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MAPPING OF SOCIAL SERVICES SECTOR FOR THE PREVENTION AND RESPONSE TO SEXUAL AND GENDER BASED VIOLENCE AFFECTING WOMEN AND GIRLS

ACRONYMS

AAL	Attorney-at-Law
BIA	Bandaranaike International Airport
CA	Counseling Assistant
CIF	Client Information Form
CP	Central Province
CRPO	Child Rights Promotion Officer
DCDC	District Child Development Committee
DGH	District General Hospital
DO	Development Officer
DS	District Secretariat /Secretary
DvS	Divisional Secretariat /Secretary
DV	Domestic Violence
DWCDC	District Women and Child Development Committee
ECDO	Early Childhood Development Officer
EP	Eastern Province
FHB	Family Health Bureau
FPA	Family Planning Association
FRC	Family Rehabilitation Centre
GAMCA	Gulf Approved Medical Centers Association
GCC	Gulf Cooperation Council
IEC	Information, Education, Communication
INGO	International Non-governmental organization
IFSD	Institute for Social Development
IPV	Intimate Partner Violence
IWD	International Day of Women
KII	Key informant interviews
LAC	Legal Aid Commission
MOH	Medical Officer of Health
M&E	Monitoring and Evaluation
MoJ	Ministry of Justice
MoPISE	Ministry of Primary Industries and Social Empowerment
MoU	Memorandum of Understanding
MoWCA	Ministry of Women and Child Affairs
MP/NP	Mithuru Piyasa/ Natpu Nilayam (befriending clinic)
MoH	Ministry of Health
NCEWHH	National Centre for Empowerment of Women Headed Households
NCP	North Central Province
NCW	National Committee on Women
NFAGBV	National Forum Against Gender Based Violence
NGO	Non-governmental organization
NIC	National Identity Card
NP	Northern Province
NPA SGBV	National Plan of Action for the Prevention of Sexual and Gender based Violence
NPC	Northern Provincial Council
NPWHH	National Plan for Women Headed Households

PCCS	Probation and Child Care Services
PDVA	The Prevention of Domestic Violence Act
PHDT	Plantation Human Development Trust
PHI	Public Health Inspector
PHM	Public Health Midwife
PFWO	Plantation Female Welfare Officer
RA & M	Risk Assessment and Management
RDHS	Regional Director of Health Services
RHIMS	Reproductive Health Information Management System
RPC	Regional Plantation Corporation
RS	Relief Sister
SLBFE	Sri Lanka Bureau of Foreign Employment
SGBV	Sexual and Gender Based Violence
SP	Southern Province
TH	Teaching Hospital
TSH/TSHDA	Tea Small Holdings / TSH Development Authority
UN	United Nations
UNFPA	United Nations Fund For Population Activity
UNDP	United Nations Development Programme
VAW	Violence Against Women
VOG	Visiting Obstetrician and Gynaecologist
WB	Women's Bureau
WDC	Women's Development Centre
WIN	Women In Need
WHH/WW	Women Headed Household/War Widow
WPO	Women Police Officer

* Names of the survivors in the case stories have been changed to protect their identities.

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TABLES

EXECUTIVE SUMMARY

This rapid mapping of the social services sector response for survivors of sexual and gender based violence was carried out in the Northern, Eastern, Central and Southern provinces. The 12 components of the UNFPA Social Services Sector module 4 of the Essential Services Package was used as the tool to review service delivery at the district/ divisional levels by MoPISE Counseling units, MoWCA Women and Child Units (WC Units, and MoH Mithuru Piyasa/Natpu Nilayam clinics, Legal Aid Commission regional centers, and Police women and child desks, NGOs crisis centers and shelters supported by the state, NGOs and a faith based organization.

Service providers identified the following priority needs as key for victim/survivors of SGBV:

1. Economic empowerment through equitable access to sustainable livelihoods to break the cycle of poverty and SGBV;
2. Shelters to provide security and safe accommodation for women and children in emergency/crisis situations;
3. Formalized mechanisms to strengthen intra and inter- sectoral collaboration, coordination, monitoring and oversight to improve service efficiency and effectiveness;
4. The adoption of a standardized service delivery for family violence that would be inclusive of women, children and rehabilitation of perpetrators.
5. The availability of a high level guidance and oversight mechanism to strengthen and ensure timely implementation of the national SGBV response.

The mapping showed that coverage of services was best by the legal, police and the health sectors. Coverage of communities at the divisional level was challenged by issues of land size, transport, travel allowances and uneven distribution of trained officers of the MoWCA and MoPISE. The mapping found that the Public Health midwife trained in SGBV prevention was a currently underutilized resource and the Plantation Family Welfare Officer may be strengthened to sustain community based SGBV prevention services in estates.

Access to services at fixed facilities[1] and phone based services other than general hotlines was limited by their availability during routine working days and hours of institutions and organizations, and calling costs to women. The WIN hotline and the mobile app for android and iPhones appeared to be the best available option to provide immediate access for girls and women to crisis services in an emergency. Timely access to shelters was challenged by the lack of a walk-in option, admission procedures, and in the Eastern province, by the ethnic polarization and cultural barriers among communities.

Shelter facilities for women and accompanying children were generally adequate. Measures were required to ensure the right to psychosocial well-being of girls/ women retained in shelters beyond their Court stipulated periods without compromising their right to safety and security while in state custody and care. Similarly, measures were required to safeguard the right of access to SGBV preventive services of all women and

[1] Divisional secretariat (WC Units/Counseling Units), MP/NP clinics, LAC regional centers, NGO crisis centers shelters, phone based services as help lines/ hot lines

girls with disability, especially those who are mentally challenged. Women's' drop out from long term counseling was linked to failed expectations of receiving monetary and material benefits. This combined with the lack of equitable access to livelihood opportunities increased their vulnerability to microcredit schemes of poor transparency that trapped them in a cycle of repetitive domestic violence linked with higher risk of migration and suicide.

NGO consortiums in the North and East engaged in livelihood projects and many combined this with community outreach/IEC/ awareness activities and referral of women for SGBV prevention services. Rights awareness programmes for WW/WHH in the North and women in the tea plantations community were almost entirely delivered by NGOs. An extensive network of women's societies established by a leading NGO in the CP used skills building for income generating activities to empower women at the grass root level.

The mapping showed that strengthening and sustaining the SGBV response requires:

- Standard operating procedures and protocols/guidelines to formalize/ monitor referrals and strengthen intra and inter-sectoral collaboration and coordination between services.
- Oversight mechanisms to ensure equitable allocation of livelihood opportunities
- Joint training activities and performance/progress reviews to strengthen delivery of a coordinated prevention response
- Development/use of standardized risk assessment and management tools for comprehensive client management
- The timely availability of quality data to strengthen policy and programme formulation, improve service delivery, and advocate donors and private sector for livelihood related support, and media engagement
- A system of appointing divisional officers based on land size, population density, prevalence/incidence of SGBV and poverty indices to improve service coverage at community level
- The formulation and implementation of subnational plans that factor issues of coverage and the needs, ethnic and cultural sensitivities of local communities.

The timely implementation of the UNFPA assisted multi-sectoral National Action Plan on Women Headed Households (WHH-NAP) is important. It is key to empowering war widows and women who head households and are among the most vulnerable, challenged and under-represented in the post-conflict processes of reconciliation and peace building in Sri Lanka.

The mapping showed that service delivery was most affected in the NP,EP and CP where the highest levels of domestic violence have been reported. The noteworthy achievements of the line ministry in policy and programme formulation are likely to be further enhanced by the availability of a high level multisectoral guidance and oversight mechanism. This would enable the delivery of a more coordinated SGBV prevention response to provide timely relief to victims / survivors of SGBV.

INTRODUCTION

Violence against women (VAW)

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.[2]

Gender based violence, Sexual and Gender Based violence

Gender based violence is “any act of violence that is directed against a woman because she is a woman or that affects women disproportionately”.[3] Gender based violence may present as partner and non-partner violence. The term "sexual and other forms of gender-based violence" is intended to encompass the range of sexual violence including rape and attempted rape, various forms of sexual abuse (incest and grave sexual abuse), sexual exploitation, forced early marriage, domestic violence, intimate partner violence and marital rape, trafficking and female genital mutilation. All forms of violence are associated with serious consequences to physical and psychological health and social well-being[4] especially when repetitive and prolonged.

Responding to Sexual and Gender Based Violence[5]

Effective response to violence against women and girls needs to be comprehensive, multidisciplinary, coordinated, systematic and sustained. It requires a collaborative effort by multi-disciplinary teams, personnel and institutions from all relevant sectors to implement laws, policies, protocols and agreements and communication strategies. Coordination needs to occur vertically and horizontally between and within the different hierarchical and administrative levels engaging state, NGOs, civil society, faith based organizations and the private sector. Affected communities need to be integral actors in all policy and strategy formulated on their behalf. Effective coordination also requires high level guidance and oversight to ensure that a transparent, comprehensive, rights based holistic and inclusive response is achieved.

In Sri Lanka, victims/survivors of GBV/SGBV are a diverse group that includes those of higher vulnerability such as conflict affected women, domestic migrant workers, women workers on tea plantations, women with disability, the elderly and ex-combatants. Empowering women to recover their health and wellbeing and reintegrate into society without stigma requires SGBV services that have adequate coverage, are available, accessible, appropriate, timely, and sustainable.

Burden of SGBV[6]

In Sri Lanka, 17% of ever-married women age 15-49 have suffered from domestic violence from their intimate partner and 2% of them experience some form of domestic violence daily. The highest percentage of domestic violence was reported from the Batticaloa (50%) and Kilinochchi (50%) districts. Among the 28 % of women who had sought help, the majority (75%) reached out to parents/brothers/sisters/relatives while another 27% sought friends/neighbhours (27%) and the Police (18%). Among women in the urban/rural sectors, 50% identified the “Sri Lanka Women Bureau (urban and rural sectors), and 26% each knew of the Women help line and the Midwife. Less than one fifth identified the Legal Aid Commission (18%), the Department of Social Services (17%), the Mithuru Piyasa (13%), and the MOH (10%). The estate community had

[2] UN Declaration on the Elimination of Violence Against Women. Article 1.
[3] CEDAW, General Recommendation No. 19, para. 6.
[4] https://www.who.int/hac/techguidance/pht/SGBV/en/
5 UNFPA ESP = Module 4; Social Services
[6] Sri Lank Demographic and Health Survey. 2016

low knowledge of formal organizations and specific individuals who could intervene but 37% identified the category 'Other" as being able to stop violence and 25% named the public health midwife specifically in the same role. Recent studies and community based surveys indicating the increasing willingness among women to admit to intimate partner violence underlines the need to strengthen and expand SGBV prevention services.

Conflict affected women

Conflict affected women are mainly found in the Northern Province and the marked increase in WHHs is one of the most significant features of post-war Sri Lanka. Such women experience severe psychological distress due to lack of closure related to missing spouses, and their indeterminate civil status makes them more vulnerable to sexual bribery by state officials when attempting to recover vital civil documents to claim their rights and inheritances. The burden of being the sole family support leads some to enter into informal relationships and liaisons at the risk of being abandoned and children from such non-formalized unions are likely to be stigmatized and face difficulties at school enrolment. War widows (WW) and women heads of households (WWH) are prioritized for livelihood opportunities in state and NGO programmes aiming to improve their quality of life through economic empowerment.

