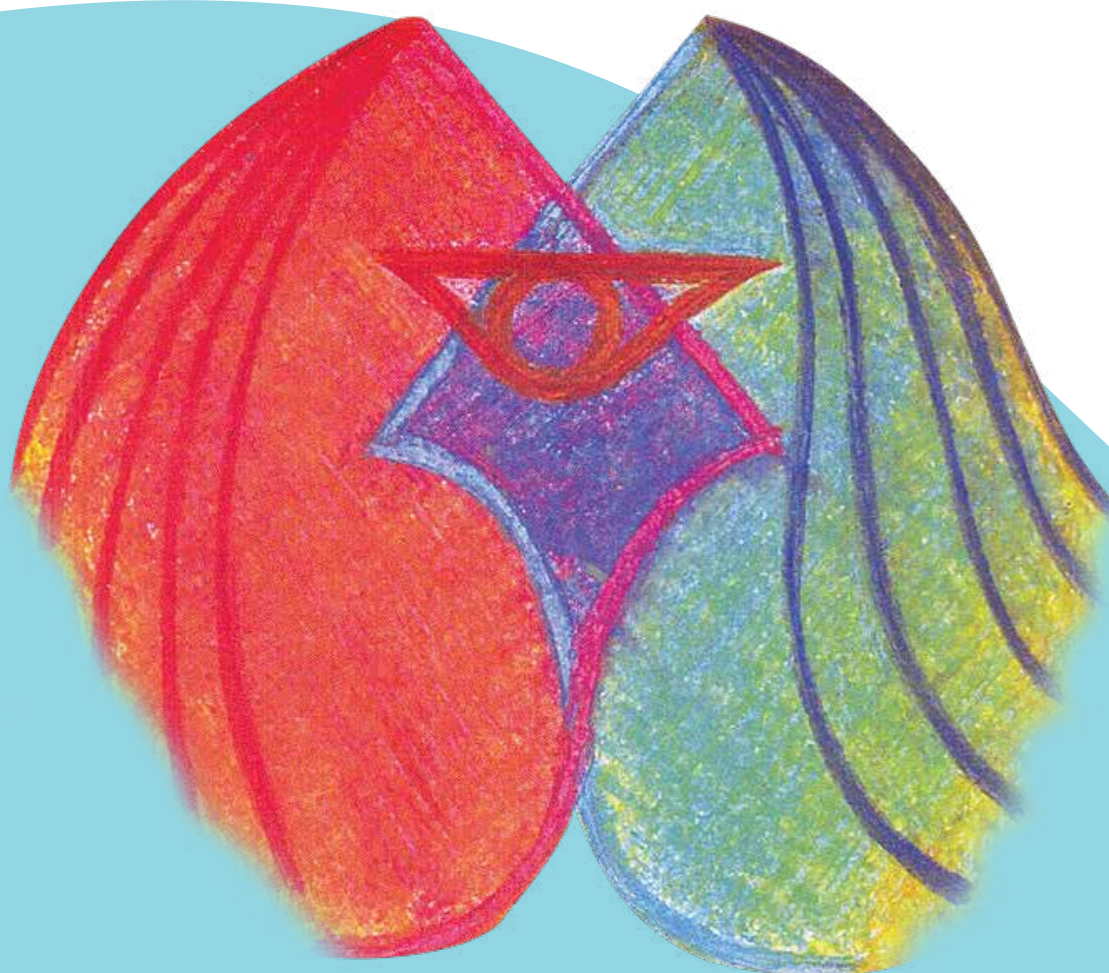


Health Sector Response to Gender Based Violence

# **NATIONAL GUIDELINE FOR FIRST CONTACT POINT HEALTH CARE PROVIDERS**

Sri Lanka



Ministry of Health, Nutrition  
& Indigenous Medicine



Family Health Bureau



British  
High Commission  
Colombo

# 2019



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**Ministry of Health, Nutrition & Indigenous Medicine**

Supported by

**United Nations Population Fund-Sri Lanka**

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# Contents

Contributors	ii
Contents	iii
Message from Director General of Health Services	v
Message from Unfpa Representative In Sri Lanka	vi
Acknowledgments	vii
Preface	viii
III. Acronyms & Abbreviations	ix
IV. Terms used	x
<b>1 About this Guideline</b>	<b>1</b>
1.1 What is the guidance about?	1
1.2 Justification: Why was the guideline developed?	1
1.3 Process of development: How was the guideline developed	2
1.5 Target Group	3
<b>2 Introduction to Gender and Gender-based Violence</b>	<b>4</b>
2.1 Gender	4
2.2 Introduction to GBV/DV	5
2.2.1 The magnitude of GBV/DV	7
2.2.2 Health consequences of GBV	9
2.2.3 Domestic Violence and Pregnancy	10
2.3 Health sector response to GBV/DV	11
<b>3 Essential services to address GBV/DV</b>	<b>13</b>
3.1 Essential services package	13
3.2 Identification of survivors of intimate partner violence	15
3.2.1 Providing information on GBV/DV	15
3.2.2 Asking about GBV/DV	16
3.3 Screening for GBV/DV	17
3.4 First line support	18
3.4.1 Listen	20
3.4.2 Inquire about needs and concerns	20
3.4.3 Validate	21
3.4.4 Ensure safety	21
3.4.5 Support	23
3.5 Care of injuries and urgent medical treatment at the first contact point	23
3.5.1 History taking	24
3.5.2 Examination	26
3.6 Sexual assault examination and care	27
3.6.1 Medico-legal functions of the first line medical professionals	27
3.6.2 Mandatory Reporting	28
3.6.3 Pregnancy prevention and management among girls who have been sexually abused	29
3.6.3 Post-exposure prophylaxis for sexually transmitted infections	31
3.6.4 HIV post-exposure prophylaxis treatment and adherence	32
3.7 Mental health assessment and care	33
3.8 Documentation	39

4 Guiding principles derived from ethical principles and human rights standards	40
4.1 Survivor centred care	40
4.2 Confidentiality	40
4.3 Non-discrimination	41
4.4 Safety	41
4.5 Respect and ensuring the dignity	41
4.6 Human rights approach	42
4.7 Gender sensitive approach	42
4.8 Consent	43
5 Pathway of care	44
6 Referrals	45
7 Prevention of GBV	47
8 Prevention of Domestic Violence Act 2005 and legal assistance to survivors of GBV	59
9 Self-care: Looking after yourself	61
10 Implementation of the Guideline	62
Annexure I - Consent form	63
Annexure II - List of Mithuru Piyasa /Natpu Nilayam Centres and their contact details	64
Annexure III - Inventory of other service providers at National level	66

## Message from Director General of Health Services

Gender Based Violence (GBV) is a global, public health and a clinical concern. GBV affects the health and well-being of the women and their children, and is also considered as a gross violation of human rights. GBV causes adverse physical, mental, sexual and reproductive health outcomes, which lead the survivors to make extensive use of health care services and resources. As such, health care providers frequently, and often unknowingly encounter survivors of GBV. The health care system can provide survivors a safe environment where they can confidentially disclose experiences of violence, and receive supportive responses and services.

Affirming the important and specific role that the health system of the country should pay in responding to Gender Based Violence, Family Health Bureau as the nodal organization responsible for women's health in the Ministry of Health, has taken a significant step forward, by developing 'A Guideline for the First Contact Point Health Care Providers on Prevention and Management of GBV'. The interaction of the survivor with the first contact health care provider is a crucial interphase, which ensures service provision, and generates first step of trust which promotes and encourages continuity of care.

I congratulate the Family Health Bureau for taking this important initiative to streamline the health sector response to GBV in a sustainable manner. I expect that this new guideline would bring a new dimension to already existing services in dealing with GBV in Sri Lankan health care settings, and would like to pledge my fullest support in further enhancing the quality of care provided by health sector to the citizens of Sri Lanka.

### **Dr. Anil Jasinghe**

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## Message from UNFPA Representative In Sri Lanka

The United Nations Population Fund (UNFPA) is the lead UN agency working to further gender equality and women's empowerment in Sri Lanka. We are pleased to be a part of the joint effort with the Ministry of Health to develop the first 'Standard Operating Procedures on sexual and gender-based violence for first-contact-point healthcare providers'.

Gender-based violence is one of the most prevalent human rights violations in the world. It is estimated that globally 1 out of 3 women have experienced physical and/or sexual violence in their life time. When women and girls are victims of violence, they are more likely to become vulnerable to forced and unwanted pregnancies, unsafe abortions, and sexually transmitted infections including HIV, let alone long-lasting psychological trauma.

In Cairo 25 years ago, at the International Conference on Population and Development, world leaders placed women's rights at the centre of population and development policies. This meant advancing gender equality, empowering women and eliminating all forms of violence against women and girls. As gender-based violence is often shrouded in a culture of silence, stigma and discrimination; supporting survivors of violence and providing them with essential medical and psychosocial services is a key priority and a critical effort towards achieving universal health coverage and the 2030 Agenda for Sustainable Development.

We need to ensure that women and girls who suffer from violence have the confidence to approach healthcare providers and be assured that they will be in safe hands. This is what these operating procedures aim to achieve; by providing a comprehensive set of actions to healthcare providers to effectively manage and address incidents of sexual and gender-based violence. The operating procedures will assist in improving coordination in service delivery and enhance the quality of response and prevention mechanisms to survivors of sexual and gender-based violence. The use of the 'Standard Operating Procedures' can make the clinical practice more comprehensive, uniform and more responsive to the needs of the survivor. It will further help to build gaps between data on gender-based violence and clinical practice within the first contact point-of-care.

These operating procedures were developed alongside the 'National guidelines on sexual and gender-based violence', which aims to strengthen Sri Lanka's health systems response to survivors of violence. We are grateful to the British High Commission in Colombo for their support in developing these guidelines and procedures as they mark an important milestone in creating a safer Sri Lanka for all women and girls. UNFPA is proud to be a part of this journey, and we stand ready to provide continued assistance to the Government of Sri Lanka and all key stakeholders to ensure women and girls receive essential services that support their safety, well-being and access to justice and to create a violence-free Sri Lanka.

**Ms. Ritsu Nacken**

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## Acknowledgments

This document was developed utilizing the inputs from many individuals and organisations committed towards elimination of SGBV, and incorporating published literature. We greatly appreciate the contribution made by those who assisted us in numerous ways. Space does not permit us to mention them all and we acknowledge their support.

Development of these SOPs would not have been a reality without:

- the services of the technical experts Dr. Lakshmen Senanayake and Dr. Manoj Fernando who compiled the document utilising the international literature and align the document with the Essential Services Package while keeping it suitable to the Sri Lankan context.
- the time and energy spent by all reviewers and resource persons who participated at the consultations and provided input that added much value to the SOPs and made it applicable to the Sri Lankan health delivery system.
- the assistance given by UNFPA Colombo in completing this task and in particular, the contribution made by Ms. Ritsu Nacken the Country Representative and Ms. Sarah Soysa National Programme Analyst- Sexual and reproductive Health and Rights in encouraging us throughout the process of development.

We would like to acknowledge the commitment and courage of all categories of staff who provide care for survivors of GBV under difficult circumstances which is an encouragement to us.

Finally, we acknowledge the bravery of survivors who defy the social barriers to seek care from the health delivery system in Sri Lanka who are an inspiration to us to work towards a society free from GBV.

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## Preface

Sri Lanka has made a concerted and comprehensive response within the health sector to address Gender-based Violence (GBV/DV) over the years, using a multi-pronged and systematic approach. In the early stages apathy and indifference of the policy makers and service providers limited the response but as this waned off, is presently replaced by understanding, enthusiasm and a drive to assist fellow human beings.

These efforts were accompanied by the development of training tools and protocols that were designed to suit the local context and sensitivities. The development of the *Mithuru Piyasa/Natpu Nilayam* a GBV/DV service point in health institutions unique to Sri Lanka followed and is very successful with 68 hospitals throughout the island providing this service at present.

Introduction of the Essential Services Package at global level brought to light the need of streamlining the health sector response and aligning it with international standards to make the response more effective, survivor centred and comparable with other countries.

One of the activities conducted to achieve this was to develop a national level guideline targeting the first contact health care providers, which would provide a wide knowledge base for them, to work according to the SOPs published concurrently, to generate a high quality response to survivors of SGBV/DV.

This guideline covers many areas related to GBV/DV, follows the flow of the Essential Service Package, and utilizes the information from many international documents in order to serve as a guideline and a reference source on an issue which has become a subject of concern and action in Sri Lanka.

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### III. Acronyms & Abbreviations

<b>A &amp; E</b>	Accident and Emergency
<b>CCP</b>	Consultant Community Physician
<b>CEDAW</b>	Convention of the Elimination of All forms of Discrimination against Women
<b>DGHS</b>	Director General of Health Services
<b>DHS</b>	Demographic and Health Survey
<b>DV</b>	Domestic Violence
<b>EC</b>	Emergency Contraception
<b>ECCD</b>	Early Childhood Care and Development
<b>ENT</b>	Ear Nose and Throat
<b>FGM</b>	Female Genital Mutilation
<b>FHB</b>	Family Health Bureau
<b>GBV / DV</b>	Gender-based Violence / Domestic Violence
<b>HCP</b>	Health Care Provider
<b>HITS</b>	Hits, Insults, Threats and Screams
<b>HIV</b>	Human Immune deficiency Virus
<b>HPB</b>	Health Promotion Bureau
<b>IPV</b>	Intimate Partner Violence
<b>IYCF</b>	Infant and Young Child Feeding
<b>L.I.V.E.S</b>	Listen, Inquire, Validate, Ensure safety, Support: components of first line support
<b>MO/OPD</b>	Medical Officer/Out Patients Department
<b>MOH</b>	Medical Officer of Health
<b>MoH</b>	Ministry of Health
<b>MOMCH</b>	Medical Officer: Maternal and Child Health
<b>OCP</b>	Oral Contraceptive Pills
<b>OMF Clinics</b>	Oro Maxillary Facial Clinics
<b>OPD</b>	Out Patients Department
<b>PCU</b>	Preliminary Care Units
<b>PDA</b>	Personal Digital Assistant (hand held PC)
<b>PDHS</b>	Provincial Director of Health Services
<b>PEP</b>	Post Exposure Prophylaxis
<b>PHM</b>	Public Health Midwife
<b>RDHS</b>	Regional Director of Health Services
<b>SGBV /DV</b>	Sexual and Gender-based Violence / Domestic Violence
<b>SOP</b>	Standard Operating Procedure
<b>STIs</b>	Sexually Transmitted Infections
<b>UN</b>	United Nations
<b>VAW</b>	Violence Against Women
<b>WHO</b>	World Health Organization
<b>WWC</b>	Well Woman Clinic
<b>YFHS</b>	Youth Friendly Health Services

## IV. Terms used

**Befriending** literally means to act as, or become a friend to (someone), especially when they are in need of help or support. It doesn't necessarily mean 'make a friend of'. It is typically used when a person offers support to someone in difficulties, rather like the Good Samaritan as a form of basic emotional support. Befriending creates and maintains a link with the person and the institution that can be protective. Befriending and the resultant connection is governed by limits, rules and codes of conduct.

**Controlling behaviours** includes, for example: not allowing a woman to go out of the home or to see family or friends, insisting on knowing where she is at all times, often being suspicious that she is unfaithful, not allowing her to seek health care without permission, or leaving her without money to run the home<sup>1</sup>.

**Empowerment** is helping women to feel more in control of their lives and able to take decisions about their future. Empowerment is a key feature of advocacy interventions and of some psychological (brief counselling) interventions<sup>2</sup>.

**Essential Services** encompass a core set of services provided by the health care, social service, police and justice sectors. The services must, at a minimum, secure the rights, safety and well-being of any woman or girl who experiences gender-based violence<sup>3</sup>.

**First-line support** refers to the minimum level of (primary psychological) support and validation of their experience that should be received by all women who disclose violence to a health care (or other) provider<sup>4</sup>. (Detailed information given later).

**Female Genital Mutilation** comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

**Gender** refers to the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed<sup>5</sup>. (Detailed information given later).

**Gender-based Violence** is “any act of violence that is directed against a woman because she is a woman or that affects women disproportionately”<sup>6</sup>. (Detailed information given later).

**Health Service Provider** is an individual or an organization that provides health-care services in a systematic way. An individual health-care provider may be a healthcare professional, a community health worker; or any other person who is trained and knowledgeable in health.

**Health organizations** include hospitals, clinics, primary care centres and other service delivery points.

**Primary Health Care providers** are Public Health Midwives, Public Health Inspectors, Public Health Nursing Sisters and Medical Officers of Health<sup>7</sup>

**Intimate Partner Violence (IPV)** includes sexual assault, physical assault, and stalking perpetrated by a current or former date, boyfriend, husband, or cohabiting partner. (Cohabiting means living together as a couple). Both same-sex and opposite-sex cohabitants are included in the definition<sup>8</sup>.

<sup>1</sup> A clinical handbook Health care for women subjected to intimate partner violence or sexual violence WHO/RHR/14.26

<sup>2</sup> Responding to intimate partner violence and sexual violence against women: clinical and policy guidelines. WHO 2013

<sup>3</sup> Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines Module 2 <http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/essential-services-package-en.pdf?la=en&vs=3648>

<sup>4</sup> Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, WHO; 2013

<sup>5</sup> WHO <https://www.who.int/gender-equity-rights/understanding/gender-definition/en/>

<sup>6</sup> CEDAW, General Recommendation No. 19, paragraph 6, <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>

<sup>7</sup> Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, WHO; 2013

<sup>8</sup> Costs of Intimate Partner Violence Against Women in the United States, Department of Health and Human Services Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control

## Terms used contd.

**Mandatory reporting** refers to legislation passed by some countries or states that requires individual or designated individuals such as health-care providers to report (usually to the police or legal system) any<sup>9</sup> incident of actual or suspected domestic violence or intimate partner violence<sup>10</sup>

**Perpetrator** refers to a person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her will<sup>11</sup>.

**Physical violence** includes causing injury or harm to the body by, for example, hitting, kicking or beating, pushing, hurting with a weapon<sup>12</sup>.

**Prevalence of IPV** is the number of women aged 18 and older who has been victimized by an intimate partner at some point during their lifetime (Lifetime prevalence), or during the 12 months preceding the inquiry. (Prevalence in the past 12 months).

**Psychological/Emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources<sup>13</sup>.

**Rape** is defined in the Article 363 of the Penal Code as sexual intercourse with a woman in five specific scenarios:

- (1) Sexual intercourse without consent,
- (2) Sexual intercourse even with consent where the woman is in lawful or unlawful detention or where consent is obtained through intimidation, threat, or force,
- (3) Sexual intercourse where consent has been obtained when the woman is of unsound mind or in a state of intoxication administered to her by the man or some other person,
- (4) Sexual intercourse where the woman has consented because she believes she is married to the man,
- (5) Sexual intercourse with or without consent if the woman is under 16 years of age unless the woman is the accused man's wife, she is over 12 years of age, and she is not judicially separated from the accused. Penetration constitutes sexual intercourse for the purposes of article<sup>14</sup>

**Sexual assault** refers to forced sex or rape: it can be by someone a woman knows (partner, other family member, friend or acquaintance) or by a stranger.<sup>15</sup>

**Sexual coercion** is an act of forcing or attempting to force, another individual through violence, threats, verbal insistence, deception, cultural expectations, or economic circumstances to engage in sexual behaviours against her will. It includes a wide range of behaviours from violent forcible rape to more contested areas that require young women/men to marry and sexually service men/women not of their choosing<sup>16</sup>.

**Sexual harassment** is an unwelcome act of a sexual nature, using assault, criminal force, or words or actions, which causes annoyance or pain of mind to the person being harassed<sup>17</sup>. While the act is unwelcome, humiliating, disgusting, revolting

<sup>9</sup> Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines Module 2

<sup>10</sup> Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines Module 2

<sup>11</sup> Guidelines for Gender-based Violence Interventions in Humanitarian Settings IASC

<sup>12</sup> A clinical handbook Health care for women subjected to intimate partner violence or sexual violence- WHO/RHR/14.26

<sup>13</sup> Centres for Disease Control and Prevention. Intimate partner violence: Overview. 2007, <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>.

<sup>14</sup> Sri Lanka Penal Code art.363 and its explanation.

<sup>15</sup> A clinical handbook Health care for women subjected to intimate partner violence or sexual violence WHO/RHR/14.26

<sup>16</sup> National Guidelines Health sector response to GBV Maldives

<sup>17</sup> National Guideline on Sexual Harassment at work place. 2018 Ministry of Health / FHB

## Terms used contd.

and repulsive, to the victim, the perpetrator may view/claim it as complimentary, harmless, funny, 'normal' and even flattering. It is nevertheless sexual harassment if the act is unwelcome as perceived by the recipient. Sexual harassment can happen in private or public life at the workplace, public places and transportation.

**Sexual Violence** is violence of sexual nature inflicted upon a person and includes but not limited to: forcing her to have sex or perform sexual acts when she doesn't want to, harming her during sex, forcing her to have sex without protection from pregnancy or infection<sup>18</sup>.

**Temporary shelter** is also known as a safe house or refuge, and is usually a place, often at a concealed location, where women stay temporarily away from the abusive partners. Usually run by government or nongovernmental organization (NGO). However, it can also refer to a church, community group, or other setting that provides a safe haven for survivors.<sup>19</sup>

**Mithuru Piyasa/Natpu Nilayam** is a service point established in Government hospitals by MoH/FHB in Sri Lanka to provide dedicated services to adult survivors of SGBV/DV.

**Stalking** is repeated visual or physical proximity, non-consensual communication, and/or verbal, written, or through electronic/social media or implied threats directed at a specific individual that would arouse fear in a reasonable person. The stalker need not make a credible threat of violence against the victim, but the victim must experience a high level of fear or feel that they or someone close to them will be harmed or killed by the stalker.<sup>20</sup>

**Survivor / Victim** refers to the persons mostly women and girls who have experienced or are experiencing gender-based violence to reflect both terms used in the legal agencies and other organizations that help them. "Survivor" is the term generally preferred because it implies resiliency and thus used in this document.

**Incidence of IPV** is the number of separate episodes of IPV that occurred among women aged 18 years and older during the 12 months preceding the survey or the inquiry.

For IPV, incidence frequently exceeds prevalence because IPV is often repeated.<sup>21</sup>

**Violence Against Women** means "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life<sup>22</sup>.

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<sup>18</sup> Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines Module 2

<sup>19</sup> Responding to intimate partner violence and sexual violence against women clinical and policy guidelines WHO 2013

<sup>20</sup> Centres for Disease Control and Prevention. Intimate partner violence: Overview., 2007, <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>

<sup>21</sup> Centres for Disease Control and Prevention. Intimate partner violence: Overview., 2007, <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>

<sup>22</sup> 1993, Declaration on the Elimination of all Forms of Violence Against Women, United Nations: Geneva, Article 1.

# 1. About this Guideline

## 1.1 What is the guidance about?

Gender-based Violence/Domestic Violence (GBV/DV) has plagued all societies over many centuries, and the health care providers have treated for the injuries and other consequences of GBV/DV as isolated events in an individual's life. Attention was drawn to this subject as a public health issue, only in the last few decades and a considerable number of providers are still not knowledgeable or skilled adequately to provide effective and sensitive care to the survivors.

This situation leads to the health care providers being reluctant to proactively address the issue and thereby losing a critical opportunity to help the survivors of GBV/DV.

