources; www.neighboursfriendsandfamilies.ca
- *The White Ribbon Campaign engages boys and men to address* gender inequality and build relationship skills; www.itstartswithyou.ca
- Ontario Network of Sexual Assault/Domestic Violence Treatment Centers is an association that provides research, education, and training for hospital and shelter staff, who provide services for sexual assault and DV.
- Standards of practice have been developed by Ontario Network of Sexual Assault/Domestic Violence Treatment Centers to ensure consistency in assessments for women who have been affected by IPV.

Alberta (AB)

- AB's Family Violence Framework directs programs and services for IPV.
- The framework includes 5 strategic priorities to end IPV: (1) Strengthen efforts in prevention, (2) Enhance services, supports and justice response, (3) Partner with AB's diverse communities (4) Promote family and community safety through policy and public engagement, and (5) Evaluate collective success
- The Integrated Threat and Risk Assessment Centre takes a team-based approach and provide assistance to law enforcement and agency workers within the province who work with women experiencing IPV.

British Columbia (BC)

- BC's Violence Against Women in Relationships (VAWIR) policy sets out protocols and responsibilities for service providers to ensure coordinate services to provide more effective care and support to women experiencing IPV. .
- VAWIR policy is reiterated in BC's Domestic Violence Action Plan, which aims to promote safety, shared responsibilities, and integrated and culturally inclusive services.
- Safety and Health Enhancement for women experiencing abuse Framework provides a tool kit for health care providers and planners to conduct an audit of their practice and/or organization, by looking at the safety of women impacted by abuse.

Nova Scotia (NS)

- NS's action plan sets out priorities for action including ensuring women's safety by increasing services to those affected by IPV, strengthening case processing and management, coordinating and management of support and rehabilitation programs and focusing on prevention of IPV.
- In NS, the Domestic Violence Court Program provides offenders education about behavior change.
- The Nova Scotia Advisory Council on the Status of Women and the Government of Nova Scotia have developed educational resources including a website www.nsdomesticviolence.ca, which provides resources to women experiencing IPV, service providers, and researchers.

This is summary is based on a paper under review for publication
For more information visit our website at:
http://www.addressingipvsrilanka.ca

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