Women workers in plantation communities

Women form nearly 52% of the 320,000 strong labor force on the RPC estates in the Central Province that contribute almost 30% to the foreign exchange reserves of the country. The PHDT[7] provides health care[8] and implements social development programmes to enhance the quality of life of estate workers on the RPC estates. The PFWO recruited from the community works closely with families on issues of health and welfare. The estate sector reports a high prevalence of DV[9]/IPV but the majority of estate women do not demonstrate help seeking behaviour as they are disempowered by the cultural entrenchment and "normalizing" of violence within the estate community. Following a GOSL policy decision in the mid-nineties, estate communities access the benefits of state health care including preventive services delivered by the PHM. However, the reportedly lower acceptance of the PHM in the RPC estates may be due to the language barrier as well as the preference of women workers to be served by the familiar and known traditional midwives in the community.[10]

The Tea Small Holding estates managed by the TSH Development Authority are found predominantly in the Southern Province. In 2016, the TSHDA accounted for 74.5% of made tea produced in the country.[11] Women form over 90% of the work force and are mostly unpaid family workers while the majority of estate owners are men. There are no social security benefits such as statutory pension, insurance or health schemes operating in the tea smallholder sector, although such schemes are available through private establishments.[12] Anecdotal evidence points to concerning levels of alcohol related problems, domesticviolence and sexual abuse of girls. The lack of evidence based data relates to the failure of the TSH Development Act and the Federation of TSH societies to identify health related interventions for the community and the absence of a body similar to the PHDT to address the health and welfare of families.

Domestic women migrant workers

7 The PHDT is a Tripartite Organization consisting of the Government of Sri Lanka (GOSL), Regional Plantation Companies (RPCs) and Plantation Trade Unions (TU).

8 The healthcare team within the estate sector comprises the Estate Medical Assistant (EMA), Plantation Family Welfare Officer (PFWO), Public Health Midwife(PHM) Child Development Officer (CDO) Crèche Assistant and Dispenser and other minor staff. MCH/FP services are provided by the estate health staff (Estate Medical Assistants and Estate Midwives) similar to that provided by the government sector

9 "Department of Census and Statistics (DCS) and Ministry of Health, Nutrition and Indigenous Medicine 2017. Sri Lanka Demographic and Health Survey 2016 Sri Lanka,pp.200"

10 Personal communication, Medical Director, PHDT. 2019

11 Annual Report –TSHDA 2016. www.parliament.lk/.../annual-report-tea-small-holdings-development-authority-2016.

12 Future of Work for Tea Small Holders in Sri Lanka –ILO. 2018. https://www.ilo.org/wcmsp5/groups/public/---asia/---ro.../wcms_654641.pdf

Domestic women migrants workers are at risk of sexual violence at every step of the migration cycle. Sri Lankan missions in the Gulf Cooperation Council destination countries provide safe facilities for abused women but anecdotal reports show that women are likely to be at risk of sexual exploitation within the missions as well. The demand for skilled migration in destination countries combined with MoWCA policy decisions centering the well-being of children (< 5 years of age) has led to a decline in the outflow of women as domestic migrant workers during the past 5 years. These factors have also led the MoWCA to initiate a number of alternate livelihood schemes to prevent such women from leaving the country. The SLBFE provides temporary shelter facilities for returning migrant women workers at the BIA, Katunayake.

Sexual violence places domestic migrant women workers at risk of HIV. In 2013, among all reported HIV cases, 49% of males and 55% of women gave a history of external migration although the nature of the disease makes it difficult to determine the point of infection.

There are many gaps and shortcomings in the Sri Lankan governance framework around health of migrant domestic workers in both origin and destination countries. Sri Lanka has not ratified the ILO Domestic Workers' Convention (C189) that addresses the health and labour rights of women migrating for domestic work abroad. The compulsory welfare insurance scheme of the SLBFE does not provide or compensate for 'venereal diseases" (HIV) risk to workers and the SLBFE lacks a specific mechanism to routinely link returnee migrants and those who have been deported due to testing HIV positive in the destination country, to general healthcare services including STI/ HIV prevention, treatment and care services.

Women with disability

Women represent 57% of the 8.7% of the population with disability who are among the poorest segment of the Sri Lankan population. They are found mostly in the Kandy, Trincomalee and Puttlam districts[13]. Women with disability are subject to marked discrimination as shown by the gender disparities in access to education, employment, and income[14]. War related disability is particularly stigmatizing and former woman combatants reportedly experience being stigmatized by the community as well as within their family.[15] The stigmatizing and negative stereotyping of women with disability may also lead to a failure to recognize that they have the same sexual and reproductive health needs as other women. This, combined with the desexualisation of women in their own eyes is likely to increases their risk of being sexually exploited.

[13] Census of Population and Housing 2012.
[14] The National Policy on Disability 2003
[15] "Out of the Shadows": War affected Women with Disabilities in Sri Lanka. Dinesha Samararatne, Karen Soldatic Bimali Perera. Western Sydney University and Law & Society Trust. 2018.

THE SOCIAL SERVICES SECTOR

This sector provides a range of support services to improve the general well-being and empowerment of people by linking with other key service providers in the state and NGO sectors, civil societies, community actors and faith-based organizations.[16] Quality services are inclusive of women who have a higher vulnerability to violence due to poverty, migration, the impact of conflict and disability.

Mapping

This mapping of the Social Services sector response moves forward on recommendations made at the high level multi-sectoral stakeholder meeting[17] in July 2018 that launched ESP by UNFPA together with key line Ministries.

Social services sector components of the Essential Services package [18] (ESP)

The 12 components of the ESP social services sector (Table 1) was used as a comprehensive tool to assess the quality of the social sector response.

Objectives (as given in the TOR) :

- To map social sector services for SGBV response
- Identify gaps and challenges
- Provide recommendations

16 UNFPA ESP - Module 4; Social Services .

17

18 Ibid 2

Table 1 Essential services Package - Social services sector components

• Crisis information	• Legal and rights information, advice and representation, including in plural legal systems
• Crisis counseling	• Psycho-social support and counseling
• Help lines	• Women-centered support
• Safe accommodation	• Children's services for any child affected by violence
• Material and financial aid	• Community information, education and community outreach
• Creation, recovery, replacement of identity documents	• Assistance towards economic independence, recovery and autonomy

METHODOLOGY

The following assumptions were used to identify provinces that would permit the application of the tool within the limited time available for the activity.

- Some /all of the service components of the tool was available for review
- Services were provided by State, NGO and faith based organizations
- The services had been operating for a sufficient length of time to allow gaps and challenges to service delivery to be identified
- It would be possible to assess service provision for women at higher risk of SGBV
- The ICES[19] recommendation on shelters could be addressed[20]

Due consideration was also given to the UNFPA and MoWCA mapping of SGBV services recently conducted in the districts of Hambantota (Southern province) and Mannar (Northern province) .

The selection of the Northern, Southern Eastern and Central provinces for the mapping was guided by a review of key documents[,21,22,23,24,25] and discussions with senior officials of the MoWCA at the Women's Bureau, the National Committee of Women, and the National Commissioner of Probation and Child Care Services, and the Director Counseling, MoPISE, as well as the Head of the Women's Health and Gender Unit, Family Health Bureau Ministry of Health, and leading NGOs delivering SGBV response services. The support of the National Forum Against Gender Based Violence Forum (NFAGBV) was solicited to identify member NGOs working in the 4 provinces ahead of the visits.

Data collection

Key respondent interviews, Field visits and Focus Group Discussions and phone interviews and a check list based on the tool were used to collect data. Key respondent interviews were conducted with senior officials of the relevant stakeholder ministries –MoWCA, MoPISE, MoH / FHB, UN agencies, INGOs and NGOs, the Chairman, Legal Aid Commission, Director Health, Plantation Human Development Trust, and the UNFPA Technical Officers who conducted the mapping of SGBV services in Hambantota and Mannar. In addition, KII were conducted with the Head of the Matara Child and Women Police Bureau, the Provincial Assistant Commissioner of Probation and Child Care Services Kandy. Field visits to the provinces included site visits to the Mithuru piyasa/Natpu NIlayam clinics in government hospitals, Safe shelters and livelihood projects being implemented by NGOs and government stakeholders. Focus group and one-on one discussion were held with the officers of the MoWCA WC Units and MoPISE Counseling units at the District and Divisional Secretariats as well as with consenting women/girl victims/

19 Domestic Violence Intervention Services in Sri Lanka: An Exploratory Mapping. The International Centre for Ethnic Studies 2009-2011; updated e-version 2012

20 The ICES Survey recommended further research to understand the exact nature of the shelter provided by NGOs, charities, and one faith-based organisation, including on issues of confidentiality and security; possible duration of stay (short term or long term); the availability of accommodation for children; and the nature of counseling and other services available.

21 Country Profile of Gender Based Violence in Sri Lanka .WHO 2018

22 The Policy Framework and National Plan of Action to address Sexual and Gender Based Violence (SGBV) in Sri Lanka 2016-2020. Ministry of Women and Child Affairs. June 2016.

23 Mapping of Socio-Economic Support Services to Feale Headed Households in the Northern Province of Sri Lanka. United Nations. Sri Lanka 2015.

24 Developing State Sector Counseling Service in Sri Lanka. The Asia Foundation. December 2018

25 The Report of the Leader of the Opposition's Commission on the Prevention of Violence against Women and the Girl Child. December 2014

survivors in safe shelters and attending NGO crisis centers. Phone based interviews were conducted with Attorneys-at –Law of the Legal Aid Commission Regional Centers in the four provinces and the Head of a Faith based organization in Vavuniya providing shelter facilities for pregnant teenage girls. A check list based on the tool was circulated twice to the National GBV Forum. Additionally, a shelter providing facilities for sexually abused disabled girls managed by an NGO in Kekirawa, Anuradhapura district[26] of the NCP was reviewed during the field visit to the Northern Province.

This report is based on discussions held with a range of state officials and officers (MoWCA, MoPISE, MoH, district and Divisional Secretariat Administrators, NGO Coordinators), NGO representatives and consenting women /girl victim /survivors and UN and INGO officials.

The report is presented according to the components of the tool as shown in Table 1.

REVIEW OF THE SOCIAL SERVICE SECTOR RESPONSE FINDINGS OF THE MAPPING

The SGBV prevention response in the four provinces linked officers of the Women and Child Unit of the MoWCA and MoPISE Counseling Unit [27], at the Divisional Secretariat[28], health professionals and volunteers at the Mithuru piyasa/Natpu Nilayam (MP/NP) befriending clinics in state hospitals, women officers of the police women and child desks, and Attorneys –at-Law of the Legal Aid Commission and NGOs.

Crisis information

Crisis information was available and accessible free of charge during regular working hours of the WC and Counseling Units at the Divisional Secretariats, MP/NP befriending clinics , NGO crisis centers and LAC regional centers. The index service provider[29] (service of first contact) provided crisis information through help/hot lines and face to face client–provider discussions. Depending on the service, access was limited after hours, on weekends and public holidays. . Crisis information was also provided in IEC material (posters, pamphlets and brochures) at MP/NP clinics and NGO crisis centers, TV and radio programs, organizational websites and social media.