This guideline attempts to provide the reader a technical update on GBV/DV, its prevalence in Sri Lanka and describe essential services that needs to be provided in detail.

Survivors of GBV are mostly women and girls. But it is acknowledged that there are instances of GBV perpetrated by women on men and boys. As majority of survivors are women, the feminine pronoun 'she' is used in this document to indicate survivors. However, if the survivor is a male, the same guideline could be used for provision of services.

It is supplemented with a SOPs targeting different categories of health care providers, at first contact level, which carry on from where this guideline ends, to give explicit instructions on the precise steps and the manner in which care should be provided.

Both these documents have been developed taking in to consideration, the international documents: Essential Service Package developed by UN Women, UNFPA, WHO and other partners which was launched in 2018 and the Handbook developed by WHO to assist the care providers among many others. The source of information is indicated as a foot note.

## 1.2 Justification: Why was the guideline developed?

The first contact with the health care providers, when survivors access the health care system is a crucial interphase, which not only ensures service provision, but becomes the first step in generating trust, promoting and encouraging continuity of care. This interaction if done effectively, becomes the first step in the process of rehabilitation of the survivors.

It is essential that Health Care Providers (HCPs) provide uniform, survivor Centred, holistic care with empathy and without discrimination. This document is developed to serve as a guide in receiving the survivor and providing appropriate care particularly at the initial contact. This will also include basics of subsequent management options inclusive of referral mechanisms to assist the survivors.

Recently developed, Policy Framework and National Action Plan to address SGBV/DV in Sri Lanka,<sup>23</sup> and the National Action Plan for Health Sector response on Prevention and management of GBV/DV in Sri Lanka, based on the former, iterate the importance of developing and disseminating a National Guideline for health care providers. Under "*Strategy 1.1: Capacitate and empower Preventive Health Care staff and Strategy 3.2 Facilitate survivor care through survivor friendly services and referrals*", development of a National Guideline and Standard Operating Procedures to include both preventive and curative staff, has been included.

Report of the Leader of the Opposition's Commission on the Prevention of Violence Against Women and the Girl Child (2014)<sup>24</sup> identifies the need of capacity building of the health care providers at all levels and this Guideline would fulfill this need.

<sup>23</sup> Policy Framework and National Action Plan to address Sexual and Gender-based Violence in Sri Lanka 2016-2020 Ministry of Women and Child Affairs [http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/LKA/INT\\_CEDAW\\_RLI\\_LKA\\_26\\_728\\_E.pdf](http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/LKA/INT_CEDAW_RLI_LKA_26_728_E.pdf)

<sup>24</sup> Recommendation 20; Report Of The Leader Of The Opposition's Commission On The Prevention Of Violence Against Women And The Girl Child (2014) <http://www.webs.lithium.lk/childwomenmin/resources/30/REPORT.pdf>

## About this Guideline contd.

### 1.3 Process of development: How was the guideline developed

Steps in the development of the National Guideline were:

1. The process was initiated by the Gender and Women's Health Unit of the Family Health Bureau, with financial support of the UNFPA Sri Lanka, as an activity identified in the National Action Plan for Health Sector Response on Prevention and Management of Gender-based Violence in Sri Lanka (2017-2021) based on the Policy Framework and National Action Plan to address SGBV/DV in Sri Lanka ratified by the Cabinet in 2016.
2. Technical experts were selected to compile the National Guideline and reviewers were identified.
3. List of suitable international documents to be used for guidance was selected.
4. The Guideline was compiled by the technical experts in symmetry with the Essential Services Package<sup>25</sup>.
5. Compiled draft was reviewed by the reviewers and their comments were incorporated.
6. The draft was presented at a consultative meeting participated by Care providers, (including first contact point providers from the field and health institutions), Health administrators and Consultants
7. The suggested changes were made accordingly and the document was finalized .

### 1.4 Objectives:

#### Primary Objective:

To provide guidance in providing Essential Services including receiving the survivor, delivering appropriate and survivor Centred GBV/DV care within the health care system and preventing GBV/DV in the community.

#### Specific Objectives:

1. To describe briefly, Gender and GBV/DV to ensure conceptual clarity and understand the prevalence, health and non-health consequences of GBV/DV and its impact on the individual, family and the society.
2. To describe in detail the guiding principles and approaches, in providing care for survivors in line with the Essential Services Package and standards recommended by international agencies such as WHO.
3. To provide clear and detailed guidance in receiving and providing comprehensive survivor centred care to survivors of GBV/DV.
4. To provide guidance in using a multi-sectorial approach to ensure delivery of comprehensive care through referrals for appropriate services.
5. To assist the Health Administrators in facilitating the delivery of high quality care to survivors of GBV/DV.

<sup>25</sup> Essential services package for women and girls subject to violence: UN Women, UNFPA, WHO, UNDP and UNODC  
<http://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence#view>



## About this Guideline contd.

### 1.5 Target Group

The guideline target, the first contact health care providers, who are likely to meet survivors of GBV/DV at the health institutions or during field care delivery including home visits and other officials who could facilitate and supervise their work.

All Medical Officers providing Judicial medical services / Forensic pathology services are excluded in this document, on account of the specialized nature of services they provide, and as detailed guidance is provided by the comprehensive document, “National Guidelines for Health Care Providers Sri Lanka on Examination, Reporting and Management of Sexually Abused Survivors for Medico Legal Purposes” developed by the Sri Lanka College of Forensic Pathologists.<sup>26</sup>

#### The Guideline targets the following health care providers:

Curative care services	
	<b>Medical Officers attached to:</b> <i>Out Patients Departments (OPD), Preliminary Care Units (PCU). Accident and Emergency services, Emergency Treatment Units (ETU)</i>
	<b>Medical Officers including Dental Surgeons attached to:</b> <i>Mental Health units, ENT clinics, Eye clinics, Antenatal Clinics, OMF clinic and any other relevant clinics, units or wards</i>
	<b>House Officers (Intern/ Relief/Senior), Postgraduate (Registrars and Senior Registrars):</b> <i>Surgical wards, Maternity and Gynaecological wards, Paediatric wards, Medical wards, Burns units, Accident wards &amp; Triage and any other relevant clinics, units or wards</i>
	<b>Nursing officers and Nursing Sisters attached to:</b> <i>OPDs, PCUs, Accident services, ENT clinics, Eye clinics, Antenatal clinics, Surgical wards, Maternity and Gynaecological wards, Burns units and any other relevant clinics, units or wards</i>
Preventive care services	
	<b>Medical Officer of Health</b>
	<b>Public Health Nursing sister</b>
	<b>Supervising Public Health Inspector</b>
	<b>Public Health Inspector</b>
	<b>Supervising Public Health Midwife</b>
	<b>Public Health Midwife</b>

<sup>26</sup> National Guidelines On Examination, Reporting And Management Of Sexually Abused Survivors For Medico-Legal Purposes; The College of Forensic Pathologists of Sri Lanka and MoH 2014 <http://medical.sjp.ac.lk/downloads/forensic-medicine/Medico%20Legal%20Purposes.pdf>

## 2. Introduction to Gender and Gender-based Violence

### 2.1 Gender

The term 'Gender' refers to the roles, attitudes, behaviours, expectations, responsibilities and limitations that society expects men and women to conform to, in any society. While the biological differences between men and women are intended for the explicit purpose of procreation, the gender differences are determined by the individual society, and are often influenced by the patriarchy which is common in most of the countries in the South Asian Region, including Sri Lanka. Through patriarchy, gender differences between men and women are converted into gender inequality, gender discrimination and eventually, to gender subordination (Figure 01). This creates a power differential between men and women, which can lead to domination of women by men making women more liable to violence. The impact depends on how strongly patriarchy is entrenched in that particular society. It is unfortunate that in some countries in the world the discrimination is so overwhelming that even education is denied to girls and is penalized for attending schools.<sup>27</sup>

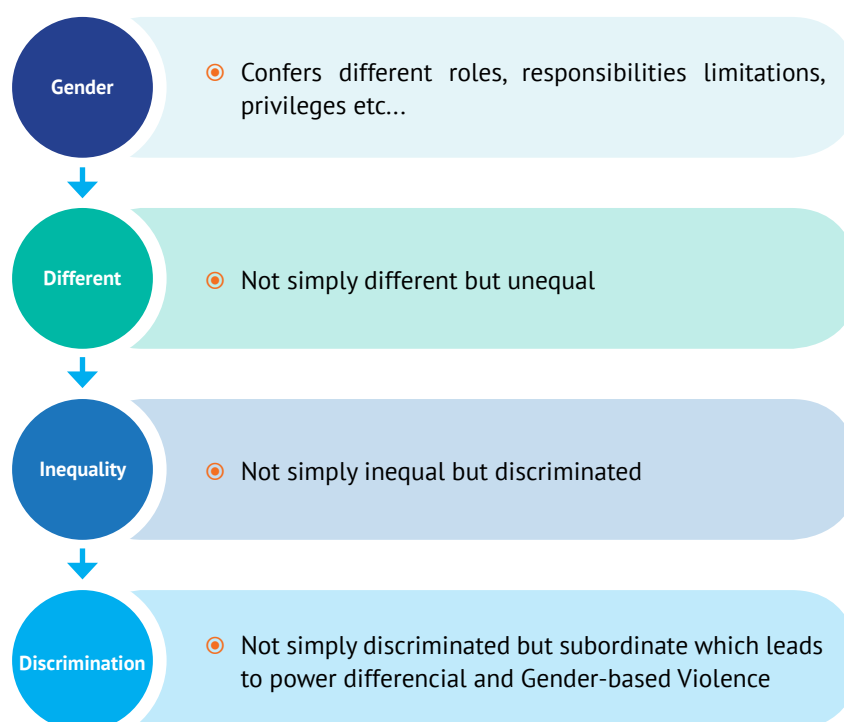


Figure 1 Gender as a basis for violence

More often than not, gender 'norms' have evolved in a way more disadvantageous to women and girls than to men and boys. These gender 'norms' are often subtle, perceived as 'normal' and accepted as the 'way things are' or 'way things should be'.

A multi country study (2013) found that masculinity linked gender attitudes were prevalent in Sri Lanka<sup>28</sup>:

- more than half of the respondents (male and female) agreed that "woman's most important role is to take care of the home and cook for the family".
- 57% of men said that "they dictate who their partner spends time with".
- most of the men who admitted perpetration of sexual violence said that they did so because "they are entitled".
- 78 % subscribed to the view that "a woman should obey her husband."
- 58% agreed that "a woman cannot refuse to have sex with her husband."

<sup>27</sup> Paula Bronstein "I Won't Be a Doctor, and One Day You'll Be Sick" Girls' Access to Education in Afghanistan 2017 Human Rights Watch <https://www.hrw.org/report/2017/10/17/i-wont-be-doctor-and-one-day-youll-be-sick/girls-access-education-afghanistan> (last accessed 27.01.2017)

<sup>28</sup> Neloufer de Mel et al. Broadening Gender :Why masculinities matter (2013) Care International Sri Lanka and Partners for Prevention

## Introduction to Gender and Gender-based Violence contd.

These attitudes are reflected in men's controlling behaviour over their intimate partners which contributes to Intimate partner Violence or Domestic Violence (IPV/DV).

According to the Demographic and Health Survey (2006), only 47% of women agreed that physical abuse of a wife by the husband is not justified for any reason.

Wife beating was justified for: neglect of children (42%), arguing with the husband (41%), for going out without telling the husband (35%)<sup>29</sup>.

It was surprising to note that 43% of women with higher education attainment (passed GCE ordinary Level and above) subscribed to such negative gender attitudes.

Such gender norms and attitudes supported by the power imbalance existing in a patriarchal society is the basis for violence perpetrated by some men (rarely by women) mostly on women and girls. The term Gender-based Violence is used to describe such violence.

### 2.2 Introduction to GBV/DV

Gender-based violence (GBV/DV), and in particular sexual violence, is a serious, life-threatening issue, primarily affecting women and girls, but to a lesser extent men and boys.

In technical terms, GBV/DV has been described as ; *"Gender-based violence (GBV/DV) is the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society."*<sup>30</sup>

The background of gender dimensions and the link between a female's subordinate status in society and her increased vulnerability to violence is clear.

The term Violence against Women (VAW) is often used synonymously with Gender-based Violence and recognizes only Violence Against Women in contrast to GBV/DV which includes violence against men and boys.

<sup>29</sup> Demographic and health Survey 2006-2007, Department of Census and Statistics Colombo Sri Lanka (2009)

<sup>30</sup> Shehala Bloom Violence against Women and Girls: A Compendium of Monitoring and Evaluation Indicators  
<https://genderbasedviolenceinindia.wordpress.com/2014/10/16/what-is-gender-based-violence/>.

## Introduction to Gender and Gender-based Violence contd.

The National Plan of Action to address Gender-based Violence for Sri Lanka uses the term Sexual and Gender-based Violence in order to emphasize sexual violence as the most degrading and pervasive form of GBV/DV.

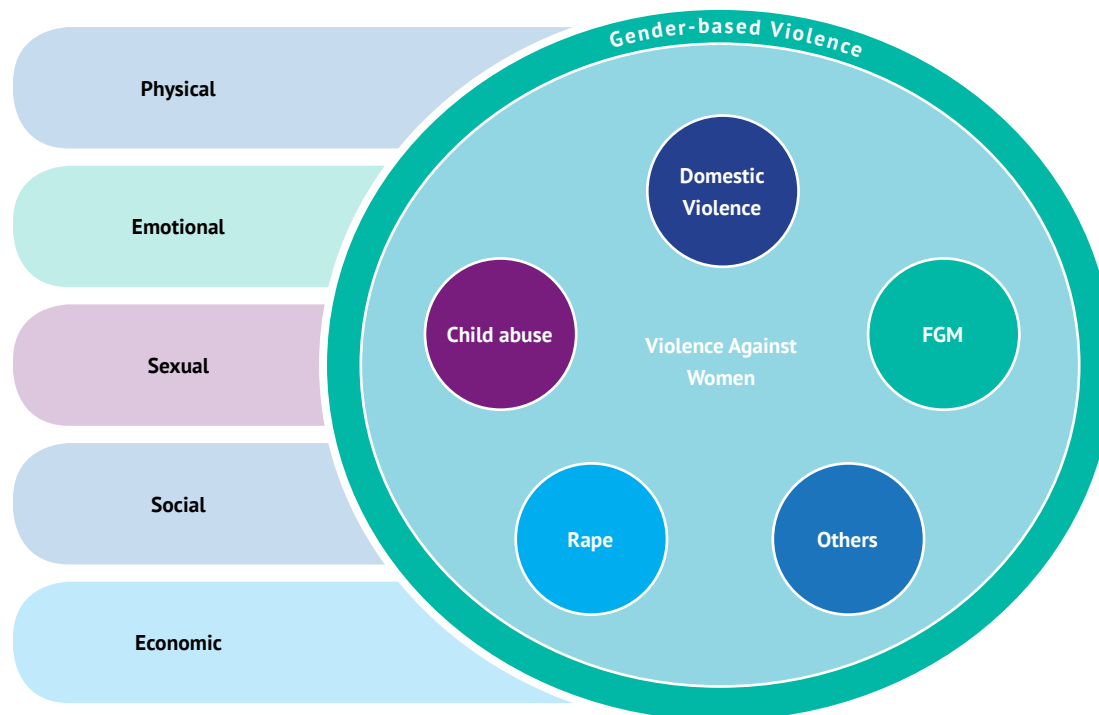


Figure 2 Relationship between the terms used to describe GBV/DV

The manner in which violence is perpetrated can be described as physical, emotional, psychological, economic, social or sexual violence. GBV/DV inflicts harm on women, girls, men and boys<sup>31</sup> but mostly on women and girls.

The most prevalent form of GBV/DV is domestic violence/intimate partner violence (DV/IPV) which is generally understood as “violence within a marital or an intimate relationship between partners”.

Domestic violence in the legal terms as given in the Prevention of Domestic Violence Act of Sri Lanka 2005 is wider to include abuse, perpetrated within a relationship by others such as the father, mother, grandfather, grandmother, stepfather, stepmother etc.

Many health workers ask ‘*what about men?*’ Whilst men are at much less risk from gender-based violence, some men and boys are abused in similar manner by women. However, men are more likely to be perpetrators than victims of gender-based violence. It can be difficult for men to disclose abuse because of stigma attached, or the fear that they will not be seen as ‘real’ men. Being aware of this possibility is important for helping men to disclose. Anyone who is affected by abuse, whether women or men deserves the best care we can give.

<sup>31</sup> Sexual and Gender-based Violence: UNHCR <http://www.unhcr.org/sexual-and-gender-based-violence.html>

## Introduction to Gender and Gender-based Violence contd.

### 2.2.1 The magnitude of GBV/DV



Figure 3 Prevalence of GBV :Global situation

Worldwide, almost **one in three women** (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner or sexual violence from a non-partner in their lifetime. As many as 38% of murders of all women, have been committed by a male intimate partner<sup>32</sup> in contrast to 8% of murders committed by a female.

In Sri Lanka, although National level data is lacking there is sufficient data to indicate the magnitude of the problem.

A cross-sectional community survey, exploring Intimate Partner Violence (IPV) against women in the Western province of Sri Lanka showed a lifetime prevalence of: physical violence of 34%, controlling behaviour 30%, emotional abuse 19% and sexual violence 5%<sup>33</sup>.

A multi country study including Sri Lanka (2013) using self-reporting methodology with PDAs, found that one in five men reported committing sexual violence against their intimate partner in their life time ; life time prevalence of 18%.<sup>34</sup>

<sup>32</sup> Violence against women; Intimate partner and sexual violence against women WHO Fact sheet Updated November 2017

<sup>33</sup> Jayasuriya V, Wijewardena K, Axemo. P.; Intimate partner violence against women in the capital province of Sri Lanka: prevalence, risk factors, and help seeking. Violence Against Women 2011 Volume: 17 issue: 8, page(s): 1086-1102 <https://doi.org/10.1177/1077801211417151>

<sup>34</sup> Neloufer de Mel et al. Broadening Gender: Why masculinities matter (2013) Care International Sri Lanka and Partners for Prevention

## Introduction to Gender and Gender-based Violence contd.

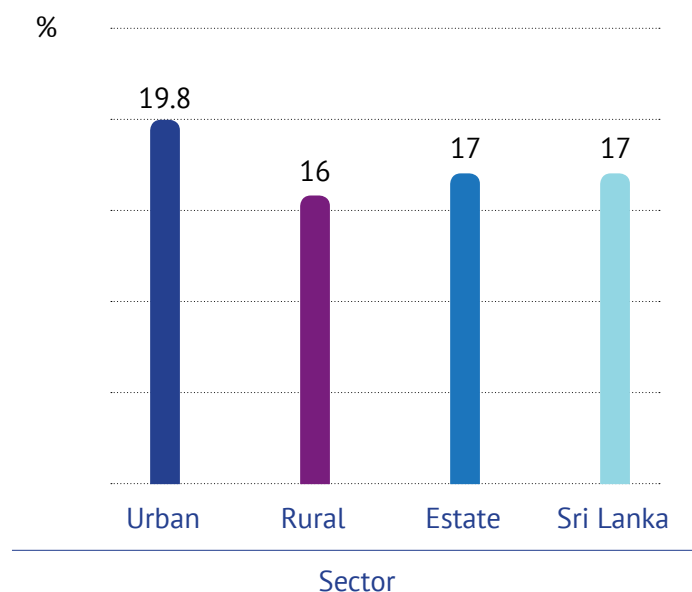


Figure 4 Prevalence of DV/IPV Sri Lanka ( SLDHS 2016)

Recently conducted Sri Lanka Demographic and Health Survey 2016<sup>35</sup> showed:

- an overall prevalence of IPV 17% for ever-married women during preceding 12 months with a slightly higher percentage in urban areas (Fig 4.)
- marked differences between districts on IPV prevalence rates ranging from 5.6% in the Southern district of Hambantota to 49.6% in the Northern and Eastern part in Kilinochchi and Batticaloa was recorded. However in-depth analysis was not included and many factors such as normalization of violence in the conflict affected areas and conservative attitudes that may have limited divulging in other areas.
- the manner in which DV/IPV was perpetrated is given in Fig.5 .Out of women who were subjected to IPV within last twelve months, 13% were beaten with an object and 15% were forced to have sex by their intimate partners.
- of the women who reported current IPV, described violence as : daily 12.7% , weekly 15.1% ,monthly 47.6%, and less often 66.9%.

High prevalence in Estates has been reported in some smaller studies with 83% of women interviewed, reporting some form of GBV/DV some time in their life (2003).<sup>36</sup>

<sup>35</sup> Sri Lanka Demographic and health Survey 2016, Department of census and Statistics Sri Lanka and Ministry of Health Sri Lanka

<sup>36</sup> Kamalini Wijethilake, Harsh Realities: A Pilot Study of Gender-based Violence in Plantation Sector. Plantation Human Development Trust 2003.

## Introduction to Gender and Gender-based Violence contd.

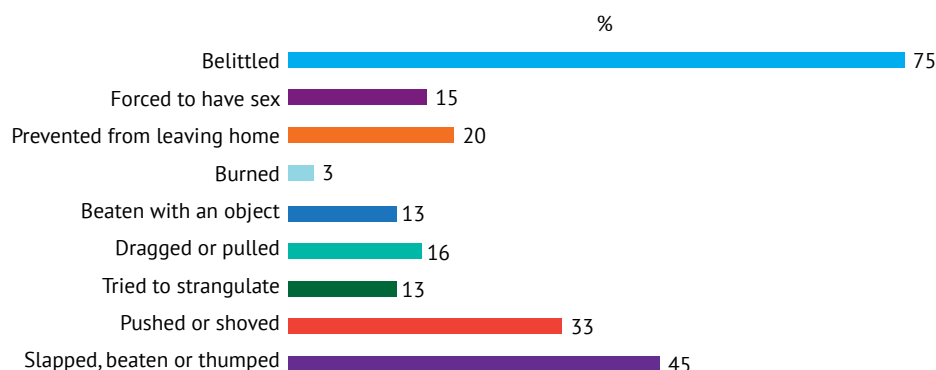


Figure 5 Manner in which DV/IPV was perpetrated (SLDHS 2016)

A clinic based study on gender-based violence in pregnant women in Sri Lanka among 1200 pregnant women, reported (2004) as 18.3% being ever abused, 10.6% reported as being abused during the last 12 months<sup>37</sup>.

### 2.2.2 Health consequences of GBV/DV

The consequences of all forms of abuse on physical, mental and sexual health can be profound and detrimental and are strong risk factors for poor health outcomes and compromised functioning<sup>38</sup>.

Domestic Violence, one of the common forms of GBV/DV is gradually being acknowledged as one of the most severe threats to women's health. Pregnant women comprise an important segment of this larger group of women.