Crisis counseling

Crisis counseling was provided free of charge by the staff at WC and Counseling Units MP/NP clinics, NGO crisis centers and LAC regional centers. Counselors at the Divisional Secretariat could be met at their officers on Wednesday and Monday on a walk–in-basis, by referral or by appointment and on the other three week days during their field visits. Crisis counseling provided empathetic support to affected women and girls and included information on other service providers[30] but referral was provided only on request which highlights that the survivors rights are respected. Typically, a face –to-face crisis counseling session lasted from 15 minutes to about one hour. Usually, each client attended one to three counseling sessions but this was variable. On average, MoPISE counselors and MoWCA counseling assistants reported seeing about 10 clients per week. [31]

[26] The Anuradhapura district is a former conflict affected area has considerable poverty and reports a high incidence of teenage pregnancy. Girls are referred to this shelter through a network of grassroots level women's societies base in the 7 divisions in the Anuradhapura district.

[27] Ministry of Primary Industries and Social Empowerment

[28] Ministry of Women and Child Affairs

[29] Divisional and district officers of the MoWCA and MoPISE, Mithuru piyasa/Natpu Nilayam (MP/NP) befriending clinics in state hospitals, the police women and child desks, LAC regional centres , NGOs

[30] Police,/police women and child desks, LAC, hospital/MP/NP, NCPA, SLBFE and NGOs etc.

[31] Mapping Study on Capacity and Work Experience of Counseling Assistants attached to the MoWCA . –The Good Practice Group. 2013. (Unpublished)

Hotlines /Help lines

The toll free hot lines (Table 2) with 24-hour island wide coverage were limited as they were general service lines requiring referral of women to specific SGBV crisis support services. The MoPISE[32], WIN hot line services had varied coverage but were limited by calling costs. The LAC hotline was a SMS service without the benefit of a discussion to the woman. Access to help lines (Table3) was limited to the routine working hours of organizations/institutions and with the exception of the 1938, entailed a calling cost. The NCW Gender Complaint Unit data showed that in 2018, the 1938 Help line was accessed least by women in the NP and EP (3.5% each) despite it being a trilingual service with many advantages. Direct help lines that allowed confidential discussions were preferred by women and service providers. In nearly one third of MP/NP befriending clinics help lines were routed through the hospital exchange reducing privacy. All women accessing hotlines/help lines were routinely referred to the nearest service center for further support.

Hot lines/Help lines routinely connect women with support services but are particularly important in crisis situations when physical access to services is prevented by barriers of distance, transport, and the risk of provoking further violence. Service providers considered hot lines essential for women who experience severe and repetitive DV/IPV and those at higher risk of suicidal ideation, attempted suicide and suicide.

Staff at the Matara MP/NP (SP) routinely advised women who complained of repeated abuse to call the help line instead of provoking more violence by visiting the clinic. Service providers considered hot lines essential for women who experience severe and repetitive DV/IPV and those at higher risk of suicidal ideation, attempted suicide and suicide. A positive feature was that children exposed to DV/IPV DV/IPV have direct access to the NCPA 1929 Listen Respond hotline line for support.

The WIN trilingual mobile app[33] for android and iphones allows women and girls to access crisis response information through a personal mobile phone quickly with privacy and confidentiality in an emergency situation though not widely in use at present.

- *Crisis support to women victims/survivors may be enhanced by widely publicizing the WIN App for android and iphones; establishing toll free direct SGBV help lines/hotlines, and developing standard operational procedures for hot lines/help lines and strengthening the capacity of the 1938 Women's Help Line in suicide prevention ahead of its proposed conversion to a 24- hour hotline in 2019; while rectifying the factors linked to underutilization of the 1938 help line is likely to particularly benefit women in the NP and EP.*

Safe Accommodation (Shelters)

Shelters were assessed according to the core elements identified for Safe Accommodation in the ESP Social services module No.4. The review of the Kekirawa shelter is summarized separately.

Shelters provided safe and secure accommodation in crisis situations (100%), were sited in confidential locations (83%), had security personnel (50%), used access protocols for entry and exiting from shelter (83%), provided basic accommodation needs free of charge (100%), and ensured accommodation is accessible for girls and women with disability (33%). Shelters did not have security systems and NGO policies prohibited acceptance of unaccompanied

[32] The MoPISE mobile hot line service is a package deal where calls are subsidized up to Rs. 500/= at the District level and Rs.300/= at the Divisional level. The counselor meets the balance costs. Often, clients will request the counselor to call back as their mobile credit is over. This limits client –counselor interaction.

[33] This innovative trilingual application developed in 2017 through a WIN and the Asia Foundation collaboration can be downloaded freely and provides information on SGBV related health, legal, police and NGO services. It is currently being piloted in select districts supported by a media campaign. WIN has reported an increase in the number of service related inquiries on its Facebook page and uptake of services following the launch of the app.

Table 2 - HOT LINES

Service provider	Type/ Number	Coverage	Availability / Accessibility	Language
WIN - Head Office Colombo	Landline 011 4718585	Island wide	24 x 7	Sinhala/ Tamil/ English
LAC Head office Colombo	Mobile 0719994618 0719993618	Island wide	24 x 7 SMS service	S/T/E/
Senior Counselors MoPISE	Mobile 84 Numbers	Division of work Adjacent divisions	24 x 7 Mobile service	S/T
NCPA	1929	Island wide	24 x 7	S/T/E
Police Emergency	119	Island wide	24 x 7	S/T/E
Government Information	1919	Island wide	24 x 7	S/T/E1
CCC Line [1]	13 11 14	Island wide	24 x 7	English
WIN App for android & iphones	See text			

Table 3 – HELP LINES

Institution/ Organsation	Type	Coverage	Availablitiy	Service provider	Language proficiency
MOWCA Gender Complaint Unit	1938 Toll free Direct Fixed	Island wide	Monday to Friday 8.30 am -5.00 pm	Counselors NCW Legal officers	Sinhala/ Tamil/ English
AGA Office/ Divisional Secretariat – MoWCA & MoPISE	Personal mobiles of counselors	District/ Division	Monday to Friday 8.30 am -5.00 pm	MoWCA Women and Child Unit MoPISE Counselors	S/T
Mithuru piyasa/ Natpu Nilayam	Direct or through hospital telephone exchange	Within District and adjacent districts if there is no MP/NP	Monday to Friday 8 am – 4.30 pm. Saturday 8 am -12pm	Medical officer/ Nursing officer/ Volunteers	S/T
Legal Aid Commission regional Centres	Direct Fixed	island wide	Monday to Friday 8.30 am -4.30 pm	Legal officers	S/T/E
Women In Need Crisis centers - Jaffna , Batticoloa Matara	Direct Fixed	Within district & adjacent districts.	Monday to Friday 8.30 am -4.30 pm	Counselors	S/T/E
Women's Development Centre Kandy	Direct Fixed	CP and adjacent areas.	Monday to Friday 8.30 am -4.30 pm	Counselor	S/T/E
Jaffna Social Action Center	Direct Fixed	Jaffna / NP	Monday to Friday 8.30 am -4.30 pm	Counselor	Tamil
SURYA Women;s Development Centre Batticoloa	Direct Fixed	Batticoloa/ EP	Monday to Friday 8.30 am -4.30 pm	Counselor/ Trained staff member	Tamil
FPA /SDPs – Nuwara Eliya Ampara, Koggala Batticoloa	Direct Fixed	Within district	Monday to Friday 8.30 am -4.30 pm	Center manager / trained staff member	S/T

children.

4.1.a. The confidentiality of the location was further maintained by the NGO policies that prohibited visitors including family members and restricting knowledge of the location to officers of the WC Unit and others at the Divisional /District Secretariats who engaged with the shelter on a needs basis. In addition, IEC material and community awareness programmes did not provide information or contact details for shelters, and women / girls had no access to telephones or mobile phones during their period of temporary residence. There were no security guards at the EP and SP shelters in accordance with the policy of the managing NGO. At the NP shelters, male security guards housed in security posts built within the shelter compounds provided 24-hour security. At the NP and EP shelters, additional security was provided by high parapet walls, permanently locked gates and strong grills on windows. No shelter had security systems such as alarms or CCTV cameras.

4.1.b. NGO policies guided entry/exit of girls/ women to shelters in the absence of formal protocols. A court order[34] was mandatory for the entry/exit of girls from shelters and a police entry was similarly required for women. At the NP, EP and CP shelters, a staff member (warden/case manager/matron) completed the client registration form after admission of the girl/ woman to shelters. At the SP shelter, the admission form was completed at the NGO crisis center before transferring the woman to the shelter. At the NP shelters, the "Agreement Clause"[35] in the NGO Admission guideline was explained to the girl/ woman before she signed the form. Discharge forms were completed for all girls/women when exiting the shelter at the end of the period of temporary residence. At the SP shelter, women who left by choice were required to sign a letter to this effect instead of completing a discharge form.

4.1.c. The CP and EP shelters had suitable ramps and toilets to accommodate women/girls with physically disability. In general, shelters did not accept girls/women with disability due to their inability to adequately care for them. The NP shelters indicated that women/girls with physical disability may be accepted under exceptional circumstances for brief periods of time. Mentally challenged girls/ women were not accepted at any shelter under any circumstances.

Core elements 4.2 – Responsiveness (Table 5)

Shelters provided spaces that ensured confidentiality and privacy (83%), had child friendly accommodation and met needs of children (83%), provided an assessment of immediate needs (100%), and developed an individualized support plan for the woman/ child in consultation with them (100%).

[34] The Court order is issued on the submission of an application to Court by the Probation officer on behalf of the girl.

[35] The Agreement Clause informs the woman/girl of the terms and conditions related to staying at the shelter and her rights. For example, the Agreement clause states that…the girl is aware of the services provided at the shelter; she is staying of her own free will or on Court order; and accepts that she cannot leave the shelter for visits etc

Table 4 - Core element 4.1. - SAFE ACCOMMODATION

Location –Province / District		SP	NP		EP	CP –	NCP*
		Matara	Jaffna	Mullaitivu	Batticoloa	Haragama	Kekirawa
Ownership/Administration		**WIN**	**JSAC– MoWCA**		**WIN– MoWCA**	**WDC – Prov. Dept PCCS**	**RPK**
a.	Provides safe and secure emergency accommodation until immediate threat is removed	+	+	+	+	+	+
b.	Security measures in place						
	❖ Confidential location	+	+	+	+	+	_
	❖ Security personnel	-	+	+	-	+	-
	❖ Security systems	-	-	-	-	-	-
c.	Access protocol for entry/exiting shelter	+	+	+	+	+	-
d.	Basic accommodation needs provided free of charge	+	+	+	+	+	+
e.	Ensure protocol for unaccompanied children, including for long term alternative care where needed and appropriate, aligned to existing national laws and international standards	Unaccompanied children not accepted.					
f.	Ensure accommodation is accessible for girls/ women with disability	-	-	-	+	+	-

Key : SP- Southern Province : NP- Northern Province: EP —Eastern Province: CP- Central Province: NCP —North CP
WIN —Women in Need : JSAC —Jaffna Social Action Center :MoWCA — Ministry of Women and Child Affairs.
WB- Women's Bureau :WDC — Women's Development Center : RPK —Rajarata Praja Kendraya

Psychosocial support programme for women and girls at a state shelter in the Northern Province

4.2.a. Spaces for confidentiality and privacy were available as a dedicated room (CP shelter), a library and shrine room (SP shelter) and the livelihood training room and the large bedrooms provided space for privacy and reflection when not in use (NP and EP shelters) .