Experiencing GBV/DV contributes to a range of physical and sexual health problems including:

- Globally, as many as 38% of murders of women are committed by a male intimate partner<sup>39</sup>
- A study in Sri Lanka found that one in four women who were subjected to physical violence by their intimate partner, had to stay in bed, 16% had to take days off work and 32% had to seek medical attention, because of injuries relating to the physical violence<sup>40</sup>.
- In a study of 116 cases in a forensic department of a Teaching Hospital in Sri Lanka, of those reporting injuries : 9% had grievous injuries, 1% had injury endangering life, 1 % had injuries fatal in the ordinary course of nature. <sup>41</sup>
- Greater risk of chronic health problems particularly gynecological problems, urinary tract infections, gastrointestinal symptoms, especially Irritable Bowel Syndrome; chronic pain, chronic pelvic pain.
- Higher rates of risk behaviours such as smoking, risky sexual behaviour, teenage pregnancies and greater vulnerability to sexual exploitation are consequences of exposure to GBV/DV.
- In one study of suicides in Sri Lanka the primary reason for suicides was found to be Domestic Violence in 12 %<sup>42</sup>.
- Among 25% of the women who had experienced IPV reported having suicidal thoughts, compared to 7% of women who had never experienced IPV<sup>43</sup>.

<sup>37</sup> Moonasinghe L. and Rajapakse L., Development of a screening instrument to detect physical abuse and its use in a cohort of pregnant women Asia Pacific Journal of Public Health 2004,16 (2)

<sup>38</sup> What health workers need to know about gender-based violence: an overview, NHS Guideline: Scotland compiled by Shirley Henderson [www.shirleyhenderson.co.uk](http://www.shirleyhenderson.co.uk)

<sup>39</sup> Violence against women; Intimate partner and sexual violence against women Fact sheet WHO (Updated November 2017)

<sup>40</sup> Neloufer de Mel et al. Broadening Gender :Why masculinities matter (2013) Care International Sri Lanka and Partners for Prevention

<sup>41</sup> Neloufer de Mel et al. Broadening Gender :Why masculinities matter (2013) Care International Sri Lanka and Partners for Prevention

<sup>42</sup> Flemming Konradson, Wim van derHoek, Pushpalatha Peiris Reaching for the bottle of pesticide—A cry for help. Self-inflicted poisonings in Sri Lanka Social Science & Medicine Volume 62, Issue 7, April 2006, Pages 1710-171

<sup>43</sup> Neloufer de Mel et al. Broadening Gender :Why masculinities matter (2013) Care International Sri Lanka and Partners for Prevention



## Introduction to Gender and Gender-based Violence contd.

### 2.2.3 Domestic Violence and Pregnancy

Domestic Violence in pregnancy has emerged as a national and a global health issue, which has the potential to produce serious negative health impacts, sometimes fatal, to the mothers to-be, and to the unborn foetus.

- In contrast to the common belief, Domestic Violence is seen frequently in pregnancy, often starting or escalating during pregnancy.<sup>44</sup>
- More than 30% of women abused in pregnancy, violence first started during the pregnancy,<sup>45</sup>
- Women are four times more likely to suffer increased abuse as a result of an unintended or unwanted pregnancy.<sup>46</sup>
- It is well established that Domestic Violence contributes to many pregnancy complications: miscarriage, ante partum haemorrhage, premature labour and negative health behaviours: late registration and inconsistent attendance for antenatal care which in turn increases her risk status.<sup>47</sup>
- Many investigators have found a significant association between Domestic Violence and pregnancy losses such as miscarriages, still births and neonatal deaths,<sup>48,49</sup>
- One of the studies noted that while the incidence of preterm labor was 6.9%-10% in the general population that of the study population was 15.4% for moderately abused women and 17.2% for severely abused.<sup>50</sup>
- some studies show that women who suffered from DV had a four times higher chance of getting a low birth weight baby than those who were not abused.<sup>51</sup>
- A study from Canada on women abused during pregnancy had 3.5 higher risk for ante partum hemorrhage than those not abused.<sup>52</sup>
- Women who have been physically or sexually abused by their partners are more than twice as likely to have an abortion, almost twice as likely to experience depression, and in some regions, 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence.<sup>53</sup>
- Very often the freedom to use contraception is limited in a relationship with violence.<sup>54</sup>

Recognizing the significance of GBV/DV in the outcome of pregnancy, many professional organizations have made recommendations that care providers should be vigilant to identify and support women who are abused as a part of their routine antenatal and postnatal care.

Royal College of Obstetricians and Gynaecologists of the United Kingdom recommends that: “Healthcare professionals need to be alert to the symptoms or signs of Domestic Violence and women should be given the opportunity to disclose Domestic Violence in an environment in which they feel secure”.<sup>55</sup>

<sup>44</sup> Zero tolerance for domestic violence. The Lancet 2004; 364: 1556

<sup>45</sup> Newberger, Eli H, et al. Abuse of pregnant women and adverse birth outcome. Midwifery Today 1993; Issue 26, <http://www.midwiferytoday.com/reviews/abuse.asp>

<sup>46</sup> Heise, L. “Reproductive Freedom and Violence Against Women: What are the Intersections?” The Journal of Law, Medicine and Ethics 27: 1993.

<sup>47</sup> Lakshmen Senanayake Domestic violence: an emerging concern in maternity care Sri Lanka Journal of Obstetrics and Gynaecology 2011; 33: 142-149

<sup>48</sup> Moreno CG, Henrica AF, Jansen MM, Ellisberg M, Heise L, Watts. WHO Multi-country Study on Women's Health and Domestic Violence: Initial Results on Prevalence, Health Outcomes and Women's Responses. Published by WHO Press, Geneva, 2005: 63-72

<sup>49</sup> Pallittio CC. Domestic violence and maternal, infant and reproductive health: a critical review of the literature. Submitted to Pan American Health Organisation (PAHO) Washington, 2004. <http://www.docstoc.com/docs/40362692/Domestic-violence-is-a-serious-public-healthproblem-that-affects-or-RABU-13-04-2011> <http://bahankuliahkesehatan.blogspot.com/>

<sup>50</sup> Shumway et al. Preterm labour, placental abruption and preterm rupture of membranes in relation to mental and verbal abuse. Journal of Maternal and Fetal Medicine 1999, 8:76-80

<sup>51</sup> Bullock MF, McFarlane J. The birthweight/battering connection. American Journal of Nursing 1989; 89: 1153-5.

<sup>52</sup> Shumway et al. Preterm labour, placental abruption and preterm rupture of membranes in relation to mental and verbal abuse. Journal of Maternal and Fetal Medicine 1999, 8:76-80

<sup>53</sup> Facts and figures: Ending violence against women; UN WOMEN <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

<sup>54</sup> “Abused Women Have Special Needs” Network 18 (1998) Family Health International <http://www.fhi.org/en/fp/fppubs/network/v18%2D4/nt1844.htm>

<sup>55</sup> Antenatal care routine care for the healthy pregnant woman. Clinical Guideline 2008, National Collaborating Centre for Women's and Children's Health Published by the RCOG Press at the Royal College of Obstetricians and Gynaecologists, 2008.



## Introduction to Gender and Gender-based Violence contd.

### 2.3 Response to GBV/DV in Sri Lanka

Policy response from the government of Sri Lanka:

- Sri Lanka Constitution (1976) Article 12; recognizes gender equality and freedom from discrimination on the grounds of sex as a fundamental right.
- Convention of the Elimination of all forms of discrimination against Women was ratified by Sri Lanka in 1981 and acceded to CEDAW Convention Optional Protocol in 2002
- Women's Charter, the first state policy document on women was formulated in 1993 and a National Committee on women was established.
- Sri Lanka acceded to the UN convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 1994.
- Beijing Declaration and Platform for Action was adapted in 1995 and Sri Lanka drafted the first National Plan of Action for Women in 1996.
- Population and Reproductive Health Policy (1998)
- Women and Children's desks were established in Police Stations first in 2000.
- Prevention of Domestic Violence Act (PDVA No.34) came in to operation in October 2005.
- Provisions related to trafficking were introduced to the Penal Code in 2006.
- National Action Plan for Protection and Promotion of Human Rights was formulated in 2011
- National Policy on Maternal and Child health (2012)
- Policy Frame Work and National Plan of Action to Address SGBV in Sri Lanka. (2016-2020)

### Key events in the Health Sector Response to GBV/DV in Sri Lanka

- 2007 : Setting up of the first GBV/DV care centre: *Mithuru Piyasa/Natpu Nilayam* at the Matara Base Hospital as a pilot initiative.
- 2008 - 2010: Development of targeted IEC Material to be used in Institutions and field
- 2009: Development of a booklet targeting newly married couples and launching the preventive programme
- 2011: Development of the training module and Inclusion of the subject of GBV/DV in the curriculum of PHMs
- 2011 : 1st Training of Trainers' workshop conducted to establish a pool of trainers at National level
- 2012 : Development of a "training pack" for training Institutional staff comprising of Training Module on GBV/DV, Hand book for health care providers
- 2012: Protocol for *Mithuru Piyasa/Natpu Nilayam* was developed
- 2012: 1st Sharing of Experiences Workshop held for the staff of *Mithuru Piyasa /Natpu Nilayam* which is being conducted regularly as an annual event.
- 2014: Establishment of the database to collect information from the *Mithuru Piyasa/Natpu Nilayam* centres
- 2016: Development of the Guidelines for establishing and operating temporary shelters for survivors of GBV/DV
- 2016: Development of the Core curriculum on GBV/DV for medical undergraduates and launching of the document with the collaboration of SLMA and Faculties of Medicine in all Universities
- 2016: Establishment of a *Mithuru Piyasa/Natpu nilayam* at the Army Hospital
- 2017: Development of the National Operational Action Plan to address SGBV/DV for health sector based on the National Action Plan to address SGBV/DV
- 2017; Establishment of a *Mithuru Piyasa/Natpu Nilayam* in the Free Trade Zone at Katunayake at the Office of the Medical Officer of Health
- 2017: Advertisement of post of "Medical Officer *Mithuru Piyasa/Natpu Nilayam*" in the Grade Medical Officers annual transfer list in the Ministry of Health
- 2018: Development and launching of the National Guideline on Sexual harassment at workplace focusing on the health sector in collaboration with SLMA
- 70<sup>th</sup> *Mithuru Piyasa/Natpu Nilayam* centre was launched in 2019.
- The home grown Sri Lankan model of the GBV/DV care centre; *Mithuru Piyasa/Natpu Nilayam*, has drawn the attention of other countries and study teams have visited Sri Lanka: Nepal, Maldives and Afghanistan.
- Many documents published internationally have recorded the Sri Lankan Experience as case studies or scientific articles

## Introduction to Gender and Gender-based Violence contd.

### **GBV/DV Care Centre: Mithuru Piyasa/Natpu Nilayam**

*Mithuru Piyasa/Natpu Nilayam* is aligned to the One Stop Crisis Centre (OSCC) model, it is designed to open its boundaries beyond those who report to hospital with sexual assault, injuries with domestic violence or other incidences of GBV/DV, and to promote and encourage countless individuals suffering in silence who do not want to formally report or seek assistance. Any adult survivor seeking assistance could walk in to be received by a Nursing Officer who is trained specifically to care for such individuals. Services of a trained Medical Officer is offered to the survivor thereafter. The *Mithuru Piyasa/Natpu Nilayam* provides services such as befriending, referral for other services and follow up visits to the centre. In addition, *Mithuru Piyasa/Natpu Nilayam* offers to enter in to a dialogue with the family members and the perpetrator, if the survivor requests, in order to provide a platform to assist to resolve contributory issues. The operational activities are described in the “Protocol for *Mithuru Piyasa/Natpu Nilayam*” which was developed with input from relevant stake holders and updated with the experience gained over time.

At present, all centres are open during working hours of week days while few function on week ends. The staff nominated from the regular staff of the hospital, undergo a four day training on a pre-designed module prior to starting work at the centre. The training uses a participatory approach and is conducted by dedicated expert trainers from the training pool and addresses gender attitudes and attempts to create a survivor centred, sensitive and empathetic mind set in the service provider, in addition to imparting knowledge on GBV/DV. In-service training is continued through workshops conducted on a regular basis, especially targeting emotional support and updates on emerging issues such as cyber violence.

One of the priorities set for the staff identified is networking with the other providers within and outside the health institution. Close links with Women Development Unit at the Divisional Secretariat, Police and Social Services is promoted and encouraged.

Monitoring of the centres is done at many levels. While self-monitoring through the monthly meeting of the centre staff is encouraged, quarterly meetings held with the participation of hospital staff and networking agencies forms a strong monitoring as well as a supportive mechanism. A visit by the staff from the Gender and Women's Unit of the FHB, sometimes accompanied by an expert in the field and the Annual Sharing of Experiences Workshop conducted collectively completes the regular monitoring mechanism.

### **Preventive Programmes including the programmes for newly married couples**

Public Health Midwife forms a crucial link between the health care system and the community and her domiciliary visits provide an excellent opportunity for her to be the message bearer, good observer, empathetic listener and a care provider, especially for those survivors suffering in silence. PHMs are expected to be vigilant, when necessary carefully probe and offer a listening ear and if agreeable, refer them to support services, especially to *Mithuru Piyasa/Natpu Nilayam*. They are expected to maintain confidential record in her diary ( H 511 ) of the instances of GBV/DV survivors identified and what action was taken .

One of the innovative programmes initiated by FHB/MoH is the preventive programme offered to the newly married couples through the PHM and the MOH staff. This new programme which is named as 'Package for Newly Married Couples', was introduced with the objective of optimizing the health status of both partners prior to their pregnancy. Through this service package, the programme also aims to lay a firm foundation to a good marriage where happiness and expectations of the couple at the time of marriage are preserved throughout their married life. A good married life will in return ensure the good health of the entire family including children.

### 3. Essential services to address GBV/DV

#### 3.1 Essential Services Package



Figure 6. Five Components of Essential Services Package

The need of a coordinated multi-sectorial responses for survivors of SGBV/DV has been addressed by the identification of a package of services known as Essential Services Package, developed by The United Nations Joint Global Programme on Essential Services for Women and Girls Subjected to Violence. The package describes the provision, coordination and governance of a triad of essential services: health, police, justice and social services.

This multi-pronged approach can significantly mitigate the effects of GBV/DV on the well-being, health and safety of women and girls' lives, assist in the recovery and empowerment of women, and stop violence from reoccurring.

Providing essential services collectively, can diminish the losses experienced by survivors, families and communities in terms of productivity, school achievement, public policies and budgets, and help break the recurrent cycle of violence.

The Essential Service Package also plays a key role in long term outcomes such as poverty reduction, development and support the efforts to achieve the Sustainable Development Goals for the country.

This Guideline utilizes the approach described in the Health section of the Essential Services Package. The role of the different levels of health care institutions is illustrated in the Fig. 6.<sup>56</sup>

<sup>56</sup> Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines Module 2. Health <http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/essential-services-package-module-2-en.pdf?la=en&vs=3835>

## Essential services to address GBV/DV contd.

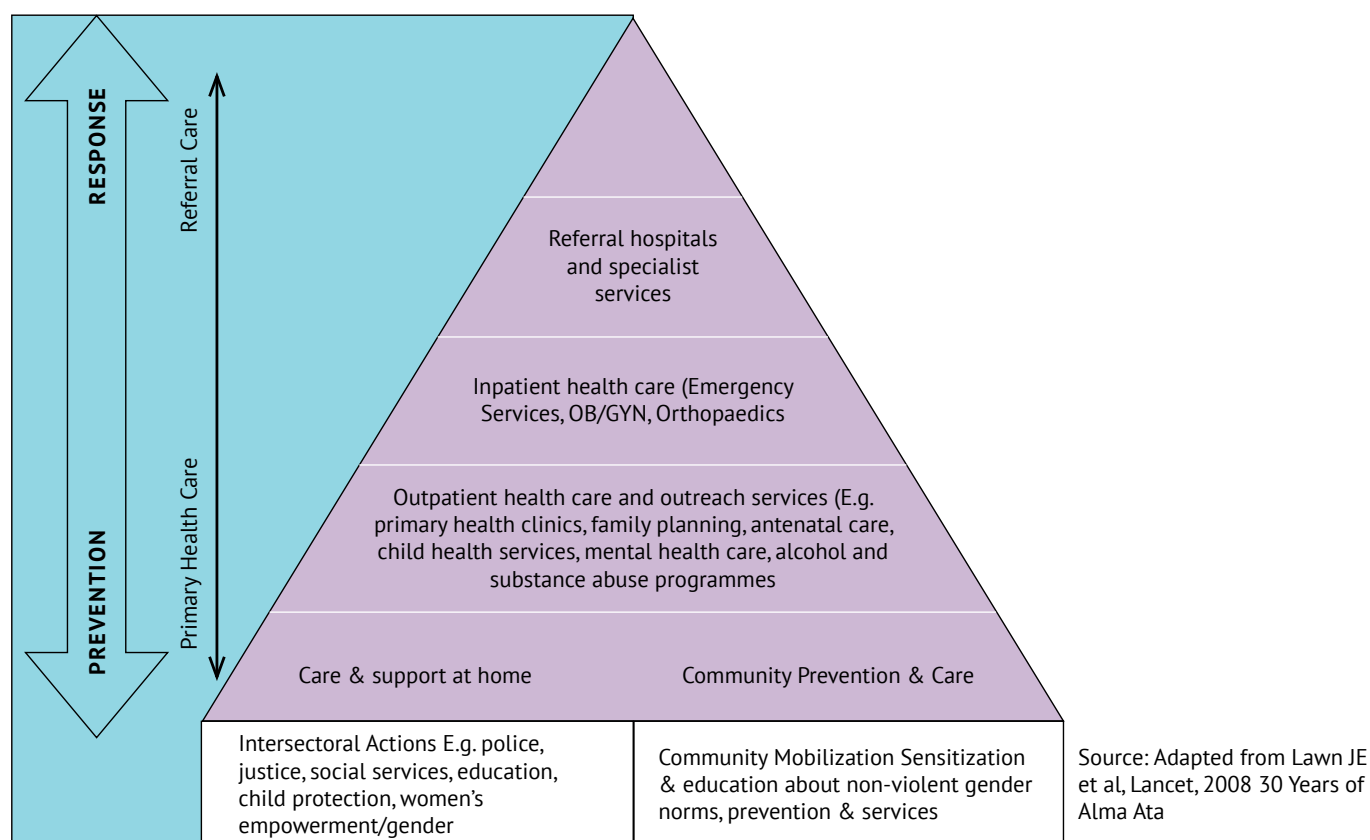


Figure 7. Primary health care and the context of the wider health system, community mobilization, and inter-sectoral action

### Key Points

- All levels of hospitals and field health care services have an important role to play.
- Weightage given for preventive activities are more, in the primary care setting while responding to GBV/DV is mostly in the hospital setting.
- As the operational level of hospitals move up towards tertiary centres, specialized responses such as surgery becomes more important.
- Community mobilization and multi sectoral involvement are essential and form the base on which all other activities are supported.
- Health sector is a key sector in the response to address GBV/DV in any country and often a woman's visit to a health service provider might be her only chance to receive support and care for GBV/DV.
- Health care professionals who are knowledgeable and skilled in the response to GBV/DV can make an important contribution to improve the health, wellbeing and safety of the survivor.
- On the other hand, lack in knowledge and skills on the part of health care professionals can put women at further risk and harm.
- Most women, even in remote areas, are likely to seek family planning or antenatal care services at least once in their lifetime, making health services, and particularly reproductive health services a critical entry point providing an opportunity.<sup>57</sup>

<sup>57</sup> Guidance for health care professionals in strengthening health system responses to gender-based violence  
<http://www.health-genderviolence.org/programming-for-integration-of-gbv-within-health-system/programming-for-integration-of-gbv-within-he>

## Essential services to address GBV/DV contd.

Health sector section of the Essential Services Package identifies the responsibility of the health providers under the following headings:

1. Identification of survivors of Intimate Partner Violence.
2. First Line Support'
3. Care of injuries and urgent medical treatment'
4. Sexual assault examination and care'
5. Mental health assessment and care.
6. Documentation (medico-legal).

The National Guideline and the accompanying SOPs follow the same plan.

### 3.2 Identification of survivors of intimate partner violence

It is well known that most survivors of GBV/DV suffer in silence for many years, and do not seek help. Those who access services are only the tip of the iceberg. The Sri Lanka Demographic and Health Survey (SLDHS) 2016 recorded that: "It means that majority attend our health institutions for different reasons while undergoing GBV/DV including domestic violence and it is our role to create an environment which promotes them to seek help."<sup>58</sup>

#### 3.2.1 Providing information on GBV/DV

Displaying information as posters, brochures or other IEC material in the health institutions, clinics, MOH offices and Midwife's offices is essential.

- IEC material need to be displayed especially in private sites such as washrooms and in common areas where the survivor feels free and could read it without fear or embarrassment.
- Designing of the material must be done with a clear message but in a very sensitive manner
- Promoting women to take home material such as brochures must be done judiciously because having such documents in possession might precipitate further violence from an abusive partner.
- When material is displayed, a health care provider at the site, must be ready to answer any queries or assistance if a survivor decides to talk after seeing the material.

<sup>58</sup> Demographic and Health Survey 2016 Dept. of Census and Statistics [http://www.statistics.gov.lk/social/DHS\\_2016a/Chapter13.pdf](http://www.statistics.gov.lk/social/DHS_2016a/Chapter13.pdf)

## Essential services to address GBV/DV contd.

### 3.2.2 Asking about GBV/DV

Apart from obvious injuries, other health conditions, may be caused by, associated with, or related to GBV/DV in the past or on-going. The presenting symptom will be that condition and not the underlying GBV/DV. They often do not talk about the violence unless prompted and encouraged.

#### **Only 28% of the women suffering from Domestic Violence asked for help from anybody.**

Of those who sought assistance:

- 75% from “Parents/brothers/sisters/relatives”
- 27 % from “friends/neighbours,
- 18 % from “Police”
- 7.4% from “Public Health Midwife”
- 1.4% from “government institutions including hospitals” (SLDHS 2016)

#### **Think of the possibility of GBV/DV if the patient has any of the following:<sup>59</sup>**

- ongoing emotional health issues, such as: depression or anxiety states
- suicidal ideation (thoughts, plans) or acts of self-harm (attempted suicide)
- injuries that are not well explained, does not tally with the history or repeated
- harmful behaviours such as alcohol or drug abuse
- recurrent Sexually Transmitted Infections
- unwanted pregnancies, teenage pregnancies, unsafe abortions
- unexplained chronic pain or related conditions : pelvic pain, dyspareunia, gastrointestinal problems (irritable bowel), recurrent UTIs, headaches)
- repeated hospital attendance or admissions with no clear diagnosis or pathology

#### **Think of the possibility of GBV/DV when:**

- a woman’s partner or husband is intrusive, extra protective or does not leave her side during consultations.
- she often misses her antenatal appointments or any other scheduled clinic visits.
- she misses immunization schedules or health-care appointments of her children.
- her children have emotional and behavioural problems such as stuttering, bedwetting, panic attacks or drug abuse

#### **When you suspect the possibility of GBV/DV**

- Do not ask about violence unless the woman is alone.
- Do not ask even if she is with another woman (may turn out to be mother or sister of the abuser!). Find an excuse to be alone or ask at the time of the examination.
- Ask her about violence in an empathetic, non-judgemental manner
- Use words that are appropriate, culturally sensitive that may not offend the person.
- Some women may not like the words “violence” and “abuse”. Cultures and communities have ways of referring to the problem with other words such as “issue” “problem” (“*gataluwak*”, “*prashnayak*”)

<sup>59</sup> Health care for women subjected to intimate partner violence or sexual violence WHO/RHR/14.26 A clinical handbook WHO (2014)

## Essential services to address GBV/DV contd.

### When you suspect violence, but she doesn't disclose it in spite of your inquiry:

- ⦿ do not pressure her to divulge or challenge the denial of violence directly or indirectly.
- ⦿ give her time to contemplate and decide what she wants to tell you (even at a later time/date)
- ⦿ tell her about services that are available if she chooses to use them at a later time or date.
- ⦿ indirectly provide information on the effects of violence on women's health and their children's health.
- ⦿ give her an open invitation to come back to see the provider, in case ,she needs any assistance.

The SOPs developed by the MoH/ FHB will give details of how such inquiry should be made.

### 3.3 Screening for GBV/DV

There is much discussion on the need of an effective method to identify all women experiencing Intimate Partner Violence.

Asking from all women consulting health-care providers about partner violence (called "universal screening" or "routine enquiry") is often not practical in all settings due to constraints such as lack of privacy, presence of the husband and other constraints.

Alternative is a more selective approach on inquiry during pregnancy or in identified departments such as Accident and Emergency or in the presence of specific clinical scenarios such as during pregnancy or presence of a black eye or ruptured ear drum termed selective screening or ("clinical enquiry" or "case finding"). This is recommended.

In general, studies have shown that universal screening for Intimate Partner Violence (i.e. systematically asking all women about violence) increases the identification of women with Intimate Partner Violence, but have not shown a reduction in Intimate Partner Violence, or any notable benefit for women's health<sup>60</sup>. Universal screening is not recommended in this guideline.

<sup>60</sup> Responding to intimate partner violence and sexual violence against women : clinical and policy guidelines WHO 2013  
file:///E:/27.11.2017%20data/Desktop/GBV%20National%20Guideline%20SL/WHO%20Policy%20Guidelines%202013.pdf

## Essential services to address GBV/DV contd.

Many screening tools have been used in different settings especially in research. One of the simple tools is given here: HITS (Hitting, Insults, Threats and Scream).<sup>61</sup>

### “HITS” A domestic violence screening tool for use in the community

**HITS Tool for Intimate Partner Violence Screening:** Please read each of the following activities and fill in circle that best indicates the frequency with which you partner acts in the way depicted.

How often does your partner?	Never	Rarely	Sometimes	Fairly often	Frequently
1. Physically hurt you	0	0	0	0	0
2. Insult or talk down to you	0	0	0	0	0
3. Threaten you with harm	0	0	0	0	0
4. Scream or curse at you	0	0	0	0	0
Items score	1	2	3	4	5

Each item is scored from 1-5. Thus, scores for this inventory range from 4-20. A score of greater than 10 is considered positive.

*Clinical Research and Methods  
(Fam Med 1998;30(7):508-12.)*

Universal Screening for GBV/DV is not recommended except in selected settings such as Antenatal clinics and post natal visits, ENT Clinics, Accident and Emergency departments and only after ensuring facilities for privacy and referral mechanisms for those found positive, are in place.

### If she divulges violence on inquiry:

- Provide support as described in the following sections.
- Documenting the violence on the records must be done only after adequate explanation and with the consent of the survivor.

## 3.4 First line support

First-line support means the practical care and responses to survivors' needs provided by a health care provider, especially at the first contact point with the health system, without intruding on her privacy. Four kinds of needs of the survivor deserve attention when providing first line support to a woman, who has been subjected to violence:

- (1) immediate emotional/psychological health needs
- (2) immediate physical health needs
- (3) on-going safety needs
- (4) on-going support and mental health needs<sup>62</sup>

<sup>61</sup> Kevin Sherin; Clinical Research and Methods (Family Medicine 1998;30(7):508-12.) [http://momsohio.org/resources/HITS\\_screen.pdf](http://momsohio.org/resources/HITS_screen.pdf)

<sup>62</sup> Essential Services Package for Women and Girls Subject to Violence Core Elements and Quality Guidelines Module 2. Health <http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/essential-services-package-module-2-en.pdf?la=en&vs=3835>



## Essential services to address GBV/DV contd.

### First Line Support:

- is the most important care that you can provide to the survivor.
  - you will greatly help survivor by going through these simple steps.
  - has helped people who have been through various upsetting or stressful events.
  - helps the survivor to feel connected to others and hopeful
  - empowers the survivor to feel able to help herself and to ask for help
  - helps the survivor to explore what the survivor options are
  - helps the survivor to find social, physical and emotional support
  - can be provided by any health care provider without training on it
- This may be your only opportunity to help this woman/man. As she may not come back for help again



Figure 8. Components of First Line Support (L.I.V.E.S.)

## Essential services to address GBV/DV contd.

### 3.4.1 Listen

Listening to her is very important to the survivor, and the lack of the care provider's attention will be seen by the survivor as neglecting her. Listening means giving the survivor a chance to say what she wants, in an environment conducive for her to communicate in a private place. Listening is the most important part of good communication, and the basis of first-line support. This is crucial for her emotional recovery.

#### When listening use your:

- ⦿ **Ears:** Focus intently; Genuinely hearing concerns
- ⦿ **Eyes:** Good eye contact; give your undivided attention
- ⦿ **Body:** Establish a link; Use Appropriate body language;
- ⦿ **Heart:** Feel for her; truly understand her feelings

#### Listening includes:<sup>63</sup>

- ⦿ being aware of the feelings behind her words which is more unsaid than said.
- ⦿ hearing both what she says and understanding what she does not say.
- ⦿ paying attention to body language – both hers and yours – including facial expressions, eye contact, gestures : establishing the critical link
- ⦿ sitting or standing at the same level and close enough to the survivor to show concern and attention but not so close as to intrude: common platform to share
- ⦿ listen with empathy, understanding how the survivor feels.

Refer the section on “Listen” in SOPs

### 3.4.2 Inquire about needs and concerns

#### Some statements you can make to validate survivor's experience

- ⦿ “It's okay to talk.”
- ⦿ “Help is available.”
- ⦿ “No one deserves to be hit by their partner in a relationship.”
- ⦿ “You are not alone. Unfortunately, many other women have faced this problem too.”
- ⦿ “Your life, your health and you are of value.”
- ⦿ “Everybody deserves to feel safe at home.”
- ⦿ “I am worried that this may be affecting your health”.

The purpose of asking her about her immediate needs and foremost concerns or fears is to understand what she expects and also gives the survivor the impression that we are genuinely ready to assist her which is most important for the survivor. Respect her wishes and respond to her needs within your mandate and available facilities. As you listen to the survivor's story, pay particular attention to what she says about her needs and concerns and also to what she doesn't say but implies with words or body language. She may let you know about physical needs such as change of clothes, food, emotional needs such as concern about children, or economic needs such as inability to use her phone or bus fare to get back, her safety concerns for her or for children or social support she needs such as a place to stay.

<sup>63</sup> A clinical handbook Health care for women subjected to intimate partner violence or sexual violence WHO/RHR/14.26

## Essential services to address GBV/DV contd.

It may or may not be within the power of the health care provider to fulfill all her needs but once they are known, often some of the simple issues could be attended to by the provider, by mustering support from others or using available opportunities within the system (*may admit her for 24 to 48 hrs. when temporary accommodation is not available*).

Refer the section on “Inquire about needs and concerns” in SOPs.

### 3.4.3 Validate

Validating another’s experience means letting the other person know that you are listening attentively, that you understand what she is saying, and what she is going through, that you believe what she says without judgment or conditions.<sup>64</sup>

It is essential to make the survivor feel that the care provider understands the situation and to let her know that her feelings are normal, that it is safe to express them and that she has a right to live without violence and fear.

You can do this by not challenging her statements (this is not an inquiry to arrive at the truth: you are not judiciary!), and appropriate responses both verbal and in the body language that reassures her and gives her courage to seek and accept help.

### 3.4.4 Ensure safety

One of the most important things you can do, following a disclosure of abuse is to speak to the woman about her immediate and future safety. Some survivors who have been subjected to violence may have fears about their safety. Others may not realize that they are in danger because they do not expect that the violence to happen again or worsen in the future.

Talking about safety will help the survivor to think through her options, and help you to assess the situation and guide her to find solutions to ensure safety.

Ensuring safety means to help a survivor assess her situation and make a plan for her future safety. Explain that partner violence is not likely to stop on its own: It tends to continue and may over time become worse and happen more often. Assessing and planning for safety is an ongoing process – it is not just a one-time conversation.

You can help her by discussing her particular needs and situation and exploring her options and resources each time you see her, as her situation changes.

Decisions on what steps to be taken is entirely up to the survivor and the care provider’s role is to provide guidance in the process. Some survivor will know when they are in immediate danger and are afraid to go home. If the survivor is worried about the safety, take it seriously.

Other women may need help thinking about their immediate risk. There are specific questions you can ask to see if it is safe for her to return to her home. (Refer SOP). It is important to find out if there is an immediate and likely risk of serious injury or being killed. If there seems to be immediate high risk, then you can say “*I’m concerned about your safety. Let’s discuss what to do so you won’t be harmed.*” *“mata tikak oyaa gana bayai. Oyata karadarayak novena karanna pulvan monavada kiyala hithala balamu”* You can consider options such as contacting the police and arranging for her to stay that night away from home or admitting to the hospital for a short stay.

Assessing safety: Assessing the safety (immediate risk of violence is important in all survivors of abuse).

<sup>64</sup> A clinical handbook Health care for women subjected to intimate partner violence or sexual violence WHO/RHR/14.26

## Essential services to address GBV/DV contd.

### Making a safety plan

Even women who are not apparently facing an immediate serious risk could benefit from having a safety plan. Assisting her to increase safety for herself and her children, by developing a safety plan is the responsibility of all health care providers. If she has a plan, she will be better able to deal with the situation if violence suddenly occurs.

### Raise the following issues with her:<sup>65</sup>

- ⦿ Does she have friends or family members with whom she could stay?
- ⦿ Does she want to report the abuse to the police?
- ⦿ Does this need to happen just now?
- ⦿ Does she want to go to a temporary accommodation /shelter or get admitted to the hospital for one or two days?

### Questions to assess immediate risk of violence

*Women who answer “yes” to at least 3 of the following questions may be at especially high immediate risk of violence:.*

**Has the physical violence happened more often or gotten worse over the past 6 months?**

**Has he ever used a weapon or threatened you with a weapon?**

**Has he ever tried to strangle you?**

**Do you believe he could kill you?**

**Has he ever beaten you when you were pregnant?**

**Is he violently and constantly jealous of you?**

### If she's being harassed by a former partner<sup>66</sup>

- ⦿ Discuss safety measures e.g. changing locks, fitting alarms.
- ⦿ Has she been advised by someone / police on how to protect herself and children?
- ⦿ Has she sought legal advice on using the protection of domestic violence act?
- ⦿ Can her neighbours agree to call the police if they see the abusive partner around her house?
- ⦿ Check whether schools, nurseries and so on know not to release the children to the abusive partner.
- ⦿ Advise her to keep text messages, letters and so on as supporting evidence of the harassment

**What you can do depends on the setting you work. You may only see the woman once, for example, in an OPD/E.T.U/P.C.U setting. Where possible, it is helpful to offer a follow up appointment. Always consider the woman's safety and how any approach you make might affect her and her children. Refer details on section on “Safety” in SOPs.**

<sup>65</sup> Scottish Guideline on Domestic Abuse NHS Scotland

<sup>66</sup> Scottish Guideline on Domestic Abuse NHS Scotland

## Essential services to address GBV/DV contd.

### 3.4.5 Support

Offering information; helping her access information and connecting her with other support services available is the final component of LIVES. Survivor's needs generally are well beyond what you can provide in the health setting. You can help by discussing the survivor's needs with her, telling her about other sources of help, and assisting her to get help if she wants. Which includes legal and other services that she might think helpful possible resources: A list of national level resources available is given in Annexure III More local level resources would be available.

#### In offering her support:

- it will usually not be possible to deal with all her concerns at the first meeting
- let her know that you are available to meet again to talk about other issues
- do not expect her to make decisions immediately
- it may seem frustrating if she does not seem to be taking steps to change her situation
- however, she will need to take her time and do what she thinks is right for her
- always respect her wishes and decisions

### 3.5 Care of injuries and urgent medical treatment at the first contact point by a Medical Officer

The examination and care of physical and emotional health should take place together at all points of care provision especially at the first contact point.

#### Introduction

A person who has suffered GBV/DV has experienced trauma, physical and psychological and may be in a state of agitation or withdrawal. They often feel fear, guilt, shame and anger or often all of them. Health care worker should understand this and prepare her, obtain the consent, for the examination and carry it out in a compassionate, systematic and complete manner and document it adequately and accurately<sup>67</sup>. Medical management of GBV/DV survivors involves treating potentially life threatening injuries and potential infections that may occur as a result of the violence.

GBV/DV-survivors, with life-threatening injuries, when attended at the first contact point /primary health care facility it will be important that health care providers are capable to identify life-threatening injuries resulting from GBV/DV through a primary survey and to ensure that basic life-saving emergency measures are undertaken to stabilize the patient before referral for appropriate health care.

Can patient talk and breathe freely? If obstructed, the steps to be considered are:

#### Airway

- Chin lift/jaw thrust (tongue is attached to the jaw)
- Airway Suction (if available)
- Guedel airway/nasopharyngeal airway
- Intubation. NB keep the neck immobilized in neutral position
- Cervical spine care

**Breathing:** Assess respiratory rate (12–20/min), chest wall movements, chest percussion, lung auscultation, pulsoximetry (97%–100%)

Is the breathing sufficient? If inadequate, the steps to be considered are:

- Oxygen by mask
- Artificial ventilation by Ambu bag

<sup>67</sup> Health Sector Response to GBV National Guideline on providing care and prevention For Health Care Providers Maldives

## Essential services to address GBV/DV contd.

**Circulation:** Measure blood pressure, assess circulation/ perfusion by capillary refill time and pulse rate, skin color changes, sweating, and a decreased level of consciousness are signs of decreased perfusion.

If circulatory function is inadequate the steps to be considered are:

- Establish two large-bore intravenous lines and give crystalloid solution
- In case of hypovolemic shock, caused by significant blood loss /plasma /whole blood should be given accordingly. Give type-specific blood, or give O-negative if this is not available
- Stop external hemorrhage by direct pressure at the point of injury or the arterial supply.

### Neurologic assessment

Assess level of consciousness – by alertness, voice responsiveness, pain responsiveness by using the Glasgow Coma Scale to determine the level of consciousness. Assess limb movements, and pupillary light reflexes and if possible blood glucose.

### If assessment has evidence of a cerebral condition:

- stabilize the airway, breathing, and circulation
- when the patient is only pain responsive or unresponsive, ensure airway patency by placing the patient in the recovery position, and call personnel qualified to secure the airway as intubation may be required

*Attending to life saving emergency situations and the time-dependent preventive treatments take priority over all other activities*

### Examples of indicators of Life-threatening situations:

- Rectal bleeding
- Non-menstrual vaginal bleeding
- Acute abdomen
- Suicide attempt
- Any major injuries
- Major acute wounds
- Major burns
- Fractures
- Poisoning

### 3.5.1 History taking

*(History taking for Judicial medical purposes is not included here. If necessary pl. Refer. National Guideline on rape by Sri Lanka College of Forensic Pathologists)*

Let the survivor tell the story the way she wants to and the clarifications and questioning should be done gently and at the survivor's own pace. If she breaks down and cries allow her to do without pressurising her to continue and avoid questions that suggest blame such as "What were you doing there alone". The history taking or the examination process should in no way lead to re-victimization, stigmatization, or blaming the survivor.

### Specially for rape survivor's:

If the incident has occurred recently, inquire whether she had bathed or washed herself or douched.

## Essential services to address GBV/DV contd.

Before beginning the interview

- ⦿ Explain the objective of the interview (importance of understanding the circumstances of the GBV/DV in order to provide appropriate treatment).
- ⦿ Remind the survivor of GBV/DV that she has the right to terminate the interview at any time.
- ⦿ If the survivor refuses to talk about the violence, don't pressure her but explain that the health care provider will always be available if she wants to talk at a later date.
- ⦿ Study any papers the survivor may give you in order to avoid asking questions which have already been recorded.

**The main elements of history taking are:**

### General information

- ⦿ Name
- ⦿ Address (current) /Permanent address
- ⦿ Hospital/Health facility number
- ⦿ Telephone number (Optional)
- ⦿ Sex
- ⦿ Age in years
- ⦿ Date and time of the examination
- ⦿ Name(s) of any staff /Chaperone/support persons present

### Description of the incident

- ⦿ Describe what happened and note the date, time, and place.
- ⦿ Get details of exactly what happened in order to check for possible injuries. For example did the assailant use physical force or coerced her?

### Gynecologic history (especially in cases of sexual abuse or rape)

- ⦿ First date of the last menstrual period
- ⦿ Determine if the survivor has ever tested for STIs or HIV before and her HIV status
- ⦿ Determine if the survivor has been pregnant before
- ⦿ Determine if the survivor uses contraception. If so, the type, since when, and the compliance

Although all HCPs are not trained or skilled in assessing the following if noted it may be recorded:

- ⦿ Depression /Anxiety /Mood problems /Suicidal ideation /Substance abuse
- ⦿ Past medical and surgical history
- ⦿ Ask about possible medical conditions, allergies, use of alcohol/drugs, vaccination, and previous surgery. These questions should help you to determine the best treatment and offer follow-up.

## Essential services to address GBV/DV contd.

### 3.5.2 Examination

*(Examination for Judicial medical purposes is not included here. If necessary, pl. Refer. National Guidelines on rape by Sri Lanka College of Forensic Pathologists)*

Although Forensic examination will be done by a dedicated specialist it is important to conduct a thorough examination at the first contact point:

- ⦿ This will be the first examination by a medical person: earliest record of what was seen.
- ⦿ This will detect any life threatening conditions: can be attended immediately
- ⦿ Will identify any coexisting medical conditions which may have an impact on the management

The examination should be done systematically “Head to Toe”

A physical examination involves collecting objective data using the techniques of inspection, palpation, percussion, and auscultation as appropriate. The head-to-toe examination includes all the body systems, and the findings will inform the health care professional on the patient's overall condition. Any unusual findings should be followed up with a focused examination specific to the affected body system.

#### General Examination:

Height & Weight  
Pulse and Blood Pressure

#### General Appearance:

Behaviour/anxiety/Level of hygiene/Body position/Patient mobility/Speech pattern and articulation

#### Skin, hair, and nails:

- ⦿ Inspect for lesions, bruising, and rashes.
- ⦿ Inspect for pressure areas.
- ⦿ Inspect skin for oedema.
- ⦿ Inspect scalp for lesions, tenderness or bumps
- ⦿ Inspect nails for consistency, colour, and capillary refill.

#### Head and neck:

- ⦿ Inspect eyes for bruises, sub conjunctival haemorrhages and for pupillary reaction to light.
- ⦿ Inspect mouth, tongue, and teeth for injuries, bite marks.
- ⦿ Neck for nail marks, bruises

#### Heart:

- ⦿ Palpate: Apex beat
- ⦿ Auscultate: Heart sounds and murmurs

#### Chest:

- ⦿ Respiratory rate
- ⦿ Inspect: Expansion/retraction of chest wall/accessory muscles working /alae nasi dilated
- ⦿ Palpate: For symmetrical lung expansion
- ⦿ Auscultate:  
for breath sounds anteriorly and posteriorly  
apices and bases for any adventitious sounds



## Essential services to address GBV/DV contd.

### Abdomen:

- Inspect: for distension, bruises, injuries, asymmetry
- Palpate: Four quadrants for pain and bladder/bowel distension (light palpation only), Liver and Spleen
- Auscultate: Bowel sounds

Back for injuries bruises abrasions

Buttocks for injuries, bruises or abrasions

Arms and hands Legs and feet for injuries, marks of restraints

More information on examination is given in the SOPs for Medical Officers on pages 17 - 18

### 3.6 Sexual assault examination and care

Refer to Rape Guidelines of College of Forensic Medicine

Sexual assault examination and care is currently conducted by the Consultant Forensic Pathologists or designated Judicial Medical Officers and not by the first contact Medical Officers to whom this guideline is intended to be. Hence this section is not included here.

A detailed National guideline has been developed by the Sri Lanka College of Forensic Pathologists and is available at <http://medical.sjp.ac.lk/downloads/forensic-medicine/Medico%20Legal%20Purposes.pdf>

What actions should be taken by the first contact Medical Officers excluding Judicial Medical Officers is described in the next section.

#### 3.6.1 Medico-legal functions of the first line medical professionals

*This section was contributed by Prof. M. Vidanapathirana, Professor of Forensic Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura.*

- Medico legal services will be provided by the J.M.O or the Consultant Forensic Pathologist of the institution. It is the duty of other medical professionals to inform and facilitate the process of being seen by him as expeditiously as possible because evidence will be lost every minute when there is a delay.
- At the same time, it is essential that the findings in the history and examination of the first contact medical professional that are of medico legal significance be clearly recorded and made available to the JMO or the Forensic Pathologist.
- In the presence of a medical emergency attending to that condition should be given priority.
- If criminal activity such as sexual assault is divulged Police and J.M.O or the Consultant Forensic Pathologist should be informed immediately.
- Record whether smelling or under the influence of liquor or drugs because the sexual assault may have been perpetrated using alcohol or drugs.
- Accurately record the injuries with full description such as the nature, size, shape, site, exact site, disposition (longitudinal, transverse or oblique), and level of healing and surrounding appearance.
- After discussing with the J.M.O or the Consultant Forensic Pathologist, if requested by him samples such as vomitus, blood, urine which are of medico-legal significance should be collected, labeled, stored and handed over to J.M.O or the Consultant Forensic Pathologist or Police as directed.
- If indicated, admit to a ward. Always be vigilant on the side of safety and if any doubt admit. Consider her emotional state at this point as she may benefit by being away from the abusive environment for a short time to collect her thoughts
- If the condition of the patient is grave and is dying, record a dying declaration, in her own words without asking leading questions. Eg. Sarath stabbed me after raping me .

## Essential services to address GBV/DV contd.

- As medicolegal examination and reporting to courts is done by the J.M.O or the Consultant Forensic Pathologist it is very unlikely that you will be asked to attend courts But if requested or summoned get guidance from the J.M.O or the Consultant Forensic Pathologist and attend. Having this possibility though remote record your findings clearly on the BHT or other medical records in every patient you see.
- Be non-judgmental and empathetic throughout the process of caring and do not attempt to influence the survivor towards your views or values.

DOs	DON'Ts
Examine her with minimum disturbances to her clothes	Don't ask her to change her to clean clothes (on admission or before examination)
Ask her not to have a bath, wash herself or brush her teeth till the examination by J.M.O or the Consultant Forensic Pathologist	Don't follow the routine of the ward that all patients should clean themselves on admission to the ward
Once informed if there is a considerable delay remind the J.M.O or the Consultant Forensic Pathologist that patient is waiting to be seen	Don't think that once informed a reminder is not correct and J.M.O or the Consultant Forensic Pathologist would get angry
Record your findings once seen by you	Don't leave out your findings relevant to medico-legal aspects because J.M.O or the Consultant Forensic Pathologist will be examining her later

### 3.6.2 Mandatory Reporting

- Mandatory reporting of violence against women to the police by health service providers is not recommended (WHO recommendation).
- Health service providers should offer to report the incident to the appropriate authorities, including the police ((WHO recommendation).
- If the woman wants to be reported and is aware of her rights report to Police immediately (WHO recommendation).
- All cases of grievous hurt and life threatening injuries must be reported to police and explain to the patient the legal requirement to do so.