4.2.b. The NP and EP shelters have separate large well ventilated and equipped rooms that separately accommodate 10-12 women with new born babies and infants, and women with pre-school and older children. The SP shelter had adequate accommodation for women with children. All three shelters had large adequately furnished and equipped rooms for teaching and recreational activities for pre-schoolers and young children, and large compounds for outdoor play. The SP shelter had many recreational equipment for indoor and outdoor

activities (climbing frames, see saws and mat slides).

4.2.c. Women and accompanying children were provided with basic necessities following an immediate assessment of needs on admission to the shelters.

4.2.d. At all shelters, counselors developed individualized care plans in conjunction with the girl/woman. Children were assessed and provided

Table 5 - Core Element 4.2. - RESPONSIVENESS

Core Element 4.2. – Responsiveness							
Province / District		SP	NP		EP	CP	NCP
		Matara	Jaffna	Mullaitivu	Batticoloa	Haragama	Kekirawa
a.	Provides spaces that ensure privacy and confidentiality for women and girls	+	+	+	+	+	-
b.	Provides child friendly accommodation/meets the needs of children	+	+.	+	+	+	-
c.	Provides an assessment of immediate needs	+	+	+	+	+	+
d.	Develops an individualized support plan for the woman/ child in consultation with them	+	+	+	+	+	+

Other Issues - Staffing

Table 6 - STAFF AND OTHER FACILITIES AT SHELTERS

Staff	Matara	Jaffna	Mullaitivu	Batticoloa	Kandy	Kekirawa
Residential Matron / Warden	+	+	+	+	+	+
Case manager	-	+	+	+	-	-
Primary school teacher	-	+	+	-	-	-
Woman Counselor	+	+	+	+	+	+
Domestic staff - Cook/Helper	-	+	+	+	+	+
In house livelihood training facilities	+	+	+	+	+	VCT on same premises*
Teachers for Livelihood training	+	+	+	+	+	VCT
Telephone (Land line)	+	+	+	+	+	+
Own Vehicle and Driver	+	-	-	-	+	-

with their needs. Healthcare was accessed free of charge at local hospitals and MOH clinics, and pregnant girls/women were admitted for delivery to government base and provincial hospitals equipped to handle obstetric emergencies. At the NP shelters NGO policy stipulated that girls breast fed babies for at least 3 months before placing them for adoption. 36 Implementation of the care plans for girls/women was usually monitored and documented. Only consenting women/girls were referred for other services. The NP and EP shelters used firewood for cooking instead of gas to prevent the risk of attempted suicide by gassing among girls/women.

Notable gaps in the care plans were the absence of a routine STI/HIV screen for sexually abused women/ girls, and the lack of provision of SRH information, contraceptive counseling and commodities.

At all shelters staff identified the need for more toys for pre-schoolers.

- The quality of care provided to girls/ women in shelters could be improved by increasing travel allowances to facilitate the regular supervisory visits by WDOs and retaining essential in-house staff by identifying funds for salaries and capacity building .
- Reviewing admission protocols and ensuring an entry level general health check that includes STI and pregnancy screening, will permit the early detection and treatment STIs and other health problems in sexually abused women/girls, including those who are pregnant, and reduce the risk of STIs and their adverse outcomes in babies.
- Empowerment of girls/women may be supported by increasing awareness of SRH rights ;providing access to RH information and commodities to foster responsible sexual behaviour to reduce risks of unwanted pregnancy following social reintegration; and linking women/girls with the MOH / PHM of their area of residence to ensure continued care
- The period of temporary residence at the shelter may also be used to create awareness/educate women about the risks of microcredit schemes ahead of their reintegration into the community.

Other Issues - Staffing

The NP shelters had additionally hired in –house case managers to care for girls/ women as supervisory visits of the WDO were irregular due to the limitations in transport /travel allowances and the isolated location of the shelter. At the EP shelter the alack of full time staff had required hiring, temporary matrons/wardens to provide in-house care for the girls, and to monitor those admitted to hospitals for delivery. According to NGO partners, retaining these essential staff categories required additional funding to provide permanent posts to matrons/wardens through competitive salaries commensurate with market rates and strengthening their counseling skills, as well as capacitating case managers in file maintenance, and data management and confidentiality.

Other Shelters

The following shelters are for girls with disability - The Rajarata Praja Kendraya (RPK) Shelter, Kekirawa Anuradhapura, NCP[37]

[36] This was a requirement of the managing NGO, the Jaffna Social Action Center (JSAC).

[37] This shelter has been established by the WDC Kandy under a project to improve access and strengthen referral mechanisms for survivor of SGBV in collaboration with its Network of Women (Now).

1. The voice of a survivor

Malini is a 16 y old girl with a hearing disability. She was sexually abused by a relative and was pregnant at the time of admission to the shelter. She miscarried. RPK has given her mother an interest free "soft" loan to support herself by stitching and selling rugs and she earns about Rs 7500/ month. She has requested the Shelter to keep Malini as fears she cannot safeguard her. Malini wishes to train in beauty culture at the RPK Vocational Training Center when she is old enough.

2. The voice of a survivor

Sriyani, a 15 yr old girl with a handicap leg is intelligent and artistic. She was sexually abused by a relative. RPK provides livelihood support of Rs. 3000/= every month to the mother for a self- employment venture. Sriyani remains at the shelter as her family cannot afford to care for her.

Case Study

RPK is registered NGO working in the Anuradhapura district that is a former conflict affected area reporting considerable poverty and a high incidence of teenage pregnancy. The RPK complex is sited adjacent the main Kekirawa road and consists of a Vocational Training Center (VTC), Office and a shelter for sexually abused girls with disability was established with assistance from WDC Kandy UN agencies, and INGOs. Admission to the Shelter is limited to sexually abused girls with disability including those who are pregnant, referred through a grassroot level network of women's societies based in the 7 divisions of the Anuradhapura district. A letter of referral from the sending organization requesting temporary residential facilities is mandatory for admission to the shelter. The shelter has all the basic amenities but lacks space for privacy and reflection, is not child friendly and is not suitable for persons with disabilities (Tables 4, 5 and 6). Trained counselors are available to support the girls admitted to the shelter. The shelter is sustained by strong links to the District Secretariat (RPK regularly attends the monthly and quarterly co-ordinating meetings at the DvS/DS), donations (of dry rations from the women societies) and volunteerism (the MOH visits to provide pregnancy related care to girls; the police ambulance is released to transport of girls for delivery to the DGH Anuradhapura). Girls remain at the facility up to a month after delivery. RPK assists girls to obtain their National Identity Cards. Girls who wish to train in livelihood are enrolled free of charge at the VTC that offers courses in Sewing, Information technology, Beauty culture and Hospitality to youth in the area. When funds are limited, girls are referred to the WDC managed Haragama shelter in the CP and a shelter of a faith based organization in Colombo. Counselors requested training and the shelter needs repair and refurbishment. At the time of visiting the facility, 19 of the 23 girls who had recently been in residence, had returned to their families after giving their babies for adoption. Two of the remaining four girls, had been abandoned by their impoverished families due to their physical disabilities (one with a handicap leg and one with a hearing disability). The registration of the shelter as a children's home with the NCP Provincial Department of PCCS is pending.

Shelter conducted by a Faith based organization in Vavuniya (NP)

This shelter is registered as a Children's Home with the NP Provincial Department of PCCS. It provides safe accommodation care and support for teenage girls during their pregnancies. The girls reunit with their families after giving the babies for adoption through the Northern PCCS. The shelter management indicated that the facility is not in need of financial assistance as it is funded by donations of well-wishers.

SLBFE shelter for returnee domestic migrant worker women

The SLBFE Sahana Piyasa Centre at the BIA airport provides shelter for domestic migrant workers who are returning or are being repatriated to the country. Those reporting harassment, injuries, traumatic situations, pregnancy or are accompanied by new born babies are provided accommodation, counseling, medical treatment and hospitalization. All Sri Lankan embassies in destination countries provide on-site safe accommodation to women workers who experience abuse but anecdotal reports indicate that women may be further violated at these places. There is no formal mechanism to ensure a STI/HIV screening of returnee/repatriated women workers.

Material and Financial Aid

In the immediate crisis women and girls may find it difficult to access crisis information and support services including counseling, safe accommodation and food due to having little or no access to material resources. Admission to shelters is a legal process and the State is responsible for individuals while they are in temporary residence at the shelter.

The study found that all shelters provided women/girls and accompanying children with free accommodation, food, and the basic necessities of clothing, toiletries and linen on admission but did not provide them with money.

WDOs in all four provinces strongly disagreed with the practice of not giving women/girls cash to hand in order to prevent them running away from the shelter. The lack of emergency funds at the DS to provide money for women/girl victims of DV/IPV was repeatedly highlighted and sharply contrasted with the availability of emergency funds to provide disaster relief to families during landslides and floods. In many instances, WDOs and fellow officers had used their personal monies to assist affected women /girls.

The MoPISE does not provide monetary support to women in crisis situations and the Department of Social Services does not identify them as a discrete category among vulnerable individuals eligible for monetary assistance.

- A decision to provide monetary support to women/girls at shelters is likely to require a discussion that engages the Secretary/MOWCA, Probation Commissioner, the Shelter Oversight Committees, the District Secretaries and the WDO/District Coordinators.

CREATION, RECOVERY, REPLACEMENT OF IDENTITY DOCUMENTS

CASE STORY

In the Ampara district, WDOs assisted non-Muslim girls who had been abandoned after converting to Islam to marry Muslim men. The WDOs accompanied to obtain birth certificates for their babies. The task required tracing the newspaper notice informing the change of name of the woman following conversion to Islam as it was required to apply for the birth certificate. The BC is the key legal document that mandates enrolment in primary school and issue of the NIC at 16 years of age.

A range of civic documents are required by individuals to claim and safeguard their rights, personal security, and inheritance. WW/WHH particularly require the death certificates of husbands and legal documents relating to land to claim their rightful inheritances[38].The limitations in public transport and the high cost of hiring vehicles were barriers to women/WHH/WW accessing the decentralized services established in Divisional Secretariats for the timely issues of these documents. Further, there were many allegations that the indeterminate civil status of these women increased their vulnerability to sexual bribery by state officials tasked with issue of these documents. The MoWCA has provided relief to WHH and their dependents to obtain these vital documents by conducting mobile clinics in conjunction with the Registrar General's office. This on-going activity is being expanded through the implementation of the National Action Plan on Women Headed Households 2017-2019.[39]

WDOs in the CP and SP informed that they were generally not requested for assistance to obtain citizenship documents.

In the CP, a long standing failure of the Court to recognize the separate responsibilities outlined in the MoU between the two stakeholders, the Provincial Department of PCCS and the WDC has resulted in WDC being ordered to obtain the NICs for girls at the Haragama shelter.