(Based: WHO Guidelines Recommendation 36 and 37 in the Hand book for health care providers<sup>68</sup>).

<sup>68</sup> Health care for women subjected to intimate partner violence or sexual violenceA clinical handbook WHO/RHR/14.26

## Essential services to address GBV/DV contd.

### 3.6.3 Pregnancy prevention and management among girls who have been sexually abused

Pregnancy as a result of rape is often not thought of by the provider or even the survivor but is a matter for concern. A study in USA found a national rape-related pregnancy rate of 5.0% per rape among victims of reproductive age (aged 12 to 45) and an estimated 32,101 pregnancies resulting from rape each year. Among 34 cases of rape-related pregnancy in the study, the majority occurred among adolescents and 32.4% of these victims did not discover they were pregnant until they had already entered the second trimester.<sup>69</sup> For women abused by intimate partners the percentage of resultant pregnancy can raise to 20%<sup>70</sup>. It is well known that some of these can result in unsafe abortions and even maternal deaths. Therefore, emergency contraception is recommended for all cases of rape or sexual abuse.

Determining whether a survivor was pregnant prior to the rape is not a prerequisite for using emergency contraceptives, as these will not harm a pre-existing pregnancy. If a pregnancy test was positive prior to the incident, emergency contraception is neither necessary, nor effective.

The use of emergency contraception is a personal choice to be made by the woman herself, and the provider should give objective counselling on this method for the purpose of making an informed decision.

Emergency contraceptive methods work by interrupting a woman's reproductive cycle - by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. Emergency contraceptives do not interrupt or damage an implanted pregnancy and thus they are not considered by the WHO to be a method of abortion.<sup>71</sup>

- Emergency contraception should be offered to all women or adolescents who seek health care within a few hours and up to five days post sexual assault.
- If accepted, emergency contraception should be given as soon as possible after the rape, as it is more effective if given within 3 days, although it can be given up to five days.
- If the survivor presents more than 5 days after the assault, prevention is not possible and she should be advised to return for pregnancy testing if she misses next menstrual period.
- Any woman or adolescent girl can take Emergency Contraceptive Pills.
- There is no need to screen for health conditions before taking emergency contraception.
- A woman can take ECPs along with antibiotics for STIs and PEP for HIV prevention at the same time without harm. ECP and antibiotics can be taken at different times and along with food to reduce nausea

There are two methods used for emergency contraception:

- Emergency Contraceptive Pill (ECP)
- Cu containing Intrauterine Contraceptive Devices (IUD)

<sup>69</sup> Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. *Am J Obstet Gynecol* 1996; 175: 320-324 [https://www.researchgate.net/publication/14437975\\_Rape-related\\_pregnancy\\_Estimates\\_and\\_descriptive\\_characteristics\\_from\\_a\\_national\\_sample\\_of\\_women](https://www.researchgate.net/publication/14437975_Rape-related_pregnancy_Estimates_and_descriptive_characteristics_from_a_national_sample_of_women)

<sup>70</sup> McFarlane J et al. Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes. *Obstetrics and Gynecology*, 2005, 105 (1):99-108. <https://www.ncbi.nlm.nih.gov/pubmed/15625149>

<sup>71</sup> Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005

## Essential services to address GBV/DV contd.

### Emergency Contraceptive Pills<sup>72</sup>

Two kinds of oral preparations can be used as EC.

- **Levonorgestrel-only (Postinor) should be offered as the first choice**

Works better and causes less nausea and vomiting a single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12–24 hours apart. This is available at all *Mithuru Piyasa/Natpu Nilayam* centres and can be bought over the counter without a prescription from most pharmacies. ECP recommended to be used within 5 days. (Best within 3 days)

- **Combined oestrogen-progestogen (OCP)**

If levonorgestrel is NOT available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available: Dosage: 2 doses of (OCP 30 µg ethinyl oestradiol plus 150 µg levonorgestrel) two tablets 12 hours apart.

### Copper bearing IUDs

If oral emergency contraception is not available and if services available for insertion copper-bearing intrauterine devices (IUDs) may be offered to women seeking on-going pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible (see WHO medical eligibility criteria, 2010).<sup>73</sup>

- More effective than EC pills.
- Good choice for very effective long-acting contraception, if a woman is interested in the IUD and could be referred for it immediately

***Additional information on counselling on EC is given in SOPs.***

<sup>72</sup> Recommendation 13; Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines WHO 2013 ISBN 978 92 4 154859 5

<sup>73</sup> A Clinical Hand book; Health care for women subjected to intimate partner violence or sexual violence WHO 2014

## Essential services to address GBV/DV contd.

### 3.6.3 Post-exposure prophylaxis for sexually transmitted infections

Risk of contracting Sexually transmitted infection is always a possibility whether the perpetrator is unknown or known after sexual assault.

- The survivor should be made aware of the risk and STI prophylaxis (presumptive treatment) offered to all women after rape or sexual abuse.
- This needs to be done at the first contact point, prior to, at the same time or immediately after seen by the Judicial Medical Officer/Consultant Forensic Pathologist.
- Women who have been sexually assaulted should be given antibiotics to prevent common sexually transmitted infections (STIs): chlamydia, gonorrhoea, depending on the local prevalence<sup>74</sup>.
- There is no need to test for STIs before prophylaxis.
- Give the shortest course available in the local or national protocol.

**Wherever available, follow the instructions/ protocols of the Consultant of the STD clinic of the hospital/ National STD/ AIDS Control Programme.**

Note: These are examples of treatments for sexually transmitted infections based on WHO-recommended STI treatments for adults (may also be used for prophylaxis).<sup>75</sup>

STI	Treatment	
<b>Gonorrhoea</b>	cefixime	400 mg orally, single dose
<b>Low abdominal pain, bleeding or vaginal discharge</b>	Azithromycin	1 g orally, in a single dose
	Doxycycline (Contraindicated in pregnancy)	100 mg orally, twice daily for 07 days

All survivors should be referred to a STD clinic immediately if they have symptoms or referred to a STD clinic in 2 weeks even if they do not have symptoms.

<sup>74</sup> Recommendation 19 Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines WHO 2013 ISBN 978 92 4 154859 5

<sup>75</sup> Clinical Management of Rape Victims; Developing protocols for use with refugees and internally displaced persons 2004 WHO/ RHR/02.08 Revised edition <http://www.unhcr.org/403a0b7f4.pdf>

## Essential services to address GBV/DV contd.

### 3.6.4 HIV post-exposure prophylaxis treatment and adherence

The first Sri Lankan with HIV was detected in 1987, and by 2015 estimated adult HIV prevalence was 0.02% while the HIV prevalence among most at risk populations such as Sex Workers (SW) (0.8%), men who have sex with men (MSM) (0.9 %). Although the country is currently experiencing a low level HIV epidemic there is a steady upward trend of HIV positives<sup>76</sup> and the risk should be thought of in cases of rape.

- Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible up to 72 hours after possible exposure to HIV. Discuss with the survivor whether Post Exposure Prophylaxis (PEP) is appropriate in her situation<sup>77</sup>.
- Victims of sexual assault presenting later than 72 hours post-incident would not normally be considered eligible for PEP.
- HIV testing should not, however, be mandatory nor should a prerequisite for providing PEP drugs, and the testing results be treated in the strictest confidence.

#### When should PEP be considered?

Clinical scenarios where PEP should be offered are given below:

Situation/Risk factor	Suggested procedure
Perpetrator is known to be HIV-infected	PEP Recommended ✓
Perpetrator is of unknown HIV status	Consider giving PEP ✓
Survivor's HIV status is unknown	Offer HIV testing and counseling Give PEP and make follow-up appointment ✓
Survivor has been exposed to blood or semen (through vaginal, anal or oral intercourse or through wounds or other mucous membranes.	Consider PEP ✓
The survivor was gang-raped.	Consider PEP ✓
The survivor is known to be HIV-positive	Do NOT give PEP ✗

#### Communicate to the survivor that:

- PEP can lower her chances of getting HIV, but it is not 100% effective.
- She will need to take the medicine for 28 days, either once or twice daily depending on the regimen used
- About half of people who take PEP have side-effects, such as nausea, tiredness, and headaches. (For most people side-effects decrease in a few days.)

#### If PEP is accepted:

- Start the regimen as soon as possible and before 72 hours.
- Provide HIV testing and counseling at the initial consultation.
- Two-drug regimens (using a fixed-dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side effects.
- The choice of drug and regimens for HIV PEP should follow national guidance.
- Immediately refer to STD clinic.
- Once PEP is started should continue for 28 days.
- Ensure patient follow-up at regular intervals.
- Adherence counseling should be an important element in PEP provision.
- Contact nearest STD clinic/ Venereologist if further advice needed
- Hepatitis B immunization- rapid course

<sup>76</sup> Ending Aids In Sri Lanka A Road Map The Sri Lanka Medical Association And The National Std/Aids Control Programme 2016 [http://www.aidscontrol.gov.lk/images/pdfs/publications/programme\\_plans/road\\_map\\_to\\_ending\\_aids\\_in\\_sri\\_lanka.pdf](http://www.aidscontrol.gov.lk/images/pdfs/publications/programme_plans/road_map_to_ending_aids_in_sri_lanka.pdf)

<sup>77</sup> Health care for women subjected to intimate partner violence or sexual violence A clinical handbook WHO/RHR/14.26

## Essential services to address GBV/DV contd.

### Adherence counselling

Many female survivors of sexual assault provided with PEP for HIV do not successfully complete the preventive regimen because PEP for HIV, results in side-effects such as nausea and vomiting and social and psychological issues. Health-care providers should be aware that adherence is very difficult to attain and efforts should be made to ensure that it is maintained.

- Taking the pills at regular intervals ensures that the level in the blood stays about the same and is important to remember to take each dose, at the same time every day, such as at breakfast and dinner.
- Use an alarm on a mobile phone or some other device can be a reminder to take the pills, or a family member or friend can remind her.
- If the survivor forgets to take her medicine on time, the survivor should still take it, if it is less than 12 hours delay.
- If it is more than 12 hours delayed, the survivor should wait and take the next dose at the regular time.
- The survivor should not take 2 doses at the same time.
- The survivor should report back to the clinic/OPD/hospital if side-effects do not go away in a few days, if the survivor is unable to take the drugs as prescribed, or if the survivor has any other problems.

#### Communicate to the survivor that:

- PEP can lower her chances of getting HIV, but it is not 100% effective.
- She will need to take medicine for 28 days.
- About half of people who take PEP have side effects, such as nausea, tiredness and headaches. (For most people side effects decrease in a few days.)
- Follow up HIV testing in 6 weeks and in 3 months

Weight	Antiretrovirals	Dosage		Duration
Adults over 40 Kg	Tenofovir Emtricitabin Efavirenz (TNF+FTC+EFV) <ul style="list-style-type: none"><li>○ Hepatitis B vaccination</li><li>○ Screening for STIs<ul style="list-style-type: none"><li>-baseline</li><li>-after 2 weeks</li></ul></li></ul>	1 tablet	OD	28 days

## Essential services to address GBV/DV contd.

### 3.7 Mental health assessment and care

Survivors of Gender based Violence undergo psychological trauma leading to mental problems and diseases. Most people will recover when the violence is over but long standing trauma leave permanent effects. Health Service Providers (mainly the Medical Officers and Nursing Officers in the wards and *Mithuru Piyasa / Natpu Nilayam* centres should be able to help these survivors by reducing their psychological pressure through effective emotional support. However, some of them continue to have psychological problems for a longer period or suffer serious psychological problems such as depression and suicidal ideation. It is the duty of the health service provider to identify them correctly and as early as possible for better support through specialized services whenever necessary.

There are three core elements of mental health assessment and care for the GBV/DV survivors:

1. Mental health assessment for survivors of GBV/DV
2. Provision of basic emotional support (Befriending)
3. Addressing more severe mental health problems

#### 3.7.1. Mental health assessment for survivors of GBV/DV

The first thing a health care provider should do is assessing all survivors of GBV/DV for signs of acute stress conditions such as feeling down, social withdrawal, sleep disturbances and other psychological issues such as post-traumatic stress disorder, depression and suicidal feelings. Health care providers should be able to do a proper assessment for all GBV/DV survivors accurately as possible to identify these issues among them. Referral for management of serious problems and managing others to ease psychological trauma is one important intervention done by health care providers at the first contact point.

#### 3.7.2. Providing Basic Emotional Support

This is mainly strengthening an emotionally affected person using psychological techniques such as befriending.

##### The objectives of basic emotional support :

- To reduce both immediate and long term psychological pressure of the affected person.
- To help that person to cope with negative emotions such as handling anger, fear, sadness, etc.
- To empower them to face problem situations better.
- To guide them to find best possible options for that moment.

#### Why basic emotional support is mandatory in caring for survivors of GBV/DV?

In any community, individuals suffer from emotional trauma due to many causes. However, it is often unrecognized that GBV/DV is one such cause.

With survivors of GBV/DV recovery is complete, if the they are emotionally supported and violence ceases.

If such emotional support is provided in the early stages, recovery is quicker and compliance for therapies is much better

#### 3.7.3. Addressing more severe mental health problems

It is necessary to observe and look out for major mental health issues at the first contact point for immediate risk or self-harm or suicide and, for moderate-severe depressive state.

Even those with serious psychological problems such as depression, will benefit from basic emotional support offered at the first contact point before being referred for in depth counselling and other appropriate therapies.



## Essential services to address GBV/DV contd.

### What is 'befriending'?

Befriending is a method of providing basic counselling/basic emotional support. It helps people who are emotionally distressed to overcome emotions that make them uncomfortable and cope with them in a positive manner. Listening is an important technique in befriending. By listening, you help the caller to unburden all the pent up emotions which prevent her from thinking in a rational manner. After unburdening, she will be ready to take more rational decisions.

### What is expected from providing basic emotional support (Befriending)?

There are three major outcomes of providing basic emotional support:

- Relief and recovery from negative emotional impact of GBV/DV.
- Rational thinking and decision making.
- Improved quality of life for the survivor.

The process of basic emotional support should be organized as a series of face-to-face meetings with the survivor of GBV/DV in order to achieve the expected outcomes mentioned above.

### Major principles of providing basic emotional support including befriending

- i. Attending behaviour
- ii. Conveying empathy
- iii. Privacy/ confidentiality
- iv. Active listening
- v. Facilitating the dialogue
- vi. Maintaining correct body language
- vii. Be non-judgemental
- viii. Challenging attitudes, opinions and beliefs that promote GBV/DV
- xi. Showing available option
- x. Support the client to take positive decisions

#### i. Attending behaviour

Good Attending behaviour demonstrates that one respects a person and is interested in what she has to say. This is essential to make the client comfortable. You must orientate yourself psychologically and in a pose favourable towards the client. This encourages the patient to talk. It lets the other person know that you are listening. This helps to convey empathy effectively.

Attending behaviour consists of following features:

- Face the other person
- Head nods – Nonverbal communication
- Adopting an open posture
- Verbal following
- Lean towards the other
- Make eye contact
- Be relaxed when talking to the affected person.

## Essential services to address GBV/DV contd.

### ii. Conveying empathy

Empathy is an emotional response to the feelings of another. You should be able to understand the feelings of people who come to speak to you. Try to look at their problems and concerns from their point of view and not from yours'. In other words, you should try to see the issue through their eyes. Conveying empathy is important throughout the interaction. This has a therapeutic value.

### iii. Privacy/confidentiality

Any dialogue with the survivor and the family members should be treated as confidential at all times. This should be communicated to the survivor at the outset. You should explain how you would preserve the confidentiality of the information provided and records maintained. Never share stories of clients even without mentioning their names with other people.

### iv. Active listening

Active listening is a way of listening and responding to the survivor attentively that improves mutual understanding. It is not mere listening. Actively participating as a listener is very important in befriending. In active listening, eye contact, nonverbal communication and your body language play a vital role. Focus on paralinguistic cues and body language of the survivor when listening. It will help you to understand the emotional situation of the survivor as well as empathize with the survivor appropriately. You can ask relevant questions without disturbing the flow of the dialogue to get more information from the person.

### v. Facilitating the dialogue (“Facilitating story telling”)

It is important to encourage the survivor both verbally and non-verbally to facilitate the dialogue and maintain the flow of the dialogue. Nonverbal communication includes head nodding, smiling, saying *hmm ... hmm*. Pausing or maintaining silence when the client speaks, especially about important or emotionally charged topics in the first few minutes of the interview, is recommended. Asking questions at the right time to get more information and addressing negative opinions and beliefs is also recommended.

### vi. Maintaining correct body language/tone

The dress you wear, the way you talk and the way you behave in front of the survivor could affect the outcome of the whole process. It is advisable to talk in a moderately loud voice and to have a friendly talking style. Please be aware of their language

### vii. Be non-judgmental

You are not expected to judge your client despite what she says or discriminate according to their caste, gender, sexuality, language and other factors. It prevents bonding and developing a proper intervention. This is done only to improve the outcome of the interaction and for better help.

### viii. Challenging attitudes, opinions and beliefs that promote GBV/DV

Challenging harmful attitudes, opinions and beliefs with the survivor would help them to find better options/solutions and see the issue with an open mind. Harmful opinions include, opinions about whether to seek help or not, marriage, life, alcohol related behaviour. Most of these harmful opinions and beliefs could prevent the survivor from receiving proper support. Addressing these beliefs need to be done in an empathetical manner and based on evidence. Always allow the survivor to answer freely. Open-ended questions usually help the survivor to express herself better.

### ix. Showing available options

Available options 'solutions' for a particular survivor may differ, depending on the seriousness of the issue and individual limitations. You can suggest options if the client is not aware of possible options she has. With time and the level of empowerment, they might change the earlier option. It is your duty to empower the survivor to select the best possible option available at the moment.

## Essential services to address GBV/DV contd.

### **x. Support the client to take positive decisions**

Most of the time, survivors are not capable of identifying the best option from a list of options available for that moment. You are expected to help the client to identify the best option after analyzing available options with her. You can gently question the decision of the survivor showing the pros and cons of each option.

### **The process of emotional support including befriending**

Providing emotional support for survivors of GBV/DV need to follow a process. The major steps of such process can be listed as follows:

- i. Good rapport, building understanding and lasting relationship.
- ii. Assessing the client
- iii. Conceptualizing the survivor's problems
- iv. Setting goals to be achieved.
- v. Active listening and befriending (Therapy)
- vi. Arranging for next meeting.
- vii. Referral for additional support when needed.

- ☛ Choose a private place to talk, where no one can overhear
- ☛ Assure her that you will not repeat what she says to anyone else, and you will not mention that she was there to anyone who does not need to know. If you are required to report her situation, explain what you must report and to whom.
- ☛ First, encourage her to talk, and show that you are listening.
- ☛ Encourage her to continue talking if she wishes, but do not force her to talk.
- ☛ Allow silences. If she cries, give her time to recover

### **i. Good rapport and building understanding and lasting relationship**

Your first contact with the survivor is very important. Ask others not to interrupt you during the befriending session. Introduce who you are and your responsibilities. It is important to welcome them by their name. That will ease their stress for a moment. Talk to them nicely and help them to relax. Explain to the client how you ensure privacy and confidentiality. Ensure safety and explain the safety options. Extend unconditional acceptance of the story of the survivor. This is the most important initial step in the process of emotional support.

### **ii. Assessing the client**

This is done at a very early stage of the dialogue. (Please see 3.7.1 section above) You should be able to assess the survivor for her psychological status, suicidal tendencies if any, and present situation.

You need to do the observations as accurately as possible. When you assess the client, look for physical difficulties such as injuries, which are not divulged and other information such as social status. If you find any emergency situation during the assessment phase, refer the client immediately for proper specialized help such as psychiatric help for suicidal survivors.

### **iii. Conceptualizing the survivor's problems**

Usually, the immediate issue (E.g. the most recent incident) is seen as the major problem. There may be several other similar incidents linked with the immediate issue of the survivor. Although client seeks an answer for all problems, there may not be solutions for some of the problems the survivor is facing due to practical reasons. Discuss this in detail with the client to identify the problem/s the survivor has. Help the client to identify measures to deal with her problems.

## Essential services to address GBV/DV contd.

### iv. Setting goals to be achieved

Keep it simple when you set targets to achieve. Break it into a number of steps. Choose a starting point with the client by getting the consent of the client. Set a time frame which is approved by the client. Try to take the client forward according to the plan. Choose rewards to the client for making progress.

### v. Active listening and befriending (Therapy)

After the initial dialogue, you need to help the survivor to overcome the challenges and go for the best possible options available. For this, you might have to spend more than one session with them. There are certain principles and techniques that you need to follow to get optimum results from befriending. You need to practice such techniques regularly with the client.

To understand the situation of the client, ask what the client's beliefs are with regard to the matter. Find out what the client's goals are. Help them develop a step-by-step plan to get them to reach the goals. Get agreement from client to address the first step. Set a time frame to get the first step done.

In listening, it is expected to achieve the following for better emotional support:

- being aware of the feelings behind her words.
- hearing both what she says and what she does not say.
- paying attention to body language – both hers and yours – including facial expressions, eye contact, gestures
- sitting or standing at the same level and close enough to the client to show concern and attention but not so close as to intrude.
- expressing empathy, showing understanding of how the client feels.

### vi. Arranging for next meeting

After each session, you need to assess the need for a second meeting. If so, discuss with your client about the need and mutually agree on a date and time. You can always suggest the vitality of meeting, certain high risk clients immediately and more frequently. If you are satisfied with the improvement, you can terminate the relationship after making the client aware of the decision.

### vii. Referral for additional support when needed.

You need to refer your clients to specialists and other services whenever it is necessary.

Some of your clients need immediate attention. E.g. Clients who are having strong suicidal feelings or symptoms of psychiatric diseases. It is advisable to have equipped yourself with the necessary details of such specialists and services to send your clients without any delay

Please see the referral networks of services, in Annexure II and III

### Things to avoid

There are certain behaviours that you should avoid as a person who provides emotional support. Some of those behaviours are listed below:

- Moralizing and preaching
- Reassuring and sympathizing
- Advising and offering solutions
- Being sarcastic and humouring
- Ordering, commanding and directing
- Teaching, lecturing and giving logical arguments
- Warning and threatening
- Criticizing, disagreeing and blaming

## Essential services to address GBV/DV contd.

These can negatively affect the outcome of basic emotional support and might not empower clients to deal with problem situations better.

### 3.8 Documentation

Documentation with respect to medico legal/ forensic purposes is not included here as this guideline targets non judicial care providers. (Refer to the Rape Guidelines of College of Forensic Medicine for details.)

In general health workers are professionally obliged to record in writing the details of any consultation with a patient. In the case of GBV/DV, health care providers need to explain what information will be recorded and why. If on the other hand, the survivor prefers that some information will not be recorded, then this wish should be followed unless it is absolutely necessary for the provision of care.

As medical records may be used in court as evidence, the recording of accurate and complete notes during the course of an examination is critical.

- Complete the patient record for every patient.
- Document all aspects of the consultation, including consents given; medical history; account of the abuse; outcome of the physical examination; samples taken; tests and their results; treatments and medications prescribed; and schedule of follow-up care and referrals.
- For the purpose of accuracy, make all notes during, rather than after, the course of the consultation.
- Ensure that any assessment is impartial and represents a balanced recording of the findings. It is not the role of the health care provider to make any interpretations about whether or not the GBV/DV took place. The Health Care Provider should limit herself for documenting of the findings.