WDOs in the CP and SP informed that they were generally not requested for assistance to obtain citizenship documents.

- Advocacy of the Court and the Provincial Commissioner of PCCS, Kandy may result in Probation officers of the Provincial Department of PCCS being instructed/ strengthened to adhere to the terms of the MoU when discharging their duties and responsibilities.

Legal and rights information, advice and representation, including in plural legal systems

The mapping showed that women accessed legal information, advice and representation mostly through the LAC regional centers and NGOs such as WIN (NP, EP, SP) and Surya (EP). LAC regional centers were functioning in all provinces and the majority were in the NP and EP (Table 7). All organizations provided legal services free of charge except the LAC in the instance of litigation.[40] Over 90% of LAC legal officers are women.

Women victims/survivors were provided with information about their legal rights under the PDVA, divorce laws, separation, custody of children, guardianship, and maintenance and

[38] Mapping of socioeconomic support services to Female Headed Households in the Northern Province of Sri Lanka. UN. Sri Lanka. 2015

[39] The National Action Plan on Women Headed Households 2017-2019

[40] The LAC limits litigation services are to persons whose monthly income is certified by the Grama Niladhari to be less than Rs. 25,000

Table 7 – DISTRIBUTION OF LEGAL AID COMMISSION REGIONAL CENTERS IN THE FOUR STUDY PROVINCES

Province	Total no. of divisions	Divisions with Regional Centres	
		No.	%
NP	33	8	24
EP	45	10	22
CP	36	5	14
SP	47	6	13

property rights. Women were also informed about services provided by the police, MP/ NP clinics and NGOs but referral was given only on request.

The right of women victims to obtain relief through the legal mechanism of the PDVA was challenged by the gendered attitudes among of Court and most legal officers, and the limited competencies of WPOs of the WC desk.

Inappropriate attitudes among LAC legal officers was evidenced in statements relating to women such as “deserving of violence”, “did not behave in the accepted fashion” and “after all, it is the husband”.

LAC legal officers were more likely to file maintenance cases and refer couples for family counseling, and mediation than to request protection orders under the PDVA for their clients. There was a noteworthy difference between the number of DV cases filed by LAC officers (average 8-10 DV cases/year) and NGOs such as WIN that filed 10-15 DV cases /month through their crisis center in the SP. There were strong reservations among most LAC legal officers that the protection order issued under the PDVA deprived the perpetrator of his rightful access to the comforts of the marital home and the children, of their father. This may underlie the preference seen among LAC legal officers to file maintenance cases and refer couples for family counseling and mediation than to request protection orders under the PDVA. NGO legal officers alleged that LAC legal officers leveled accusation at them of “breaking up families” by seeking protection orders.

Barriers to women obtaining relief through legal mechanisms included Court’s rejection of applications for protection orders under the PDVA. The limited competencies of women police officers in preparing filing and arguing DV cases. [41] In general, women seeking help at WIN crisis centers in the NP and EP were supported towards mediation and filing for maintenance, while in the EP, women seeking more permanent legal solutions were referred to the feminist NGO, Surya for legal advice and support.

Service providers in all provinces, noted that abused women preferred not to seek permanent legal solutions for their problems because of concerns of children, family honour and the stigma of separation and divorce. Most women were likely to tolerate the abusive relationship for many years before deciding to seek relief through separation but a proportion of them were reported to request withdrawal of cases after filing. At WIN, case files were maintained in

[41] Based on a key interview with the with the IP in charge, Police Women and Child Bureau Matara Divisions, Matara, Southern province.

the system in the event a woman returned for legal assistance.

LAC and NGO officers noted that few Muslim women presented to them for legal assistance. Muslim women have no opportunity to avail the benefits of the PDVA 2005 as they marry under the Muslim Marriage and Divorce Act and are subject to the rulings of the Quazi Courts.

NGOs were more likely to engage girls/ women in discussions that increased their awareness of rights than state officers in the health, legal and social service sectors. Service providers in the social and health sectors were less likely to be knowledgeable about the PDVA and its benefits. State and NGO service providers stated that the closing down of the WIN crisis center in Kandy had significantly limited access to legal and other support services for women.

- More woman victims/survivors of SGBV may be provided relief through the issue of protection orders by advocating Court and sensitizing legal and law enforcement officers on the benefits of the PDVA, and strengthening police curricula and training programmes with inputs on court procedures and case preparation, and building confidence of women police officers in presentation of cases in Court.
- Training programmes for health and social services sector personnel in particular need to be strengthened with the inclusion of inputs on the PDVA 2005 and concept of rights.

PSYCHO-SOCIAL SUPPORT AND COUNSELING

Case Story

Hema is a 17 year old destitute sexually abused girl at the Kekirawa Facility. Counseling had supported her to successfully complete her GCE 'O" Level examination. According to shelter staff, she requires the services of a counselor experienced in motivational counseling to support her through the GCE 'A' level examination. Hema intends to enroll on an IT course at the VTC managed by RPK after completing the 'A' level examination.

Divisional level MoPISE Counselors and MoWCA Counseling Assistants are general counselors who are accessed for many problems besides DV/IPV. Shelters relied on full time trained counselors during the daytime (Table 6) and resident staff such as matrons/wardens with basic counseling skills to support women and girls after hours. Counselors used many techniques such as Individual, Couple, Group, and Family counseling to support clients. Individual counseling is the commonest technique used.

Couple counseling is challenged by difficulties in engaging and retaining the perpetrator in the counseling process. Among couples referred by the Police, the perpetrator usually attended out of a fear of being remanded in the event of default.

A high proportion of women relied on family to help them in crisis situation[42] and the majority of service providers favoured the adoption

[42] SL DHS 2016

of a family - centric approach to see better outcomes of counseling. This approach was seen considered to be more culturally acceptable, sensitive, gender neutral, and permit engaging the perpetrator in a non-judgmental way. It also facilitated service provision for the child by making him/her an integral and mandatory component of the process. Further, this approach allowed the recognition that, at times, the woman may be at fault, while emphasizing that violence was not the acceptable way to resolve differences between partners. Family counseling was considered essential to address DV/IPV problems but in most services, the clinic or counseling room was too cramped to accommodate family sessions.

Long term psychosocial support and counseling of a minimum of six months is recommended for recovery from experiences of violence. [43] Many state and NGO sector counselors indicated that retaining such women in long term counseling was challenging as they dropped out when their expectations of receiving monetary and material benefits were not realized. One NGO working extensively in the NP[44] had innovated to retain women in the counseling process by linking the assurance of livelihood opportunity to completing the required number of counseling sessions

Among gaps noted by service providers in the health and social services sector were the inadequacies in counseling services for children, adolescents and perpetrators and the low visibility of drug rehabilitation services within the linked SGBV service response.

The general lack of services for men and the need to move beyond punitive measures and respond to problems of perpetrators to obtain better outcomes were highlighted. Access to befriending services, mental health services, alcohol and drug rehabilitation programmes, counseling for sexual problems and counseling to address unresolved issues related to childhood exposure to family violence that were likely to be provoking DV/IPV were considered essential for perpetrators.

Divisional level staff highlighted the lack of mentors and clinical psychologists to help them to cope with work related stress.

Case Story

In the Central province, a woman repeatedly lodged police complaints that her 18 years old mentally challenged daughter had been raped. Perpetrators settled the issue by paying considerable sums of money to the family to avert the police inquiry as the practice was to imply that the girl was also pregnant. The mother had obtained disability related financial and other support from state institutions for the daughter. However, a demand for a settlement of Rs. 100,000/= had resulted in a perpetrator filing a counter-complaint resulting in a police investigation. The investigation found that that the family subsists by selling the girl for sex, and the father is complicit in the activity. The two younger girls are still schooling. Charges are pending against the parents.

Women and girls with mental disability were considered to be the most vulnerable to SGBV. The mapping found that such women and girls had the least access to

[43] Ibid 3

[44] The Family Rehabilitation Centre

all services in crisis situations as shelters rejected them, disability related stigma was a barrier to availing psychosocial support and counseling services.

Feminist counseling[45] was recommended as a useful adjunct to standard counseling approaches to enhance empowerment of women victims/survivors of SGBV (feminist NGO, EP).

- The quality of counseling services may be enhanced by strengthening family counseling, mandating counseling for perpetrators and self-care for service providers and expediting the appointment of clinical psychologists for mentoring and supervision of service provided.
- Advocacy for equitable access to all services for people with disability and in particular SRH services and SGBV prevention services for girls/women with disability needs to be combined with increasing community awareness of the right of people with disability to be free from violence and stigma.

WOMEN-CENTERED SUPPORT

"Many women seeking support didn't know what they want - State and NGO service providers in the NP-

Most women come to relieve themselves of their distress by "talking to someone" but are powerless or do not want to change their present status.

– Mithuru Piyasa staff, Matara –

NGO service providers in the NP and EP noted that many women victims /survivors seeking services appeared confused as to their needs and were in the habit of "shopping" for support. In the CP, where there are high levels of alcohol related DV/IPV, the small proportion of estate women who were sufficiently empowered to seek relief faced many challenges to access services. These included obtaining approval of leave from estate managers to attend Court, transport, language barriers, trivializing attitudes of women police officers at the WC Desk, and delays in obtaining police, JMO and DNA Testing reports.

Service providers supported women also by responding to requests for assistance for alcoholic husbands and school going children whose studies they feared would be affected by exposure to DV/IPV. At the Jaffna MP/ NP, husbands of women victims of alcohol provoked violence had been facilitated admission to the Alcohol Rehabilitation Unit at the at Chavakachchery[46] BH through referral through the Mental Health Unit of the TH Jaffna.

In the Ampara district (EP), the District Secretary, WDOs and counsellors highlighted the emerging problem of drug addiction among adolescent boys. Concerns were also expressed about women victims becoming drug dealers due to limited opportunity to engage in lawful remunerative livelihoods following the breakdown of the marital home with loss of economic dependency. Community awareness programmes, self-employment options for women and prevention/rehabilitation services for alcohol and drug abuse were considered necessary to respond to this situation.

The priority need of a woman in a crisis situation is to ensure the safety of herself and

[45] Feminist counseling empowers women victims and survivors of violence to take control of their lives by making informed decisions and choices based on exploring their experiences and perceptions. The process of counseling is challenged by the need to sustain a long term client-provider interaction as the benefits to the mental health status and wellbeing are seen gradually and incrementaly. .Counseling for IPV – Chulani Kodikara, Women and Media Collective www.wmc.org /counseling- for- intimate- partner- violence- against -women

[46] The clinic had initiated a "Services Provided Record" to monitor referrals.

her children. Shelters cannot be accessed on a walk-in basis and police stations do not have woman-friendly safe spaces for temporary respite.

As shown in the SL DHS 2016, the majority of women had behaved in a culturally consistent manner by turning to family, friends and neighbours for support in a crisis situation. At the same time, 63% of referrals to MP/NP were from hospital wards indicating that a proportion of women sought hospital admission for injury and likely for safety. Shelters cannot be accessed on a walk-in basis and police stations do not have woman-friendly safe spaces for temporary respite. However, women victims admitted to general hospital wards may experience further mental distress as they are stigmatized by the scrutiny and curiosity of other women patients. The availability of a discrete temporary safe space within the hospital where women may receive medical treatment and psychological support with privacy would also ensure her immediate safety by preventing access to perpetrators. It appears that the MoWCA is currently piloting such a temporary safe facility at the District General Hospital Moneragala.[47]

Women ex-combatants requested a dedicated shelter as the high levels of stress they continued to experience made it difficult for them to integrate with family and community and share a shelter with other women.

There was evidence of risk of violence to transgender. Social Services officers indicated that Transgender women need to be identified as a vulnerable category for assistance. Counseling officers noted that LBT women have occasionally sought help over the phone but rarely visit the Counseling unit for one-on-one assistance. A WMC-IGLHRC collaboration has developed a TOT training manual and trained NGO counselors to strengthen NGO counseling services for LBT women experiencing family and domestic violence.

- Integrating Alcohol and Drug prevention and rehabilitation services and formulating guidelines / protocols for the referral of individuals for management of substance use/abuse is likely to further strengthen the current SGBV response mechanism .

CHILDREN'S SERVICES FOR ANY CHILD AFFECTED BY VIOLENCE

"The child suffers whether the family breaks up due to violence or stays together with violence continuing"- Service provider in the NP

Children exposed to DV/IPV are more likely to exhibit poor academic performance, personality and behavioural problems including a range of anti-social behaviours "normalizing" violence in their interpersonal relationships. Such children are at greater risk for substance abuse, teenage pregnancy and criminal behaviours in adolescence. The single best predictor of children becoming either perpetrators or victims of domestic violence later in life is shown to be whether or not they grew up in a home where there is domestic violence .

The mapping showed that basic needs of safety, healthcare, and education of children accompanying women had been ensured free of charge at shelters or through their transfer to other institutions with the assistance of the Department of PCCS. A proportion of children needing more in-depth mental health assessment had been referred to the Child and Adolescent units associated with MH Units. Limitations in time and trained personnel are barriers to these units from providing regular psychological support and counseling to children and adolescents

[47] Source : http://www.childwomenmin.gov.lk/about/ministry-programmes/development-division

referred by MP/NP clinics and Counselors.

The DCDC in Matara is currently reviewing a proposal to empower WDOs to intervene on behalf of children although many service providers[48] are already tasked with monitoring the welfare of children and ensuring their rights.

- Ensuring the right to psychological well- being of children exposed to family violence requires mandating/ monitoring the timely referral of children for routine mental health assessment in protocols/guidelines for management of women victims/ survivors, strengthening child and adolescent mental health services at base and provincial hospitals, rectifying cadre deficits in school child guidance counselors, strengthening case conferencing mechanisms and DWCDC to protect the rights and well- being of children affected by violence.
- Engaging the WDO on behalf of children may risk duplication as many trained officers at district and divisional level are already mandated to address the health, wellbeing and rights of children .

Community information, education and community outreach

State sector institutions and NGOs engaged in community information, education and community outreach activities related to SGBV. MP/NP clinic staff and NGOs attributed the delay in attendance for counseling to low community awareness of the benefits of counseling and the availability of services.

Service providers identified the lack of funds as the key challenge to sustain IEC and outreach activities. The regular conduction of community outreach activities is also challenged by the land size, issues of transport, travel allowances and cadres. Officers of the MoWCA and MoPISE units had overcome limitations in funds by conducting joint programmes and participating as resource in each other's activities. But problems of terrain, transport and limited travel allowances made it difficult to access communities in remote villages among whom anecdotal reports indicated higher levels of violence for outreach.

The regular conduction of community outreach activities was challenged by limitation in funds, the land size issues of transport and travel allowances. Officers of the MoWCA and MoPISE units had overcome limitations in funds by conducting joint programmes and participating as resource in each other's activities. But problems of terrain, transport and limited travel allowances made it difficult to access communities in remote villages among whom anecdotal reports indicated higher levels of violence.

Sustaining public awareness of the problem of violence was further challenged by the fewer number of NGOs addressing SGBV issues in the post- conflict period. Many NGOs had ceased to operate or had shifted their focus to developmental activities, although some continued to engage in SGBV awareness raising activities.

Most IEC and outreach activities and awareness programmes targeted groups considered to be vulnerable to SGBV such as estate communities, youth, and conflict affected women as well as teachers, parents who may be considered gatekeepers, and women's societies.

[48] Divisional Secretariat- CRPO, ECDO, CPO, NCPA officer. Department of PCCS -Probation Officer

Service providers favoured SGBV community awareness programmes that emphasized the quality of family life and protection of children as they were culturally acceptable to communities and made it easier to engage with perpetrators.

The high prevalence of DV/IPV in the upcountry plantation community is attributed to the confluence of severe male dominance, alcoholism, poverty and low literacy that disempowers women and prevents help seeking behaviours. The cessation of donor funds during the past two years has severely challenged the PHDT to complete the 50 SGBV awareness programmes that are conducted under the annual action plans for estate workers in the seven RPC regions. The PHDT is currently strategizing to engage with the MOH/MOMCH to re-schedule these programmes but the activity is constrained by the reluctance of estate managers to support the cost of refreshments for the activity.

There was considerable awareness about international events such as The International Women's Day among officers at the divisional level and the MP/NP but there was less awareness of the UN 16 days of activism campaign and its significance. The MoH annual commemoration of IWD is spearheaded by the FHB through many activities such as GBV related panel discussions, seminars and sensitization workshops for the media. The visibility of the LAC in similar activities was low. A WDO in the Ampara district (EP) had overcome the barrier of lack of funds by sensitizing and mobilizing a village community to conduct a simple commemoration of IWD. NGOs were highly aware of both events as most had regularly participated at UNFPA led events by the NFAGBV and some had conducted activities of their own during the 16 days of activism campaign. The NFAGBV is constrained to sustain the momentum generated through these high profile events by the lack of NGOs to carry out activities in the post -campaign period and funds.

IEC material on display in Mp/NP clinics and NGO crisis centers

IEC material in the form of pamphlets and brochures with information on SGBV, the PDVA, and services was freely available at MP/NP clinics and NGO crisis centers. The bilingual (Sinhala / Tamil) material content was presented in a culturally appropriate manner and included crisis information on help lines, hot lines, and NGO, police and legal services but did not provide information on shelters for reasons of security.

Well-designed pictorial IEC material suitable for women with low literacy is used by an NGO in the CP to support programmes on empowerment and rights for women workers in the plantation community. A few sensitization programmes have also been conducted for men.

Many NGOs favoured organization websites and social media to disseminate information and create awareness as these permitted wider audience reach at competitive cost.

Service providers stressed the need to seek UN, INGO and private sector sponsorships for TV/radio panel discussions to increase

public awareness and for the conduction of sensitization workshops for media to enhance ethical reporting of violence. This was considered as likely to lessen the stigma associated with SGBV among the public and create an environment more conducive for women and girls to seek services.

Less costly alternatives to mass media such as public billboards, street dramas, plays, and walks were recommended to increase public awareness. Engaging school children to paint messages about VAW and human rights was recognized to have the dual benefit of sensitizing the public and students against violence.

Outreach activities by women's societies of the MoWCA and community level networks established by NGOs/CSOs need to sensitize communities to support timely access to SGBV prevention services for women in crisis situations.

There is a concerning lack of specific IEC material on SGBV for women/girls with disability and men in general and perpetrators in particular.

- Empowering communities to support and protect women/girls including those with disability and restrain perpetrators from violence requires advocacy of international organizations and the private sector. Greater investment in programmes and activities that enhance and sustain the awareness of rights among the public, women, girls, men and state sector service providers; sensitizes media for ethical reporting; and supports the production of culturally sensitive trilingual/bilingual target audience specific IEC material.

The right to information and services for communities at higher risk of SGBV requires advocacy of the lead ministry to facilitate service delivery to communities in remote villages by rectifying anomalies in cadres, and issues of travel and transport.

ASSISTANCE TOWARDS ECONOMIC INDEPENDENCE, RECOVERY AND AUTONOMY

Women attend counseling in expectation of cash and other benefits and do not return when they don't receive these - State counselor in the NP

"Cycle of poverty and SGBV violence is broken by the economic empowerment of woman – Leading NGO in the CP

"50% to 70% of livelihood projects are a failure because there is no market analysis before starting the activity and women lack skills related to marketing" - Leading NGO in the NP

Violence impacts the health and well- being of women and girls and significantly reduces their ability to fully participate in society[49]. Poverty levels among women in the war-affected Northern Province are among the highest in the country and there have been several initiatives by the Government, NGOs and corporate sector[50] and the NPC to generate economic growth and income-earning opportunities for women, and the majority of these prioritise WWH/WW. The National Plan for Women Headed Households spearheaded by the MoWCA addresses the economic empowerment of women through six interlinked sectors among which are strategies for health, psychosocial support and livelihood opportunities. However, this is still pending cabinet approval since 2017.

The MoWCA has adopted many strategies such as loans,[51] private sector partnerships,[52]

[49] Ibid 3

[50] Ibid 10

[51] Revolving low interest loans - This incremental fund mechanism is based on a seed grant disbursed through the District Secretariat.. Amounts exceeding Rs. 60,000, are facilitated through a bank loan raised on a MoWCA letter of assurance. This scheme has temporarily been discontinued due to lack of funds to distribute the seed money.

[52] A collaboration with the David Peries Motor Company – three wheeler and motorbike repair mechanics. Training is on going and has been completed in Killinochci and Matara.

women entrepreneurship led livelihood projects at village level [53] and facilitated skills building through collaborations with vocational training authorities[54] and relevant Ministries[55] to prioritize livelihood assistance to WHH/WW, domestic migrant workers and other eligible women. Poverty stricken families with school going children and WHH/WW had been prioritized for livelihood assistance by the NPC Department of Agriculture[56] through a partnership venture for restaurants.

Goods display at the WESWA Community Development Center affiliated to the Vengalacheddikulam Livelihood Project, Ministry of Women and Child Affairs.

The inadequate monetary value and delays in payment of the many state social protection schemes[57] providing assistance to WHH/WW failed to provide timely relief. The mapping found that poor coordination limited access of NCEWHH officers to vital information on WHH/WW in the DS database for programme planning. A lack of coordination resulted in NGOs arbitrarily selecting villages and communities for outreach and livelihood programmes without the benefit of the insights of the WDO and District Secretary.

In the NP, women's uptake of counseling and participation in livelihood training programmes at the NCEWHH was strongly conflicted by their expectations of receiving money and material assistance. The failed expectations led to considerable drop out from both counseling and skills building programmes and increased their vulnerability to microcredit schemes of dubious transparency that trapped them in a cycle of debt driven repetitive violence pushing them towards migration or attempted or committed suicide.

In the SP, Human Resources Development officers at the Matara district secretariat had mediated job placements for women victims in FTZ factories on their behalf.

In the EP, a leading NGO[58] addressing the rights of Muslim women had supported alternative livelihoods for Muslim domestic migrant worker women through a catering venture. In the NP an NGO[59] with long experience of providing psychosocial support to conflict affected women linked the assurance of livelihood opportunities to long term commitment of women to complete the counseling process.