(Guidelines for medico-legal care for victims of sexual violence, WHO, 2003)

### General Considerations

Storage and access to records Patient records and other supporting information are strictly confidential. All health care providers are professionally, legally and ethically obliged to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by law.

No information or document may be disclosed without the victim's consent and without the authorization of the director of the health structure / institutions.

### Data collection

Statistical data concerning GBV/DV-cases are being collected into a separate database system, only accessible to authorized staff members.

## 4. Guiding principles derived from ethical principles and human rights standards

### 4.1 Survivor Centred Care

Survivor-centred approach means that all those who are engaged in caring for survivors of GBV/DV prioritize the wishes, needs and rights of the survivor at all times<sup>78</sup>. Autonomy of the survivor to make decisions is respected and the purpose of all actions is welfare of the survivor.

Essentially, a survivor-centred approach ensures that survivors' rights and needs are of first and foremost importance.

The survivor has a right to:

- be treated with dignity and respect instead of being blamed for the violence she underwent
- choose the course of action in dealing with the violence instead of feeling powerless and told what to do
- be ensured privacy and confidentiality instead of being exposed
- receive information to help the survivor to make own decision

The survivor-centred approach aims to create a supportive environment and helps to promote the survivor's recovery and the ability to identify and express needs and wishes. It also reinforces survivor's capacity to make decisions about the possible interventions.

In summary, survivor centred approach means; listening to the demands, desires, and needs of the survivor, considering how proposed interventions might or might not further harm the survivor, ensuring that she can make truly informed decisions on how to recover from her trauma. This approach will provide an opportunity for survivors to reclaim the power that was taken away from them in the context of their abuse<sup>79</sup>.

### 4.2 Confidentiality

Confidentiality is one of the fundamental principles of medical ethics and is the principle and legal right that health professionals will keep in confidence, all information relating to a survivor, unless she gives consent permitting disclosure.

Confidentiality is central to trust between care providers and care seekers. Without an assurance about confidentiality, survivor may be reluctant to seek medical attention or to give providers the information they need in order to provide good care<sup>80</sup>. Therefore, confidentiality of the survivor (or survivors) and his or her family must be respected at all times. Maintaining a strict level of confidentiality is sometimes necessary to protect the survivor from further violence.

However, appropriate information sharing is sometimes necessary for the specific reason of providing safe and effective care for the individual survivor and agreed to by the survivor. Some patient information may be shared with other medical colleagues on a "need to know basis" if medically justified; i.e. the survivor is being referred to another health care provider such as a medical specialist or a counsellor. It should be explained to the survivor beforehand in order to ensure that the survivor understands the process, including the type of information to be shared and with whom it is shared.

If confidentiality is breached it could bring grave consequences for the survivor, especially if adequate protection is not in place. It also may discourage other survivors from coming forward and seeking care. Wherever possible a survivor's anonymity should be maintained. All written information about the survivor must be kept locked and secure from other staff.

<sup>78</sup> The survivor centred approach to health service delivery; Virtual knowledge centre to end violence against women  
<http://www.endvawnow.org/en/articles/652-survivor-centred-approach.html>

<sup>79</sup> Gender-based Violence (GBV) prevention and response in humanitarian settings; Global protection cluster

<sup>80</sup> Confidentiality; General Medical Council Guideline [https://www.gmc-uk.org/Confidentiality\\_\\_English\\_1015.pdf\\_48902982.pdf](https://www.gmc-uk.org/Confidentiality__English_1015.pdf_48902982.pdf)

## Guiding principles derived from ethical principles and human rights standards contd.

However, certain circumstances do exist where survivor/health care provider confidentiality may be ethically disregarded:

- if someone is suicidal, a duty exists to warn/contact a referral source or relative
- if someone is a threat to another person(s), a duty exists to warn/contact the police
- suspected child abuse

### 4.3 Nondiscrimination

All Survivors of GBV/DV need to have equal access and receive equal and fair treatment regardless of their age, race, religion, nationality, ethnicity, sexual orientation or any other social characteristic. Furthermore, health service provision need to be appropriate and tailored to the needs and specifics of service users. Care providers need to identify and address any barriers faced by survivors belonging to specific groups in accessing health service<sup>81</sup>. As a member of the wider society, each individual care provider may have biases, attitudes and views on many issues but it is essential not to allow these to affect survivors of GBV/DV receiving care in any way.

### 4.4 Safety

Safety has been discussed in detail in pages 21 - 22

### 4.5 Respect and ensuring the dignity

All actions of the health care providers must be guided by the fundamental principle of respecting the survivor, her wishes, her rights and her dignity.

Most survivors of GBV/DV such as rape or domestic violence have gone through a demeaning and degrading experience often over a long period and frequently blame themselves for the violence.

Their self-esteem is likely to be very low and if the words or actions of the care provider show any disrespect it is likely to affect the survivor drastically leaving her in a very negative mindset which will affect rehabilitation.

Such inappropriate communication or behaviour will lead to secondary victimization in which service providers, rather than supporting the healing process, may further delay recovery and add to the suffering of the survivor.

Respecting a survivor means respecting her choices such as: not to separate from a violent partner or report to Police. Always make sure that your actions and behaviour are guided by what the survivor wants, which may not be what you think is appropriate or the best course of action. Health professionals should not blame a survivor for violence at any point and for any reason.

Health care providers also need to ensure that all procedures including examinations are done respecting the dignity of the survivor. All health facilities should try to make female examiners available wherever possible for examining survivors of rape or sexual abuse and making examinations and all procedures least embarrassing to the survivor. Safeguarding survivor's dignity is closely linked to measures aiming at ensuring privacy, in waiting areas, toilet and washing facility.

<sup>81</sup> Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia Resource pack 2.5 Principles and standards of service provision. <http://www.health-genderviolence.org/guidance-for-health-care-professionals-in-strengthening-health-system-responses-to-gender-based-vi-9>

## Guiding principles derived from ethical principles and human rights standards contd.

### 4.6 Human rights approach

Gender-based Violence has been recognized as a violation of human rights; Right to freedom from discrimination, Right to life, Right to integrity and security of the person, and Right to the highest attainable standard of health<sup>82</sup>.

Under human rights treaties that Sri Lanka has signed, there is a responsibility to prevent, investigate and punish all forms of violence against women. It is necessary for health care providers to understand that it is the right of every survivor to receive appropriate treatment and care without being blamed or shamed and looked after with understanding and empathy.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) which Sri Lanka has ratified, states that government should offer women-centred care in the form of acceptable health services –that “are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives”<sup>83</sup>

### 4.7 Gender sensitive approach

Gender sensitivity means being aware of how differences in power between women and men determine the way they treat each other, their access to resources to protect their health, and how the health system treats them.

It is important to understand that:

- violence against women is rooted in unequal power between women and men
- that women may have less access than men to resources such as money or information
- they may not have the freedom to make decisions for themselves
- women may be blamed and stigmatized for violence and may feel shame and low self-esteem<sup>84</sup>.

Health-care providers need to have a clear understanding of the gender-based nature of violence against women.

Health Services therefore need to demonstrate an approach which take into account the needs of specific groups of women and girls who are more vulnerable such as:

- those belonging to marginalized groups
- women with physical or mental disabilities
- women living in rural or remote areas/ estate areas/ conflict affected areas
- pregnant women and women with young children
- lesbian and bi-sexual women
- transgender persons
- sex workers
- girls and adolescent women

Women belonging to these groups may face an increased risk of experiencing violence: perpetrators often choose them as targets because they know that these women are less likely to be able to defend themselves, or seek prosecution of the perpetrator.

<sup>82</sup> Responding to intimate partner violence and sexual violence against women WHO clinical and policy guidelines, WHO 2013 ISBN 978 92 4 154859 5

<sup>83</sup> CEDAW General Recommendation 24, para 22

<sup>84</sup> Health care for women subjected to intimate partner violence or sexual violence; A clinical Hand book WHO WHO/RHR/14.26



## Guiding principles derived from ethical principles and human rights standards contd.

### 4.8 Consent

Provision of clinical care including GBV/DV care needs informed consent. Informed consent is the voluntary agreement of an individual, who is legally able to give consent for participating in clinical care. The legal age of consent for obtaining clinical care varies across countries and in Sri Lanka it is 18 years. To be able to provide informed consent, the individual must be of sound mind and be provided sufficient information (and in language that is understood by the survivor).

The individual must also have the capacity to know and understand the nature of care being offered and its benefits and consequences.

Information provided:

- all available options and their benefits and consequences,
- an explanation of the procedures, methods of examination : what will happen to them;
- information about their right to refuse any part of the care/ examination
- information about what will be shared and with whom and limits to confidentiality.

Parents or legal guardians are typically responsible for giving informed consent until their child or adolescent is 18 years. However, in situations where it is in the best interests of the child or adolescent, informed consent should be sought from that child or adolescent.

Always obtain patients' consent prior to each aspect of the examination (use the Consent Form Annexure I);

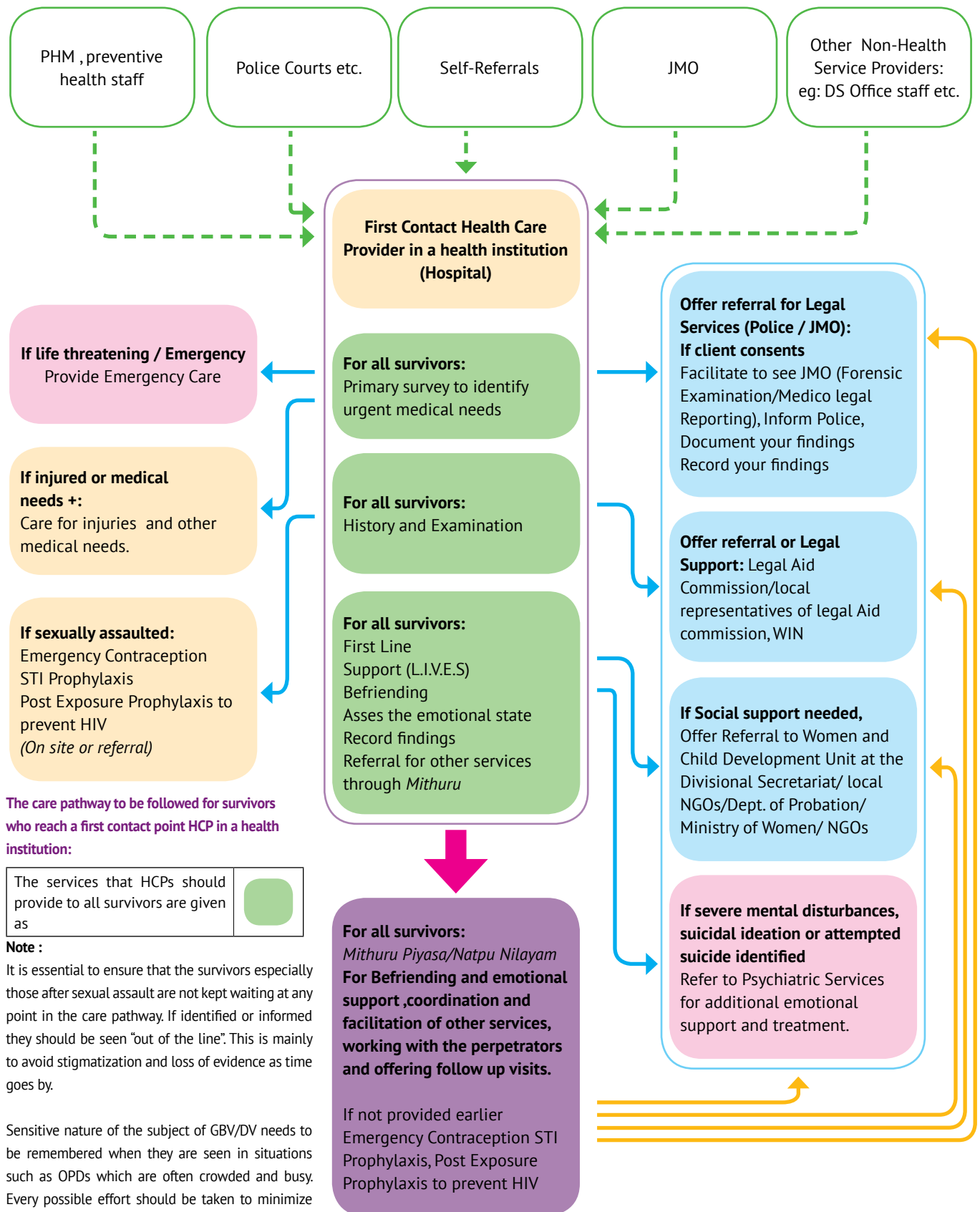
Explain and obtain informed consent for each aspect:

- medical examination
  - treatment
  - forensic evidence collection
  - for the release of information to third parties, i.e. police and courts.
- For each aspect of the exam, invite her questions, and answer fully. Make sure that she understands. Then, ask her to decide yes or no. Tick the box on the form.
  - Once you are sure that she has understood the exam and the form completely, ask her to sign.
  - Ask another person to sign the form as a witness, if required.

(Sample consent form is given as Annexure I)

## 5. Pathway of care for survivors of GBV/DV

### 5.1 For First Contact Health Care Providers in Hospitals



The care pathway to be followed for survivors who reach a first contact point HCP in a health institution:

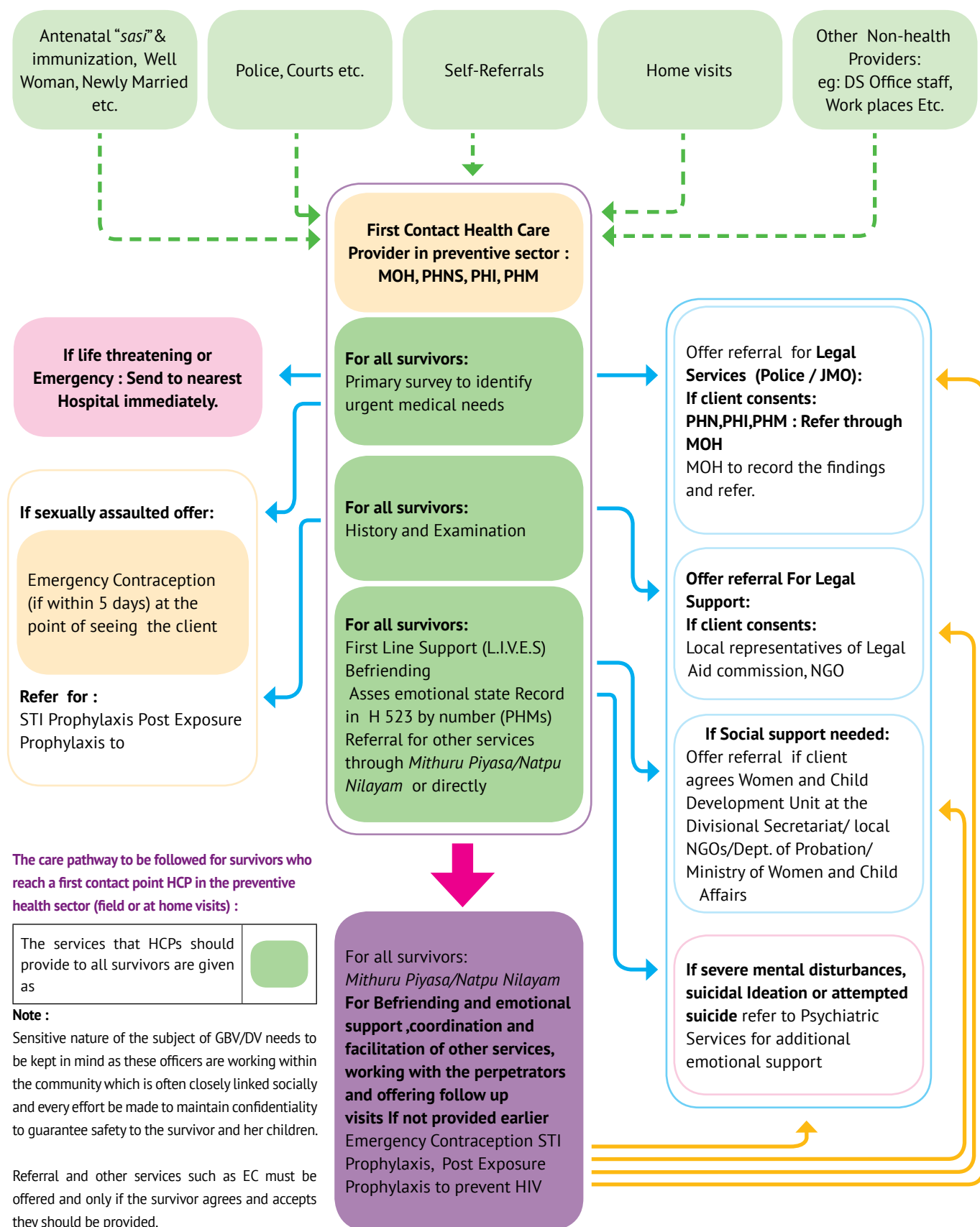
The services that HCPs should provide to all survivors are given as

#### Note :

It is essential to ensure that the survivors especially those after sexual assault are not kept waiting at any point in the care pathway. If identified or informed they should be seen "out of the line". This is mainly to avoid stigmatization and loss of evidence as time goes by.

Sensitive nature of the subject of GBV/DV needs to be remembered when they are seen in situations such as OPDs which are often crowded and busy. Every possible effort should be taken to minimize the embarrassment and discomfort that the survivor is likely to encounter.

## 5.1 For First Contact Health Care Providers in Preventive Sector.



## 6. Referrals

Survivors of GBV/DV have multiple and complex needs. In addition to medical care which can be within or outside the particular health institution, they need psychosocial counselling, police protection and/or legal advice or safe temporary accommodation. It is virtually impossible for health institutions to provide all these at the same time. Therefore, an effective response to GBV/DV requires the support of other actors providing different services of required quality and specialization.

Referral is an important step in case management as a part of multi-sectoral response and an important prerequisite for management of GBV/DV is the existence of an institutionalized referral mechanism<sup>85</sup>.

Referrals in general describe the process of a survivor getting in touch and obtaining services of an individual professional or a dedicated clinic or an agency such as Police. It also includes how professionals and institutions communicate with each other and work together to provide the survivor with comprehensive and all-inclusive support.

Partners in a referral network usually include different government departments (health or non health), women's organizations, community service organizations (CSO) and others.

As a principle of good clinical practice, referrals should happen with the consent of the survivor concerned. However, in some specific instances it may be justified that referrals to an agency such as police should occur even without the survivor's consent: in cases where her life is at a considerable risk, when there is a high risk of suicide or a substantial threat of being killed.

Referral systems benefit both the patient who experienced GBV/DV and the health care provider. Guiding a survivor through a referral system enables her to access comprehensive and specialized care and support, tailored to her individual needs.

From the perspective of health care professionals, the establishment of clear and simple referral routes can offer relief to their daily work load, as they can count on support provided by other referral partner agencies; can increase the confidence of health care professionals to ask about violence, enables them to effectively act upon the identification of a survivor of GBV/DV.

Unfortunately some survivors do not comply with the referrals from health-care providers.

### Tips on giving referrals<sup>86</sup>

- Be sure that the referral addresses her most important needs or concerns. She may not prioritize her needs in the way you do.
- If she expresses problems with going to a referral for any reason, think creatively and try to find solutions rather than going on emphasizing the need.  
eg: - no one to leave the children with  
- partner might find out and try to prevent it  
- doesn't have transport.
- If she accepts a referral, here are some things you can do to make it easier for her:
  - tell about the location, how to get there, whom to see
  - offer to telephone to make an appointment if this would be of help ( she may not have a phone or a safe place to make a call)
  - if she can't remember, only provide the written information that she needs – time, location, how to get there, name of person she will see. Ask her to think how she will make sure that perpetrator does not see the paper.
  - if possible, arrange for a trusted person to accompany her on the first appointment.
- Always check to see if she has questions or concerns and to be sure that she has understood.

<sup>85</sup> Strengthening response to GBV in Eastern Europe and Central Asia. WAVE & UNFPA

<sup>86</sup> A clinical handbook; Health care for women subjected to intimate partner violence or sexual violence WHO 2013: WHO/RHR/14.26

## Referrals contd.

Sharing information even for the purpose of referral is a highly sensitive issue. Healthcare provider is responsible for protecting GBV/DV victim's confidentiality. At the same time sharing information with other agencies can be crucial for ensuring further assistance provided to GBV/DV survivors.

### Referral for legal services:

- Police : This should be done with the consent of the survivor except in situations mentioned earlier. Mandatory reporting of violence against women to the police by health service providers is not recommended by WHO<sup>87</sup>. Health service providers should offer to report the incident to the appropriate authorities, including the police, if the survivor wants this and is aware of her rights.
- Other Agencies providing legal assistance: Legal Aid Commission, Women in Need and Complaints centre at the Ministry of Women and Child Affairs (Hot Line 1938)

### Referral for psychosocial support:

- *Mithuru Piyasa/Natpu Nilayam* for befriending and basic emotional support
- NGOs such as Sarvodaya and Women in Need, Complaints Centre at Ministry of Women and Child Affairs and other local organizations
- Specialist psychiatrist, psychologist and professional counselors where available
- Medical Officer Mental Health and the Counselling Assistant attached to the Women & Child Development units at the Divisional Secretariat Offices

### Social / Economic Support:

- Officers attached to the Women & Child Development units at the Divisional Secretariat

Women and Child Development Units have been setup in all 25 districts at Divisional Secretariat level. This process began in 2013. The units have a staff of 5 – 6 officers appointed:

Child Rights Promotion Officer

Women Development Officer

Relief Sister

Psycho Social Assistant

Counselling Assistant

Early Childhood Care and Development Officer

List of contact numbers of some of the key referral agencies are given as Annexure II and III

<sup>87</sup> WHO Policy Guidelines Recommendation 36 and 37

## 7. Prevention of GBV/DV

An effective response to Gender based Violence (GBV) is complete when there is a strong GBV prevention component included. There is growing consensus and evidence that violence against women is predictable and preventable. When planning prevention of GBV it is important to focus on strategies that encompass all levels of prevention: primordial, primary, secondary and tertiary prevention.

Prevention of GBV/DV includes:

- Addressing gender discrimination and gender inequality which occurs as a result of unhealthy gender attitudes and gender stereotyping. (Primordial prevention)
- Creating an enabling environment where human rights are respected and power is not abused. (Primordial prevention)
- Stop violence before it occurs (Primary prevention),
- To minimize further violence after it occurs (Secondary prevention)
- Prevent complications of violence (Tertiary prevention).

It reflects promoting nonviolent relationships with mutual respect among men, women, families and within any community.<sup>88</sup>

Effective prevention strategies should strive to achieve following objectives:<sup>89</sup>

- Changing socio-cultural norms prevailing in communities, with an emphasis on ensuring non-discrimination and empowering women and girls.
- Strengthening families and community structures and support systems to address GBV/DV.
- Effective legal systems and policies that are established and implemented.
- Effective management of data on GBV/DV for advocacy and planning purposes.

Even though, all levels of prevention is useful in preventing violence, there are clear conceptual differences among these levels. In reality the levels are not rigid or mutually exclusive. Keep in mind that it is not always possible to distinct between them when applying to individual behaviour that takes place in social and cultural contexts. Many prevention programmes could include all three levels. They could even be mutually reinforcing the effectiveness of the other.<sup>90</sup>

Primary prevention cannot replace or be separated from responses to violence that has already occurred. Prevention and response strategies need to be part of an overall programme that ensure women's rights to live in violence-free societies, communities and families.<sup>90</sup>

### 7.1 Planning GBV/DV prevention programmes

Considering the current practices of the community health programme in Sri Lanka there are two ways in which GBV/DV could be approached:

1. The topic of GBV/DV prevention could be included in to existing Reproductive Health programmes at hospital and field level.  
E.g. Immunization, growth monitoring, ECCD, Family planning, YFS, IYCF, WWC programmes/clinics and the home visits that PHMs and other officers already involved to provide information/counselling on these topics.
2. Programmes exclusively to address GBV/DV could be implemented Eg: Organizing a GBV/DV prevention programme with adolescent groups and with mothers groups/fathers groups.

<sup>88</sup> Fergus, L. (2012) Prevention of Violence against Women and Girls. UN Women. <http://www.unwomen.org/wpcontent/>

<sup>89</sup> WHO (2009) Promoting gender equality to prevent violence against women, WHO Library catalogue

<sup>90</sup> Ministry of women's affairs (2013) Current thinking on primary prevention of violence against women, New Zealand government

## Prevention of GBV/DV contd.

Prevention activities should be aimed at women, men, youth and children in all communities where some of them may be potential GBV/DV survivors or perpetrators. As with all public health programmes prevention strategies are most effective when all sectors are involved in designing, implementing and evaluating them.<sup>91</sup>

Prevention of GBV/DV can be done aiming individuals, relationships, families, communities expanding up to larger societies.

In any preventive programme, one of the key activities to be undertaken in the beginning is to work out factors contributing to GBV/DV in the community.

**To PREVENT Gender-based Violence, you must identify, understand and address its CAUSES and CONTRIBUTORY FACTORS.**

### Working out contributory factors

Identifying the contributory factors (causes/determinants) of GBV/DV is an important step in all prevention programmes. Many factors contribute to GBV/DV by acting at different levels. Eg: Individual, family, community and society at large. Also, these factors are interlinked with each other, either proximally or distally and influence GBV/DV situation in the area. Ecological model<sup>92</sup> provides a very useful framework to understand these contributory factors which are operating at different levels. This understanding helps us to design useful interventions to address GBV/DV effectively.

<sup>91</sup> UNHCR (2001) Prevention and Response to Sexual and Gender-Based Violence in Refugee Situations.

<sup>92</sup> Heise L, et al., (2002) World report on violence and health. Geneva, World Health Organization.

## Prevention of GBV/DV contd.

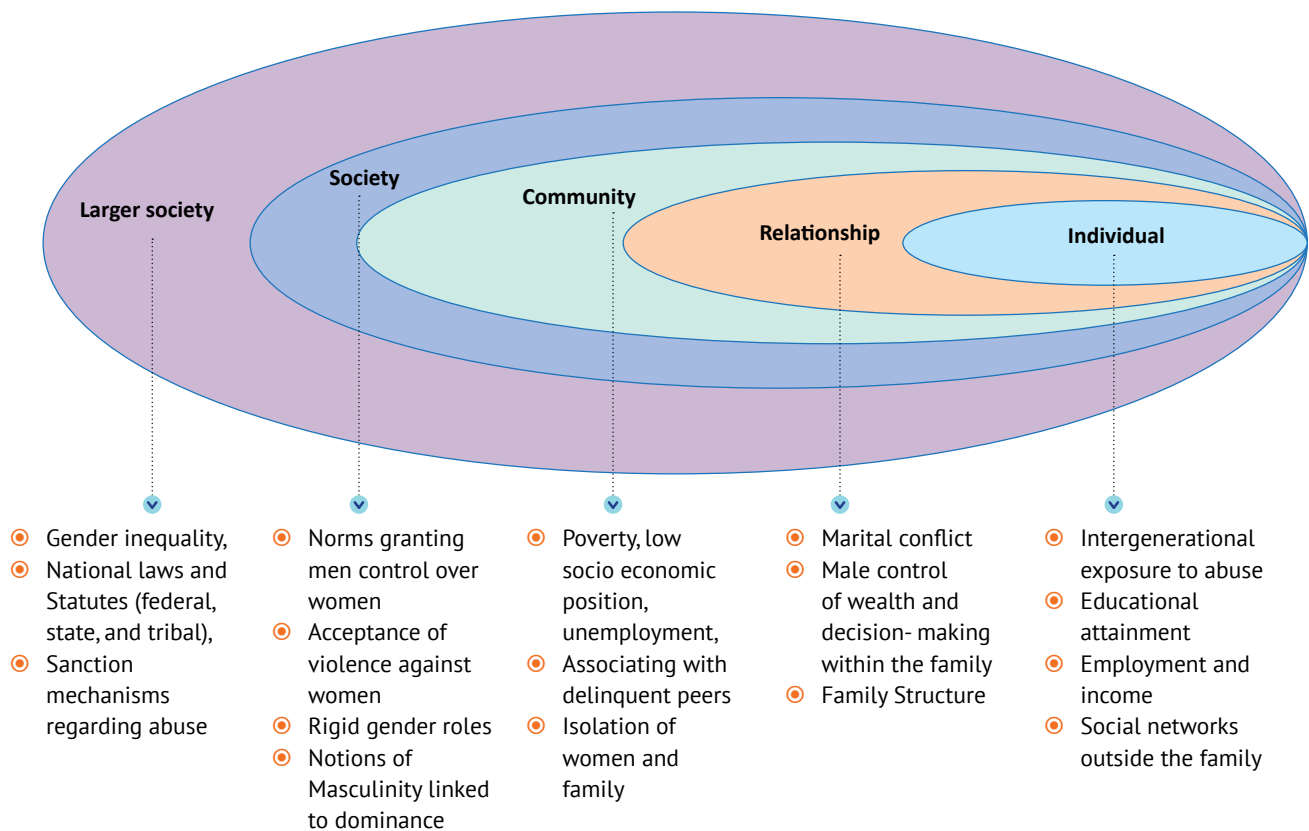


Figure 9 – Ecological model of the factors that contribute GBV/DV

During any preventive programme one useful initial task to identify contributory factors is to answer the following questions in relation to your area or community.

- What area the contributory factors for GBV in the area?
- What makes it worse?
- What can minimize it?

Initiate a dialogue with all target groups based on the answers of the above questions to identify the contributory factors and list them to be addressed in minimizing violence.

Common contributory factors are given below. It can be utilised to pick up important contributory factors at the discussion. This is intended to generate thinking about the possible factors. <sup>93</sup>

<sup>93</sup> Samarasinghe, D. (2006) Gender based Violence: Some suggestions for guiding action. FORUT



## Prevention of GBV/DV contd.

- Social approval or social encouragement of such violence
- Absence of any deterrent to violence
- Preventive efforts being undermined by a few individuals
- Preventive efforts focussing only on selected segments of the population
- The feeling in a community or neighbourhood that others should not intrude in a private or family matter
- The reluctance of those subjected to violence to report it
- Active pressure or threats that prevent violence being reported
- Accepting the excuse that alcohol use has led to the violent behaviour
- The perception that violence is common place or the norm
- Blaming the person who is subjected to violence as having provoked the abuser
- Lack of local social reprimands for individuals who are abusive
- Failure to recognize the extent of violence and its impact

Figure 10 - Possible contributory factors to gender based violence

Let the participants to debate on above factors, change them according to our collective opinion and produce our list of locally relevant contributors. We can try to set them in some order of importance or priority as well.

The discussion should focus on helping the community to understand these factors and look for ways to challenge them in their communities.

### ***Addressing identified contributory factors***

At this point it may be realised, that some of the contributory factors (E.g. : Active pressure or threats that prevent violence being reported) need immediate attention. As it can lead to life threatening actions such as committing suicides or homicides.

Whereas, most others can be addressed through systematic, sustained and well planned process targeting prevention.

### **7.2 Planning a sustained / long-term programme to address GBV/DV**

In general, sustained / long-term programmes are more productive than single short termed programmes. There is no single methodology that can work for all settings. Programmes have to be designed according to the nature of the contributing factors, target groups and local realities. However, there are some principles that could guide your planning.

#### *The importance of working at community level:*

There are many reasons why working with communities is also important other than working with individuals and families.

- The places or social contexts in which people engage in daily life affect health of individuals
- Influencing communities will have an impact over individuals too
- Cost effectiveness is more when we target communities.
- Coverage is more.
- Powerlessness, lack of control over destiny could effectively be addressed in groups/communities rather than at individual level.

Sustained / long-term programmes can be directed in two ways.

- A. Directly addressing GBV/DV as primary objective in a given community
- B. Addressing GBV/DV indirectly by targeting the contributory factors.

## Prevention of GBV/DV contd.

### (A) Directly addressing GBV/DV as primary objective in a given community

In most communities gender based violence results due to gender discrimination and gender inequality, abuse of power and lack of respect to human rights. As a result of this, women (rarely men too) are treated less fairly, differently and their rights are violated. Unhealthy gender attitudes and gender stereotyping which were acquired since birth leads to GBV.

#### **Gender Stereotyping** (Rigid gender roles and norms)

This means rigid male and female frames imposed by the society. If an individual fits on to this frame, society accept it, appreciate and reward. Those who are not fit on to this frame are punished and society acknowledges punishment. From birth, the environment starting from the parents begin to mould the girls or the boy to fit into the accepted gender frames (gender stereotyping).

#### **Abuse of Power**

There is a power difference between the two frames (parties). Even if there is a power difference they can live in harmony while respecting democracy. The party which has more power try to abuse their power and violence could occur.

#### **Human rights violation**

Any human has the right to live in an environment which is free from violence. If there is violence human rights are disrespected.

#### **Gender discrimination**

The roles, responsibilities, behaviour, expectations, limitations, privileges the society expects from the two parties (frames/groups) differ. This expectation is discriminating and harmful towards one group, usually the powerless group i.e. women. This creates gender inequality and discrimination.

People should be made aware on how the gender discrimination and gender inequality is created in their communities. Show how women suffer most of the negative impact of rigid gender norms and roles, how they are more likely to experience restrictions of their freedom and mobility, how they experience violence and harassment and have fewer opportunities to choose how to live their lives. The normalization of harassment and inaction of community members and authorities perpetuate this form of discrimination and GBV.

People need to be capacitated to address factors such as gender norms prevailing in their communities which grant men control over women, rigid gender roles existing in the society and acceptance of violence against women.

As mentioned above when trying to minimize GBV/DV in selected communities there can be no fixed steps that we implement rigidly. The dialogue with the community groups started can be taken forward by identifying activities to be implemented. These activities can be modified according to the feedback we get as we continue to assess the ongoing results of our actions.

The final goal of these actions would be to create an environment free of GBV.

## Prevention of GBV/DV contd.

### (B) Addressing GBV/DV indirectly by targeting the contributory factors

In this approach the intention is to directly address important determinants of GBV/DV in respective communities or groups. Eg: Addressing alcohol use of a given community.

Identification of main contributors to GBV/DV is usually done with the community. Along with the members of community /group try to figure out how these can be changed. If discussed openly and widely, that alone is likely to lessen their negative impact. A powerful contributor to the success of community efforts in combating GBV is unmasking factors that encourage it.

It is also important to discuss with them the ways to measure progress. This kind of planning and discussion a major part of the intervention. These plans must be considered as tentative which could be modified according to the feedback as the plan progress.

Note: *Systematic planning as described is especially important when MOH is training and supervising her staff. Promote the staff to carry out programmes that continue rather than one off awareness sessions on GBV/DV.*

### 7.3 Implementing GBV/DV prevention programmes

Irrespective of the approach following common steps can be useful in carrying out GBV/DV prevention programmes. For better results, there are four major steps that we should adhere to in implementing a GBV/DV prevention programme.

- i. Creating an ongoing process rather than one-off events to address GBV/DV in a given community
- ii. Giving control of the activities to the people/community concerned.
- iii. Identifying and addressing contributory factors/determinants using relevant activities
- iv. Measuring progress along the programme using sensitive indicators

#### i. Creating an ongoing process with target groups /communities to address GBV/DV in a given community<sup>94</sup>

A process is considered as set of activities directed towards enabling individuals and groups to take action. This is done with the target group / participants of a training and not just advising them to do what is best.

Initiating a dialogue with all target groups/communities that you work, is the way to initiate such process. There are several key features of such process.

- ⦿ Any process is directed towards a goal. Discuss with all target groups the goal they need to achieve during the initial stage. Eg: *Minimizing GBV/DV, Improving happiness within the families, etc. Help them to focus on a more sensible target if the goal they chose to achieve seems unrealistic.*
- ⦿ You can help them to initiate the process through shared assessment of the GBV/DV situation of their village/ community. Ask questions to understand the current situation. Eg: *Do you know what percentage of women in your village is subjected to violence?* It is acceptable even if they don't know the right answer as this could initiate and guide the process to work on GBV/DV.
- ⦿ People should understand why they need to do something about the 'GBV/DV/DV'. This is also a way of educating the groups on GBV/DV and could be initiated by asking whether they know the effects of GBV/DV/DV.

#### ii. Giving control of the activities to the people/community concerned

As discussed in the above section usually actions should be carried out by the people themselves and they should feel that they are a part of the actions carried out. Health Care Person should only guide the community members to come up with actions and solutions to GBV/DV in their locality. This ensures more control over the activities they want to carry out and to address GBV/DV and related problems.

<sup>94</sup> Samarasinghe, D, Guruge, D, Fernando, WMS, Amunugama, S. and Indrawansa, S. (2012) Health Promotion Process, Sri Lanka Medical Association

## Prevention of GBV/DV contd.

Adhering to this approach will facilitate a smooth and efficient progress through continuum of community empowerment. Giving orders and advises would hinder this process hence may not empower the community members, mainly women.

### iii. Identifying and addressing contributory factors

This is the next stage of implementation. Helping them to identify correct determinants of GBV/DV in their communities and identification of suitable activities to address these determinants is expected in this stage.

The main outcome of these discussions has to be our conclusions on what factors contribute most strongly to GBV/DV in our community. In many instances, people do not really come up with suggestions until someone offers examples. Therefore, we need to give our own examples for people to think about.

For successful action to result, people must see that the suggested contributors are relevant to their setting too. Such decisions are best reached by keeping a dialogue going among members of the community. After a few rounds of conversation with a few members, the ideas shared tend to spread among the rest of the community too. The next step is to start discussing how to address the selected determinants.

Better to take as examples some of the contributors listed previously, for the purposes of discussion here. Eg: Assume following factors were selected as the most important contributors in a given community.

1. The feeling among people that they have no right to intervene, even when they know of serious abuse, because it is a private or 'family matter'.
2. The acceptance of abuse due to the idea that the perpetrator is not to be blamed, because he had consumed alcohol before the event.

#### *How we reduce the power of these two contributors?*

The first is more difficult to deal with than the second. None of us would like to have others interfering in family matters. Therefore, the feeling that we should not interfere even if there is abuse happening is widespread. People who inflict violence within the family are thereby 'protected' from lack of interventions from the rest of the society. The second contributor, the 'permission' to be violent after consuming alcohol, may be easier to counter.

If we are to address GBV/DV that happens mostly in the privacy of homes, we have to make this the subject of shared attention. We can discuss with the community on how to overcome this obstacle to reduce GBV/DV in our community. Then they can, as a community, start working out answers for this. Similarly, we can try to figure out ways to disallow alcohol use being accepted as an excuse for violence.

Generating discussion within the community about how to address these determinants is itself an action. It leads to the determinant being addressed simply by having attention drawn to it. A second action is to assess how strong the determinant is. Measurement can also serve as a means of stimulating change. When we assess the present situation and provide feedback, people begin to recognize a feature about their community that they had not previously noticed.

#### *How to assess the severity or intensity of factors such as the two that we have selected?*

If we take the first, the task is to see how we can measure the strength of the feeling or opinion that we cannot do anything to prevent GBV/DV because it is a family matter. One way to assess this is to ask people how strongly they feel that any abuse inside a family has to be allowed to continue because it is a private matter for that particular family. When we have the answers of several people, we can provide feedback to our community that this is what we collectively think.

Community then have to figure out how to overcome this influence in order to reduce violence.

Questions to ask would be:

- Should we allow violence to continue, if no family member asks for help, even if we can very well see it happening?
- Is it correct to accept alcohol use as a reason to excuse someone for cruel or violent behaviour?

## Prevention of GBV/DV contd.

*We can gradually extend the dialogue further:*

This dialogue would help the community/groups to recognize many things about GBV/DV and the relationship with determinants. One is that individuals who abuse others after the consumption of alcohol usually select their targets intentionally. It appears that they exert a fair degree of selection about whom to attack or abuse after drinking.

A further step in this kind of dialogue may be that some members of the community decide Eg: *How to stop violence within families? How to refuse people who misbehave after consuming alcohol?*

More direct action then begins to flow. One step maybe that a few people start to say publicly that we should not allow violence within households or that those who have consumed alcohol should no longer be allowed to get away with indecent or violent behaviour.

The change in public perception or mood is thereby gradually converted to small actions.

If we go back to the list of suggested factors that probably contribute to GBV/DV, we can see that many of them are prevalent in society in general. Therefore, the response we need is not only in selected communities where we want to intervene. These determinants need to be addressed across the entire society. *Use all opportunities as a community health worker to address this whenever possible.*

### iv. Measuring progress along the programme using sensitive indicators to guide action

Further progress is enhanced if we are able to re-assess the situation with regard to the actions. What needs to be measured is not just the number and severity of incidents of violence but whether chosen determinants are changing as well.

Therefore, need to keep checking, for example, whether alcohol use as an excuse for violence is now less acceptable. Similarly, we can verify whether the attitudes such as *'we should not passively allow violence to continue within families'* is progressing.

If we regularly monitor, the change of mood in the community over time could be observed. This changed mood gets communicated to the individuals who most often carry out acts of violence too. Resultant change in behaviour has been well recorded when a community refuses to accept alcohol use as an excuse for violence. When the public perception changes, allegedly alcohol induced violent or aggressive behaviour does change, even though the person may continue to drink.

### 7.4 Dealing with perpetrators in the community

The number of individuals who commit GBV/DV decreases as the impunity with which the society treats the subject changes. The preceding sections dealt with changing the social milieu in the direction of more strongly rejecting GBV/DV. The more successful these efforts are the lower will be the proportion of the population that resorts to GBV/DV.

Communities can work out how to convey the message to perpetrators of violence in the most appropriate way. The feeling that others are observant is a powerful deterrent to most forms of unwholesome conduct.

### 7.5 Dealing with media portrayals

Gender-based violence is reported by the newspapers, television and radio on a daily basis. In one way it is a sign of recognizing the problem but it is also promote GBV due to the manner in which the media report on this issue. Media frames family violence, sexual assault and sexual harassment without evidence and knowledge about the real contributor rather promoting behaviours and attitudes lead to GBV. Such reports could promote GBV and impede actions of protecting women from violence.

Apart from the news media, social media and the internet recently have come into the seen by prompting myths and stereotypes that create new forums for the perpetuation of GBV.

## Prevention of GBV/DV contd.

Following are some of the recent examples from Sri Lanka which commonly promoted GBV and related factors through different types of popular media.

- Just highlighting the individual cases frequently without focusing on how GBV is taking place in a given society and where to look for help.
- Victimization of the woman through news, articles and social media posts
- Re-establishing the myths around GBV and its causative factors news, articles and social media posts
- Establishing gender norms and gender attitudes
- Photographs of GBV survivors (mostly women) used to illustrate GBV
- Giving priority to physical and sexual violence reporting
- Glamourizing the acts of violence mainly perpetrated by men
- Undermining effective preventive efforts through social media posts and some newspaper articles
- Not highlighting the determinants of GBV

Portrayals in the media as mentioned above lead to greater resort to violence. Interventions to reduce GBV/DV cannot ignore this pervasive influence of the images created by media portrayals on GBV. The way media tacitly encourage violence could immunize communities against GBV and influence our norms and attitudes on gender and GBV/DV.

Helping communities to take necessary steps to respond and correct how media reports and thereby promote GBV/DV in our communities is utmost importance. The health care worker could use examples of paper articles or recordings of such examples to make the fellow health care workers and participants aware. Then discuss the actions to address these with them. Support the successful ideas and how to measure the outcome of what they did.

### 7.6 Promoting 'Happy Family' concept

During awareness sessions, and organized community programmes, the health care worker can introduce this topic to promote family wellbeing as a way of achieving a violence free family environment.

A 'Happy Family' is usually considered as a family that is free from violence and many other negative behaviours and characteristics. There are certain qualities that a family should strive to achieve to become a happy family, and the intention of this concept is to ensure that each and every family member is happy and all of them work towards identifying and changing the factors which control happiness of a family. Create an awareness among families about this concept where and whenever possible.

Some of the qualities of a 'Happy Family' are listed below,

- i. Free from any form of violence
- ii. Male participation and shared responsibilities
- iii. Healthy and strong interpersonal relationship among the members of the family
- iv. Mutual support and protection among the members of the family
- v. Empathy towards each other
- vi. Free from alcohol, tobacco and other substances
- vii. Happiness within all members of the family
- viii. Children are well protected
- ix. Clean home environment

This is a list of general factors. Develop a list according to the target group you work with. The same process which was discussed above could be adopted to help families to work towards a 'Happy Family'. During the initial phase ask from all members 'how a happy family looks like?' This would help to develop targets or characteristics of a 'Happy Family' that they want to create. Some of the qualities mentioned above could be added to the proposed list.

## Prevention of GBV/DV contd.

When helping the family members to address determinants of 'Happy Family', focus on identifying the factors that influence well-being of families. Some of the determinants are as follows,

- i. Violence (GBV/DV)
- ii. Alcohol use and related behaviour
- iii. Unhealthy gender attitudes
- iv. Money spent on alcohol, tobacco and other substances
- v. Poor financial management in the family (purchasing unwanted stuff even when money is scarce)
- vi. Unsatisfied sexual relationship of the couple
- vii. Pressure on children for studies by parents
- viii. Unrealistic expectations from family members towards each other
- ix. Negative behaviours affecting normal life style. (Eg: Dependency on TV, Social media)
- x. Unacceptable limitation of freedom for each individual
- xi. Controlling behaviour of the husband or one of the family members.

Addressing some of the above determinants could be done by initiating a continuing dialogue with them. Some of the key steps of such a discussion can be summarized as follows.

1. Ask them to identify the characteristics of a '*Happy family*'. This can also be done by asking their views on how a '*Happy family*' looks like through interactive sessions.
2. Then complete the picture by adding your suggestions on characteristics of a '*Happy family*'. This would help them to see the unseen features of a '*Happy family*'.
3. Ask them to mention the reasons or factors that could have an impact on family wellbeing. This step would help them to think and then understand how certain factors influence family wellbeing both positively and negatively.
4. By facilitating these dialogues, try to identify factors such as domestic violence, alcohol and tobacco use, poor money management, media influence, and poor relationship between both father and the mother as key factors which negatively influence family wellbeing and happiness.
5. Help them to analyze above factors to identify how each of these factors operate at different levels.
6. Then discuss things they could do both individually and collectively to convert their family to a happy family. Emphasize the importance of addressing such factors in order to improve family wellbeing.
7. Identify suitable and sensitive indicators to measure their actions. Better if you can help them to identify simple indicators where they can use at their level to measure both process and the outcome.
8. Review above steps to see whether they have followed the steps and help them to improve further. Your role as a facilitator would be useful in helping these community groups to improve progressively.