In the CP, the WDC has established a social enterprise venture "Sthree" **(Woman)** to address the economic empowerment of women/girls at the Haragama shelter[60] and

53 The Vengalacheddikulam Livelihood Project linked to the WESWA Community Development Center supports 60 women entrepreneur families living in 20 GN divisions A range clothing, clay, candles and banana fibre products with market demand are made for local and Australian markets. Products are sold at the Centre. The District Secretariat deducts 12% as commission to hire the Manager and pay for utilities

54 A NAITA partnership has provided enrolment for women (who otherwise may have migrated) in certificate training programs for caregivers and Child Care nurses, for which there is a high demand

55 Ministries of Industry, Livestock Development, etc

56 Ammachchi Restaurants are a well patronized chain of vegetarian restaurants offering wholesome competitively priced food and run by women trained in preparation of wholesome traditional foods. The Department of Agriculture reserves a daily commission between Rs. 50/= - Rs.500/= for the facility and utilities from each woman whose minimum monthly earnings is around Rs.60,000.

57 WHH recipients of Public Assistance Monthly Allowance (PAMA), WHH Samurdhi recipients, Widows allowance for qualifying WHHs, Maternity vouchers for pregnant women in WHHs, Disability allowance for qualifying WHHs, Pensions for qualifying WHHs, WHH recipients of Self – employed Persons Pension Scheme (SPPS)

58 The Muslim Women's Research Action Forum (MWRAF)

59 The Family Rehabilitation Center

60 The on- site training center cum production unit/ weaving division at the Haragama shelter provides guided training in handicrafts, animal husbandry and home gardening sales and customer service responsibilities Goods produced by the girls are marketed at the social enterprise shop STHREE (*Woman*) in the Kandy town, with opportunity to continue marketing their products at the shop after leaving the shelter.

youth with special needs by engaging them in a creative entrepreneurship programme to, produce ecofriendly household necessities and providing a marketing outlet to sell the products.

The MOWCA required co-funding to engage resource persons to strengthen skills of girls/women in shelters to produce goods of higher quality that would be more marketable.

Service providers in all provinces emphasised that women required more vocational training opportunities, skills in managing their finances including savings, and livelihoods aligned with market demand to empower them and lift them out of poverty.

Goods made by women and girls at shelters.

Re-integration into the community

The majority of girls/ women at shelters In the NP and EP were not inclined to reunite with their families on a permanent basis. Their preference was to give the babies for adoption and temporarily reunite with families until they established themselves in self-employment ventures that would provide them independence. This decision appeared to be driven by strong concerns of being stigmatized as women who had borne children out of wedlock and how it would impact their families and themselves. Girls/ women were expecting to acquire income generating skills while at the shelter to help them become economically independent after discharge. On the other hand, in the CP, the preference of girls was to reunite with their families after leaving the shelter and they were accordingly being equipped with a range of skills for future self-employment and financial independence towards re-integration.

The WDC Network of Women (NoW) in many provinces appeared to be a viable model for SGBV prevention through economic empowerment of women[61].

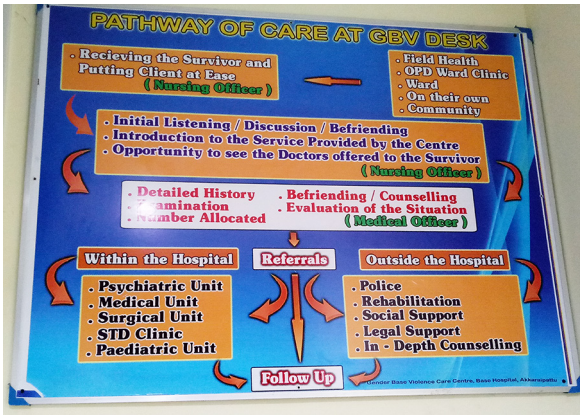
- Ensuring the economic empowerment of women by strengthening of the NCEWHH to fulfill its mandate is a priority.
- Establishing district level coordinating/
- monitoring committees to ensure the transparent and equitable allocation of livelihood opportunities to impoverished families through the development of guidelines/ protocols, a working classification of WHH/WW and eligibility criteria; supporting higher incomes for women entrepreneurs by establishing state-private sector partnerships for provision of technical expertise to improve quality of goods and secure overseas markets; advocating relevant authorities to enhance the monetary value of current social protection mechanisms to WHH/WW, and continuing to prioritize WHH / WW for economic empowerment to enable women to be retained in counseling programs for a minimum of six months towards recovery.
- Identifying co-funding for recruitment of resource persons skilled in livelihood development activities to improve the quality and marketability of products would increase skills of girls/women for empowerment through self-employment after discharge from shelters.

[61] NoW provides trainings in political participation, RTI, processes of transitional justice in peace and reconciliation and climate change

- Strengthening of liaison and coordination between all sectors to ensure a timely response in all activities related to providing economic relief to communities would reduce the impact of SGBV on women, girls and dependents.

Foundational elements essential to Social Services

Referral, risk assessment and management, and the availability of appropriately trained staff and workforce development are fundamental to service delivery and are a measure of the quality of SGBV services.



Posters depicting the range of services available for SGBV response at NGO crisis centres

Referral

Referral is key to providing women and girl victims/survivors timely access to services to address their needs routinely and in crisis situations. Formalizing referral through the use of protocols /guidelines documents the process for future reference, provides insights into the perceived needs of clients, assesses the degree of integration between services, identifies the need to link with new services based on client requests, and the resources required to enhance the overall effectiveness of the process.

All SGBV prevention services provided referrals only on request, and the service provider documented informed consent on the CIF.

Services other than the FHB MP/NP clinics lacked protocols and guidelines on the many aspects related to referral of clients between services. The FHB protocol for MP/NP clinics provides comprehensive guidance on delivery of empathetic support, referral of clients between services, ethical sharing of client information, and the principles to be adhered to when issuing letters of referral. The MP/NP clinic routinely notifies the referral to the other service by phone but a formal letter of referral is only issued at the request of the woman, in the interests of her safety.

MoWCA and MoPISE divisional officers generally relied on telephone calls and chits to refer clients for crisis related services, community based follow up and livelihood assistance.This “telephone call-chit system” was considered advantageous as it circumvented the problems of limited stationery allocations and the period of one week needed to obtain a signed letter of referral from the District/Divisional Secretary.

In the NP, the MP/NP clinic (TH Jaffna) required women who refused referral for legal

services to attest it in the CIF. This practice was not reported at other MP/NP clinics or among other services. A woman who left the shelter by choice usually did not appear to receive referral for services.

Counselors did not routinely issue reports on clients referred for counseling. A report was mandatory for couples referred for counseling by Court.

The standard practice at the NCW Gender Complaint Unit is to follow up all referred cases until they are resolved. This was not evident at other services. Some MP/NP clinics had devised simple low cost methods such as registers and serially numbered referral forms to monitor referrals.

At the MP/NP clinic DGH Vavuniya, mothers who requested referral of their children to the DCDC were issued a letter of referral. The dearth of information on follow up is due to most services placing the onus of follow up on the woman.

Referral of women between services results in the concurrent replication of her data profile in risk assessment formats that are not comparable. This has implication for estimations of the burden of SGBV and the allocation of resources for services.

- The timely referral of clients between services is likely to be facilitated by the availability of guidelines/protocols for ethical and confidential sharing of information among partner services, referral forms and monitoring the adherence of staff to the guidelines/ protocols.
- The identification of the case holding institution, case manager, and the use of unique serial client registration numbers would support confidential referral and follow up, and avoid duplication of client data. Routine recording of referral data in Information Management Systems will provide evidence for allocation of resources to enhance service delivery and strengthen collaboration between services.
- Increasing the monthly stationery allocation and authorizing an officer (other than the Divisional/District Secretary)to sign letters of referral is likely to expedite timely referral of women and strengthen formal coordination between services at the divisional level.

Risk assessment and Management (RA & M)

Risk assessment (RA) and management is the cornerstone of efforts to restore well-being of woman and girl victims. It is a step wise process based on the timely administration of comprehensive and appropriate risk assessment tools by trained staff.

The Risk Assessment (RA) and Management tool in each service was the client information (CIF) form. A comparison of CIFs showed that only those of MP/NP clinics and NGO crisis centers appeared to have been specifically developed for collecting information to respond to DV/IPV and non-partner sexual violence. The CIFs of the WC Units and Counseling Units were general forms that collected data on a range of items of relevance to each service such as livelihoods, welfare in addition to violence. The RA and M forms at shelters were those of the managing NGO partner.

The completion of the RA and M at shelters, was the responsibility of trained counselors. Residential staff such as matrons/ wardens and case managers of varied levels of competency completed the RA form when counselors were not available. Most RA tools did not collect adequate information on

children and perpetrators.

Women attending services at divisional units mostly sought help for marital and relationship problems including violence, alcohol and substance abuse of spouses/ partners and education and behavioural issues of children.

The RA by the index service provider (the service of first contact) was followed by the development of the care plan which was individualized according to each woman's needs through referral to other services. The RA was mostly completed at the first session (MP/NP clinic staff and MoWCA counseling assistants) or through a two-step screening procedure that resulted in the detailed collection of information only for those clients identified as needing counseling.

Referral of clients for mental health and gynaecological services was common. In Kandy, (CP) the MP/NP clinic was primarily linked to the Gynaecology Unit due to the high admissions of cases of sexual abuse and the VOG pro-actively engaging in SGBV prevention activity.

In all provinces, MP/ NP clinics had strong links with the Mental Health Unit.

The MH Unit TH Batticoloa felt that dissociating itself from routine MP/NP clinic services to adopt a purely technical/advisory role would de-stigmatize the clinic and encourage more women to seek services. At the same time the MH Unit expressed reservations about encouraging women victims/survivors to seek care at RDHS Community Mental Health Units as it risked doubling their burden of psychological distress by labeling them as being mentally ill. These stigma related concerns were not voiced at MP/NP clinics in the other provinces.

Data shows that women in the districts of Jaffna, Mullaitivu and Vavnuiya and Batticoloa districts seek assistance at Community MH clinics. This may partly be due to the lack of counselors in Vavuniya and 85% of counselor cadre positions in Mullaitivu being vacant. (Table 16).

Risk management options used to ensure the safety of women and girls included admission to shelters, referral to other services, use of various counseling techniques, providing services for perpetrators and case conferencing for children and women.

The MH Unit staff at the DGH Kilinochchi (NP) endorsed case conferencing whereby a multi-sectoral group of service providers including the WDO, was convened to provide family based assistance to women.

This practice was rejected by MH Unit staff at the TH Batticoloa (EP) who felt that the process stigmatized the woman by requiring her to repeat her story.

In all provinces, counselors requested closer links with child MH specialists to provide support to children affected by exposure to DV/IPV.

The MH Unit at the DGH Killinochchi routinely targeted alleged perpetrators for assessment of alcohol related problems in instances of domestic violence and child abuse. A letter forwarded through the Hospital Director with copy to Police, requests the WDO,CRPO and NCPA officers in the 5 divisions of Killinochchi to…"make necessary steps to bring the perpetrator to DGH Killinochchi for assessment of alcohol related problems."

Counselors in the Ampara district (EP) noted the lack of counselors in the SLBFE pre-departure training programme to address mental health issues of domestic migrant worker women.