There are many simple and effective tools and interventions shown to be effective in addressing family wellbeing. A tool such as '*Happiness calendar*'<sup>95</sup> or tool to measure regular expenditures of the family such as money spent on alcohol would be helpful to carry out targeted interventions to promote a happy family.

A '*Happiness calendar*' is practiced by marking the level of average emotional state of each family member usually by a child at home (Even adults can do this if they want.) This helps to improve family wellbeing by measuring the changes of emotional status of each family member ideally daily and to take necessary actions to address issues within the family whenever negative emotional status were recorded.

<sup>95</sup> Department of Health Promotion, Rajarata University of Sri Lanka, 2015


















## Prevention of GBV/DV contd.





'Happiness calendar' depicts the perception of the child on different emotional status of family members. It also shows how sensitive children are for different emotional status of family members and the impact on them. There are four major emotional status focused when marking this tool. Since there is no static emotional status throughout the day, guide the families and children to use this appropriately by marking the predominant emotional status of the day of each family member. After a week or a month or even daily, the family members could initiate a dialogue based on the status of different 'faces' of each individual family member in the calendar to identify the underlying reasons. Then the family should be able to discuss and take appropriate measures to address these reasons. Health care workers are in a better position to help families to identify appropriate interventions to address these reasons. Eg: Gender attitudes and GBV in a family.

If a family decide to practice 'Happiness calendar' as a tool to improve family wellbeing, most of the members in that family should participate in this activity and guide the child in carrying out this task effectively.

*Example of a 'Happiness calendar'*

Date of the month	Mother	Father	Brother	Sister	Me
01 / March					
02 / March					
03 / March					

### Key to mark the calendar

Happy face (positive emotional state)	- 
Sad face (negative emotional state)	- 
Angry face (negative emotional state)	- 
Average face (not sure about the emotional state)	- 

Similarly get them to address important other determinants of family wellbeing by adopting a similar approach mentioned above through relevant and effective activities. It is important to help them to measure regularly whether these determinants change positively resulting in enhancing wellbeing of the family



## Prevention of GBV/DV contd.

### 7.7 Promoting male participation

The focus on men's responsibilities in sexual and reproductive health, along with their roles in families and their participation as fathers, is increasing worldwide.

One of the main reasons for men's limited involvement in their children's affairs results from socialization and social construction. Girls and boys learn their gender specific roles from a very young age. Boys and men assume the role of protectors and providers, leaving household work and child rearing for girls and women.

While some researchers suggest that women are biologically adjusted to their children's needs, there is a growing consensus that child care is an acquired skill that girls learn at a very young age. Research also shows that if given a chance, boys and men can also demonstrate the same skills.

The present consensus among the professionals all over the world now is that men's participation as fathers, as co-parents and their role as partners of women, in domestic chores, child care, and childrearing do matter. Some studies have suggested that father's presence and participation is associated with higher attainment of school degrees, in the case of boys.

Men, who are involved with their children in meaningful ways, are of the opinion that this relationship is one of their most important sources giving a sense of well-being and happiness. Various qualitative studies and accounts of men from around the world suggest that men, who are engaged in caring and care-giving relationships, including fatherhood, may be less likely to engage themselves in certain risky behaviour types such as criminal activity. This provides men with a powerful, potential motivation for them wanting to become more involved as fathers. In some other instances, we observe that some men, who may have had only limited interaction with their children in the past, become affectionate grandfathers.

There is evidence, worldwide, that men's active and non-violent participation in the care of children is quite beneficial for children, for the women and for the men themselves. Children of such fathers show better health and developmental outcomes. According to some studies, men who develop positive connections with their children have less mental health problems.

Fatherhood needs to be addressed in conjunction with motherhood, and in the wider context of the family. It cannot be addressed in isolation. It further relates to the larger issue of masculinity and manhood. In order to change traditional notions of fatherhood, self-interest of men and boys in being better fathers needs to be emphasized.

It is essential that we tap men's self-interest on being caring fathers. When men agree that they want to play an important role in the lives of their children the chance of resistance from them are minimal. It is also the fathers' self-interest that having a close relationship with their children will make the children perpetuate their ideals and values.

## Prevention of GBV/DV contd.

Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning, maternal and child health, prevention of sexually transmitted infections including HIV, shared control and contribution to family income, children's education, health and nutrition. Male responsibilities in the family life should be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.

To create a more gender equitable society, we need to work with fathers at home and address the prevalent socialization process, which can make boys prepared for a more caring fatherhood. This intersects with child development as boys and girls gain high self esteem from a secure family environment where both mothers and fathers are involved in child rearing. As such, when fathers participate in child care, there are positive outcomes for children, family, society and the father himself. Working on fatherhood is an effective and a long term investment towards creating a gender equitable and a gender just society.

We need to reinforce the positive forms of fatherhoods that exist in the society, where fathers do care and nurture – we need to promote these practices and make them visible, so that more men/boys take pride in family care and nurturing. Finally, we need to encourage men and boys who are gender sensitive and understand and take responsibility towards their children. Indeed most men want to support their children in multiple and meaningful ways and have the potential to do so. Such men do exist amongst us; the challenge is to identify them, as they often hide behind the facade of societal expectations.

In every society, even where strict gender norms exist, there are voices of men who are willing to take on concerns affecting women and children. The challenge is to find these voices as they can become our entry points in many cases.

At the same time, we need to be realistic, as we cannot pretend to dissolve tradition that is thousands of years old. We need to celebrate small successes. This is an up hill task that requires commitment and resolve, along with a clear strategy.

Community and society at large must be sensitized and made aware of the problem of gender based violence prevalent in Sri Lanka. To begin with, society in general must be educated on the fact that domestic violence is a social issue and not a private one. Health workers should take the initiative and leading role for building up of a non-violent culture. The valuable contribution of the primary health care team is essential, so as to achieve the target of a healthy nation through a violence free culture.

## Prevention of GBV/DV contd.

### Benefits of Male Participation

- ⦿ Enhances the household security in every aspect.
- ⦿ Improves peace and harmony in the family.
- ⦿ Increased health and happiness in the family.
- ⦿ House becomes a pleasant place to live in for all members of the family.
- ⦿ Man gets a mental satisfaction because his services are appreciated.
- ⦿ Improvement of health status and educational status of the children.
- ⦿ Improvement of the nutritional status of the family.
- ⦿ Improvement of family welfare, since correct and collective decisions are taken regarding family matters.
- ⦿ Boosts the spiritual health of the family.
- ⦿ Prevention from sexually transmitted diseases such as AIDS.
- ⦿ Prevention of unintended and unwanted pregnancies and thereby prevention of abortions.
- ⦿ Enhances the mental and social development of children.
- ⦿ Family requirements could be fulfilled easily and successfully.
- ⦿ Can set an example to other families.
- ⦿ Would have a good reputation and acceptance from the society.
- ⦿ Able to have the desired number of children with adequate spacing.
- ⦿ Improved economic status of the family.
- ⦿ Self-satisfaction with regard to good parenthood/ fatherhood.

### Factors that hinder male participation

- ⦿ Men think that engaging in household chores is an insult to manhood.
- ⦿ Societal belief that household chores are only the sole responsibility of women.
- ⦿ Influence of elders, parents etc.
- ⦿ Negative attitudes of friends/peers.
- ⦿ Some women not wanting to get the support of men for their work.
- ⦿ Sometimes work done by men are not appreciated and valued by women.
- ⦿ Men's unawareness about the day to day happenings at home. E.g. If he has not experienced male participation for household chores during childhood
- ⦿ Feeling and understanding that child rearing is only the responsibility of the woman.
- ⦿ Inadequacy of time for the male to participate in household chores.
- ⦿ Traditional societal myths and beliefs.
- ⦿ Domestic violence.
- ⦿ Alcohol and drug abuse.

## 8. Prevention of Domestic Violence Act 2005 and legal assistance to survivors of GBV/DV

### Legal aspects and the Prevention of Domestic Violence Act 2005

Prevention of Domestic Violence Act, No. 34 Of 2005<sup>96</sup> was promulgated for the explicit purpose of prevention of domestic violence and does not prescribe any punitive action against the perpetrator. At the time of submission of the bill much skepticism was expressed that it will lead to disruption of the integrity of the family but experience thirteen years later it turns out to be a myth.

Prevention Of Domestic Violence Act, No. 34 Of 2005 was promulgated for the explicit purpose of prevention of domestic violence and does not prescribe any punitive action against the perpetrator. At the time of submission of the bill much skepticism was expressed that it will lead to disruption of the integrity of the family but experience thirteen years later it turns out to be a myth.

The act defines “domestic violence” as (a) an act which constitutes an offence specified in Schedule I; (b) any emotional abuse, committed or caused by a relevant person within the environment of the home or outside and arising out of the personal relationship between the aggrieved person and the relevant person. The schedule 1 includes offences contained in Chapter XVI of the Penal Code, Extortion-Section 372 of the Penal Code and Criminal Intimidation-Section 483 of the Penal Code.

Violent acts physical, or sexual or emotional that are accepted as criminal offences in the law when committed in a domestic relationship are applicable to this Act. In addition for acts included in the Penal Code the survivor of DV may seek legal redress under the criminal law.

It is important to note that emotional violence has been included as an offence in this act. “emotional abuse” means a pattern of cruel, inhuman, degrading or humiliating conduct of a serious nature directed towards an aggrieved person. The Magistrate can use his discretion when entertaining the application to issue an interim order.

An application under this Act can be made by an aggrieved person i.e. the survivor directly through a lawyer to the magistrate or through the Police. Where the aggrieved person is a child, by a parent or guardian of the child, a person with whom the child resides, a person authorized in writing by the National Child Protection Authority established under the National Child Protection Authority or by a police officer on behalf of an aggrieved person.

The aggrieved person /survivor/victim can apply for an interim order from the Courts preventing further violence from the “relevant” person.

“relevant person” includes: (i) the spouse; (ii) ex-spouse (iii) cohabiting partner, of an aggrieved person; (iv) the father, mother, grandfather, grandmother, stepfather, stepmother (V) the son, daughter, grandson, granddaughter, stepson, stepdaughter (VI) the brother, sister, half-brother,

half-sister, step brother, step-sister (vii) siblings of a parent (viii) the child of a sibling (xi) child of a sibling of a parent, The law covers a very wide group but in this Guideline our concern is violence by the spouse, exspouse or the cohabiting partner.

<sup>96</sup> Printed on the Order of Government PREVENTION OF DOMESTIC VIOLENCE ACT, No. 34 OF 2005 2005  
[http://www.childprotection.gov.lk/Child\\_Related\\_ACTs/Prevention%20of%20Domestic%20Violence%20Act,%20No.%2034%20of%202005.pdf](http://www.childprotection.gov.lk/Child_Related_ACTs/Prevention%20of%20Domestic%20Violence%20Act,%20No.%2034%20of%202005.pdf)

## Prevention of Domestic Violence Act 2005 and legal assistance to survivors of GBV/DV contd.

Upon receiving an application the court will consider it forthwith and if satisfied will issue an interim order applicable for two weeks and hold an inquiry where the perpetrator is summoned to appear. At the inquiry if the Court is satisfied that there is a possibility of violence to the applicant will issue an interim order effective for a period of one year.

The interim order may include other provisions such as prevention of the perpetrator dispersing common property, visiting children at school etc. depending on the risk recognized by the courts to the survivor or the children.

In addition, the Courts can request the perpetrator or both survivor and perpetrator to undergo mandatory psycho social counselling.

This Act does not identify responsibilities of health care provider's role or responsibilities for reporting. Request for redress under this law is entirely up to the survivor and it's her decision.

Role of the health care provider is to raise awareness with the survive that such law exists and she can seek redress to prevent further violence.

It is the duty of the care provider to provide relevant information to all survivors of GBV/DV and especially when the risk assessment as described in page 22 Identifies a considerable risk and one of the ways of ensuring safety would be to offer her the choice of seeking help under this law. The survivor can be referred to Legal Aid Commission or WIN (Annexure III) or Police according to her wishes.

The decision to seek redress under this law is entirely the decision of the survivor and our role is to facilitate it when she decides.

## 9. Self-care: Looking after yourself

Although the providers who work with survivors of GBV/DV are committed and willing to help others very often they are unaware of how much the task of listening to abuse affect them. This section highlights the importance of self-care for the provider when working with families experiencing violence and abuse and avoiding a burn out. It encourages self-reflection, peer support and working as a whole of practice approach to these families.

### Tips for self-care<sup>97</sup>

- Understand and improve your awareness of when you are stressed, tired, overwhelmed
- Ensure you have a mentor, supervisor or a trainer to support your professional work and available to talk to
- Appropriate support for the provider needs to be readily available, especially considering that some of them may have a personal history of child abuse or physical violence with an intimate partner.
- Cultivate open and supportive dialogue with your work team as in *Mithuru Piyasa /Natpu Nilyam* centres
- When the provider has a similar background to the survivor, the possibility of family violence may be more difficult for to consider especially if they are known to her
- The provider may feel powerless and fearful for the patient's safety especially when that patient chooses a path the provider considers dangerous and stresses her more
- The patient could refuse help and remain at risk and the GP has to learn to live with that concern
- Dealing with complex and seemingly hopeless situations over and over again can erode the provider's optimism and self-confidence, and diminish their sense of purpose and enjoyment of their work
- Providers need to recognize their personal signals of distress and find ways to articulate the feelings and act to redress the distress. Getting irritable, feeling tired lack of enthusiasm at work are some of these signs
- Providers with less perceived control, greater stress from uncertainty, and fewer social supports are at greater risk of burnout
- Dealing with the perpetrator of abuse or violence is even more difficult than dealing with the victim, especially when the family is known to the provider or a member of the staff
- Lifestyle choices that promote 'wellness' include relationships, religion or spirituality, a positive outlook, as well as simple measures such as getting enough sleep, exercise, nutrition and laughter.
- Learn to celebrate small achievements rather than feel overwhelmed by the big picture
- As with other complex and time-consuming occupations, it is important to have clear boundaries between work and home.

<sup>97</sup> Adapted from Abuse and violence Working with our patients in general practice (4th edition) 2014 The Royal Australian College of General Practitioners,

## 10. Implementation of the Guideline

Implementation of the National Guideline would come under the Gender and Women's Health Unit of the Family Health Bureau.

Once launched the Guideline will be disseminated to the relevant units of the hospitals throughout the country accompanied by an administrative guidance in the form of an Administrative Circular issued by the Secretary of Health.

In addition, all heads of the institutions would be sensitized to the National Guideline utilizing all opportunities such as the monthly meeting of the heads of Institutions with the DGHS.

Awareness raising programmes for key providers such as MO/OPDs, MOH both in the field and institutional will be organized through the *Mithuru Piyasa/Natpu Nilayam*.

Monitoring of the implementation will be through information collected through the *Mithuru Piyasa/Natpu Nilayam* based on the numbers of referrals and a client satisfaction survey of those referred by the relevant users of the National Guideline.

In addition an Internal assessment will be conducted at the end of one year of use and the findings will be shared with a group of stakeholders including experts and users and necessary changes made.

## Annexure I - Consent form

Name of the Health Institution .....

Note to the health worker:

Request the survivor to read the consent form. If she is unable to do so, read the entire form to the survivor in a language understood by the survivor, explain that she can choose any or none of the items listed.

Obtain a signature, or a thumb print (with signature of a witness).

I..... (Print name of survivor) authorize the above-named health facility to perform the following (tick the appropriate boxes):

Conduct a medical examination :    Yes ☐                      No ☐

Document the findings: Yes ☐ No ☐

Reporting to Police: Yes ☐ No ☐

I take full responsibility for my decision of not informing Police: Yes ☐

I understand that the health institution is legally bound to provide the information recorded, if legal authorities request to do so: Yes ☐

Signature..... Date.....

Witness.....



## Annexure II - List of Mithuru Piyasa /Natpu Nilayam centres and their contact details

City/District In alphabetical order	Mithuru Piyasa /Natpu Nilayam established at :	Contact No.
Ampara	District General Hospital- Ampara	063 2222261
	Base Hospital, Kalmunai North	067 2229261
	Base Hospital- Pothuvil	063 2248061
	Base Hospital, Kalmunai South	067 2222261
	Base Hospital, Akkaraipattu	067 2277213
	Base Hospital, Samanthurai	067 2260261
Anuradhapura	Teaching Hospital- Anuradhapura	025 2222261
	Base Hospital, Thambuttegama	025 2276262
	Army Hospital, Minneriya	0703006583
Badulla	Provincial General Hospital, Badulla	055 2222261
	Base Hospital, Diyathalawa	057 2229061
	Base Hospital, Welimada	057 2245161
	Divisional Hospital, Bandarawela	0572222261
Batticaloa	Teaching Hospital, Batticaloa	065 2222261
	Base Hospital, Valachchenai	065 2257721
	Base Hospital, Kaththankudi	0652245561
	Base Hospital, Kaluwanchikudi	0652250061
	Divisional Hospital- Chenkalady	065 2240483
Colombo	Castle Street Hospital for Women	011 2696231
	Colombo South Teaching Hospital (Kalubowila)	011 2763261
	De Soysa Hospital for Women	011 2696224
	Family Health Bureau	0112696508
	Sri Jayawardhanapura General Hospital	011 2778610
	Base Hospital, Avissawella	036 2222261
	Base Hospital- Homagama	011 5059646
	Devisional Hospital, Thalagama	011 2862313
	University of Sri Jayawardanepura	0112758000
	New Bazar Maternity Home	0112 691191
	Army Hospital, Narahenpita	011 2697219
Galle	Teaching Hospital, Mahamodara	091 2234951
	Base Hospital, Elpitiya	091 2291981
Gampaha	Colombo North Teaching Hospital (Ragama)	011 2959261
	Base Hospital, Meerigama	033 2273261
	Base Hospital, Kiribathgoda	011 2911493
	Board of Investment, Katunayake	0112256256
Hambantota	District General Hospital, Hambantota	047 2222016
	Base Hospital- Thangalle	047 2240261

## Annexure II - List of Mithuru Piyasa /Natpu Nilayam centres and their contact details

City/District In alphabetical order	Mithuru Piyasa /Natpu Nilayam established at :	Contact No.
Jaffna	Teaching Hospital, Jaffna	0212222261
	Base Hospital, Chavakachcheri	0213215429
	Base Hospital, Kytes	
	Divisional Hospital, Chankane	0212250079
	University of Jaffna	021 2218100
	Base Hospital- Point Pedro	021 2263261
Kalutara	General Hospital, Kaluthara	034 2222261
	Base Hospital, Horana	034 2261261
	Base Hospital, Pimbura	034 2244461
	Kethumathi Maternity Hospital, Panadura	038 2232361 0714432361
Kandy	Teaching Hospital, Kandy	0812222261
	Teaching Hospital, Peradeniya	0812388001
	District General Hospital, Nawalapitiya	054 2222261
	Base Hospital, Gampola	081 2352261
	Base Hospital, Teldeniya	0812374055
Kegalle	Teaching Hospital, Kegalle	0352222261
Kilinochchi	District General Hospital, Kilinochchi	021 2285329
Kurunegala	Teaching Hospital, Kurunegala	037 2222261 071 2922261
	Base Hospital- Dambadeniya	037 2266592
Matale	District General Hospital, Matale	066 2222261
Matara	District General Hospital, Matara	0412222451
Mullaitivu	District General Hospital, Mullaitivu	021 2061412
Moneragala	Base Hospital- Bibila	055 3555861
	Base Hospital- Wellawaya	055 2274861
Nuwara Eliya	District General Hospital, Nuwara Eliya	0522222261
	Base Hospital, Dik Oya	051 2222226
	Base Hospital, Rikillagaskada	081 2365261
Puttalam	Base Hospital, Marawila	032 2254261
Polonnaruwa	Army Hospital- Minneriya	027 2055330
Ratnapura	Provincial General Hospital, Rathnapura	045 2222261
	Base Hospital, Balangoda	045 2287261
	Base Hospital, Embilipitiya	047 2230261
Trincomalee	District General Hospital, Trincomalee	026 2222260
Vavuniya	District General Hospital, Vavuniya	024 2222761
Coordinating institution	Gender and Women's' Health Unit FHB	0112692744

## Annexure III - Inventory of other Service Providers at National level

### Institutions and Organizations providing services at central level

Organization	Postal Address	Hotline/ contact no.	e-Mail	Comments
<b>Family Health Bureau – Gender and Women's Health Unit</b>	No: 231, De Saram Place, Colombo 10	0112 692744	info@fhb.health.gov.lk	Co-ordinates the national health sector response
<b>Complaints Centre at National Committee on Women</b>	Ministry of Child Development & Women's Affairs 5 <sup>th</sup> Floor, Sethsiripaya Stage II, Battaramulla, Sri Lanka.	1938(Hot Line) 0112186063/ 0112186055	secycdwa@gmail.com	Receives complaints and directs to appropriate services. Provide legal and psycho-social counselling services.
<b>National Child Protection Authority</b>	No. 330, Thalawathugoda Road, Madiwela, Sri Jayawardenapura	1929(Hot Line)	ncpa@childprotection.gov.lk	Entertains all complaints regarding child abuse.
<b>Department of Probation and Child care Services</b>	Third Floor Section B Sethsiripaya Stage II Battaramulla.	011-2187285	pcc@sltnet.lk	Co-ordinates probation and child care services
<b>Police Bureau for the Prevention of Abuse of Women and Children</b>	No. 78, Mukthar Plaza Building 1st Floor, Colombo 14.	011 2337041	dir.cwbureau@police.lk	Provide dedicated police assistance on issues related to GBV/DV on women and children.
<b>Sri Lanka Legal Aid Commission</b>	No 129, Hulftsdorp Street, Colombo 12	011 433618, 0115 335281, 0112 395894	legallaid@sltnet.lk	Provides free legal assistance to servicers of GBV/DV.
<b>Sri Lanka CERT/CC</b>	4-112, BMICH, Buadhaloka Road, Colombo 07.	Emergency 0112 691692/ 0112 679888	slcert@cert.gov.lk	Entertains complaints on Cyber violence and provide guidance on issues related to GBV/DV through internet and social media.
<b>Instructions regarding Cyber Crimes: Techcert – A division of LK Domain Registry</b>	545/4, De Soysa Road, Molpe, Moratuwa	0114 462562 (Emergency Line)/ 0114 216062	info@techcert.lk	
<b>Sri Lanka Sumithrayo</b>	60/7, Horton Place, Colombo 7	011 2692909/ 011 2696666/ 011 2683555	sumithra@sumithrayo.org	Provides counselling services to servicers of GBV/DV and those with suicidal ideation.
<b>Legal Aid Commissions</b> Counselling on legal matters free of charge Any person may call over at the LAC Head Office or any of its 77 centres island-wide and seek legal opinion on matter of interest to them. In circumstances that the centres are not in a position to certain complicated legal issues, the centres get appropriate advice from Head Office. Representation in court cases for domestic violence and other issues is limited to persons whose monthly income level is Rs. 18,000/= or less. (Divorce, domestic violence, Maintenance, Fundamental rights violation cases, etc).				

# Notes

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