The temporary safe space that is currently being piloted by the MoWCA at the DGH

Moneragala is significant as it provides an women with an alternative option for safety and care with less stigma when timely access to shelters is difficult.

- Effective RA and M requires guidelines/protocols for the development/use of standardized RA and M tools with provision for services to separately collect data for their specific requirements, achieve consensus for the identification of the case holding service, case manager, use of unique serial client identification numbers, including ethical sharing of client information for referral based on informed consent of the woman and training/supervision of staff in development and use of individualized care plans , and timely referral .
- The role of mental health services in the SGBV prevention response needs to be defined through discussions engaging the service sectors, and mental health professionals (psychiatrists, community mental health specialists, psychologists, counselors) and those addressing alcohol and drug prevention and rehabilitation to ensure that women, children and perpetrators receive the necessary support to restore their mental health well-being without stigma.

Appropriately trained staff and workforce development

Service delivery in all sectors was done by trained permanent and volunteer staff.

Recruitment

Recruitment of staff at MP/NP clinics (medical officers and nursing officers), LAC regional centers (AAL), and Police WC Desks (women police officers and male sergeants) was through standard procedures following the completion of a stipulated period of basic training. Divisional Staff at WC Units and Counseling Units had been engaged through the state graduate recruitment schemes based on minimum eligibility criteria and had additional professional qualifications in diverse disciplines . The entry level recruitment criterion for MoPISE counselors is the Diploma in Counseling that is a general qualification. At NGO crisis centers organizational policy determined recruitment criteria for legal officers and trained counselors. The GCE Advanced level was the recruitment criterion for volunteers at MP/NP clinics who had subsequently been trained in SGBV prevention through state and NGO training programmes.

Training and Workforce development

In the state health sector, the undergraduate curriculum in all medical colleges teaches a module on GBV prevention. .

The Women's Health and Gender Unit of the FHB has standardized the training of public health staff by including modules on GBV prevention in the MOH orientation programme and the PHM pre-service curriculum. The FHB uses Annual refresher training programmes, experience sharing workshops and on-site reviews to continually strengthen capacity of MP/ NP clinic staff including volunteers.

The FHB conducts four-day training workshops on SGBV prevention response to build capacity of divisional officers of the MoWCA WC Units, MoPISE Counseling Units and the NCEMWHH.

NGO staff had been trained in SGBV response mostly by the parent organisation. Capacity building of WPO of police WC desks had been done by the MoWCA.

There was consensus among service

providers on the need for more inputs on self-care in FHB training workshops on SGBV prevention. NCEWHH staff specifically requested the inclusion of inputs on problems of WHH/WW in SGBV training programmes.

English was a limiting criterion for eligibility for overseas scholarship training in Gender and Development offered by the MoWCA.

Counselors access Divisional Secretaries for administrative guidance. District Coordinators provide general technical support but are unable to provide more insightful assistance with client problems due to lack of training.. Thus Counselors relied on the peer review process to facilitate an empathetic learning/ sharing of experiences to develop skills to manage complex client problems. Distance and transport costs made it difficult for MoPISE counselors in the NP and EP to regularly attend the compulsory monthly peer supervision review conducted by the Ministry.

Counselors strongly reiterated the urgent need for clinical psychologists for their supervision and mentoring and this was acknowledged by the MoPISE.

Divisional staff requested more case based training and inputs on marital/relationship, sexual, group, suicide and substance abuse counseling to strengthen their technical capacity. The relevance of feminist counselling to empower women and girls was emphasized by an activist woman NGO.

WPOs at the police women and children desks are frontline officers expected to assist women who wish to seek legal relief. WPO coordinate the different medico-legal, health and law enforcement processes on behalf of women and lead evidence in cases of DV in Court. Capacity building of WPO at police WC desks had been done by the MoWCA. Police superiors stressed the need to strengthen them in proper Court procedure, preparation and presentation of cases, and increase their self-confidence to effectively argue cases of DV/IPV, to prevent the dismissal of cases by Court on the basis of legal technicalities and insufficient evidence.

The PDVA 2005

The LAC had conducted two trainings for Judges on the PDVA 2005 through the Judges Training Institute with eminent legal persons as external resource. Advocacy of judges on the PDVA 2005 has since been discontinued as their high position is the key challenge restricting opportunity for engagement. There was consensus among all service providers on the need to sensitize judges on the PDVA.

The PDVA 2005 was not a component of the basic curriculum for AAL graduating from the Sri Lanka Law College before 2005.The LAC trains its regional staff on the PDVA through in-service training programmes but this is currently challenged by a lack of funds. The LAC has also conducted a few joint training programmes for legal officers and WPO of the police women and child desks.

The annual capacity building workshops conducted by WIN for its organizational staff includes Information on the PDVA 2005. WIN is resource for capacity building of other service providers on human rights and the PDVA.

Knowledge of the PDVA and basic Court procedure was limited among staff at MP/ NP clinics and WC and Counseling units compared to their awareness about services provided by other sectors.

Counsellors stressed the need to implement the school based programme on age appropriate comprehensive sexuality education, address gender stereotyping in secondary school curricula and strengthen

teaching of human rights as long term measures to respond to SGBV.

Workforce related issues

Service availability

Table 3 lists the routine working hours of the services.

Counsellors of the Ministry of Primary Industries and Social Empowerment

The majority (> 85%) of MoPISE Counselors are women. The TOR of Counselors of the MoPISE includes the following duties and responsibilities among others: Support/ Assist the establishment of a Counseling Unit within the Divisional Secretariat; Be present in the Divisional Office on Monday and Wednesday to provide counseling services; Conduct counseling clinics; Provide a range of counseling services including individual counseling/Family Counseling /Counseling for sexual problems/etc. and support the Hospital Mental Health Unit. The assigned workplaces for Counselors included the Divisional/District Secretariats, prisons, mental health units, children's homes, elders homes, and rehabilitation centers.[62] The Courts are not an assigned place of work as the Court system has its own family counselors. However, Counselors reported that they were burdened by the time consuming task of submitting mandatory reports on couples referred to them for counseling by Court when family counselors were unavailable.

The MoPISE is challenged to maintain an adequate cadre of officers to sustain services by its inability to recruit suitably qualified individuals, as well as retain trained officers due to delays in confirmation in service, absence of structured pathways for career advancement and salaries that are inconsistent with qualifications. At present 36% of cadre positions for counselor are vacant.

The cutbacks in annual in-service training programmes due to lack of funds had led to recently recruited counselors being prioritized for training over senior counsellors.

Policy formulation and advocacy for strengthening counseling services is constrained by the limited capacity of the MoPISE to generate evidence based data.

Counselors lack official vehicles for field work and distance and costs are particular barriers to those from the NP to attend the monthly peer supervision review mandated by the Ministry.

The MoPISE acknowledged the strongly reiterated and urgent need identified by Counselors for clinical psychologists for their supervision and mentoring.

Counselors noted that the Court directive to provide reports on couples referred for counseling burdens them with extra work but failure to do so risks being in contempt of Court.

The MoPISE is taking steps to regulate and strengthen the quality of counseling services through a process of accreditation of training institutes, introduction of a competency based annually renewable licensing system, and revision/ revamping of curricula and practical training.

There is no academic/professional body to safeguard the professional development and interests of counselors.

WDOs and Counseling Assistants of the Ministry of Women and Child Affairs

The mapping found that WDOs were engaged in developmental and SGBV prevention related activities (eg. supervision of women/ girls in shelters, facilitating livelihood opportunities for women/girls

[62] Developing State Counseling Services in Sri Lanka. Asia Foundation. 2018

discharged from shelters, maintaining a database on women/girls discharged from shelters, coordination, development and submission of livelihood related proposals, disbursement of grants, and liaison at the district secretariat). Some WDOs were strongly of the view that SGBV prevention activities (care, guidance and counseling of women and their children to mitigate the impact of SGBV) were not assigned duties of DOs.

The MoWCA noted that service delivery in the NP is challenged by the loss of man hours of work due to the preference of many officers to travel daily from their residences in Jaffna to work stations in the other districts, as well their preference to seek appointments in Colombo where educational and health facilities are better.

At the same time MoWCA officers at the divisional level expressed considerable dissatisfaction related to clarity of roles and responsibilities, designations, issues of service, ambiguities related to official vehicles and travel allowances and opportunities for career advancement.

The monthly travel allowance (Rs. 2000) is insufficient and WDOs incur out of pocket expenses related to official travel (supervision of shelters, visit remote villages with anecdotal reports of higher levels of SGBV, and cover up duties). Similarly, the lack of computer/internet facilities requires use of internet cafes at personal cost to attend to official correspondence.

The MoWCA has attempted to compensate WDOs for the lack of a structured career pathway by appointing them to the end post of district coordinators to enhance their status.

Counseling Assistants reiterated the need for a new designation that recognized the quantum of services they provided and did not denigrate them as “assistants

The MoWCA noted that English is a limiting criterion for eligibility for overseas scholarship training in Gender and Development offered by the Women’s Bureau.

- Clarifying the TOR/job description of WDOs and the ownership of vehicles assigned for official work, recognizing higher qualifications for additional increments, and facilitating timely approval of leave to obtain specialist medical care is likely to improve morale among affected staff.

Medical Officers, Nursing Officers and Volunteers of MP/NP clinics of the Family Health Bureau, Ministry of Health

The recent decision of the MoH to ensure sustainability of MP/NP clinics by appointing permanent staff through the annual transfer list is commendable. However there is a likelihood that this may compromise the quality of service as attitudes of permanent officers may differ from those of current staff who volunteer through their motivation to support women victims/survivors. Non-medical volunteer staff at the MP/NP feared that they may be moved to other units consequent to the MoH decision to appoint permanent staff.

In some stations, MP/ NP clinics had networked with staff in other units to ensure continuity of services. MP/NP clinics had adopted varied measures to ensure continuity of services, based on networking with medical and nursing staff in other units. At the DGH Nuwara Eliya, a temporary roster of nursing officers was used to sustain services following the demolition of the clinic and its relocation to a new OPD building; at DGH Vavuniya, OPD officers covered up MP/NP clinic duties on the weekends. The MP/NP clinic at the DGH Kilinochchi was supported by doctors and nurses of other

units who volunteered their services. A lack of funds to retain volunteer staff had resulted in the temporary closure of the Trincomalee clinic in 2017 and it was expected to resume services in 2019. Non-medical volunteer staff at the MP/NP feared that they may be appointed to other units consequent to the MoH decision to a

The findings indicate the need for purpose–designed MP/NP clinics staffed with appropriately trained full time staff and assured funding to ensure effective service delivery.

Under-utilized service providers - Public Health Midwife; Plantation Family Welfare Worker

An opportunity exists to mitigate the gap in community based service delivery for SGBV prevention (aka issues related to divisional officers) by increasing the visibility and engagement of two community based service providers, namely the PHM and PFWO.

The PHM has proven credentials as the trusted provider of MCH services to women in the community. She serves a defined population (one PHM/3000 population) and is trained in SGBV prevention work. The low referral (6%) from PHM to MP/NP clinics probably represents the proportion of more serious cases requiring hospital based services and that less affected women are being supported at community level. A recommendation has been made to determine the reasons for the current low visibility of the PHM in SGBV prevention.

Strengthening the PFWO to support women victims/ survivors in the plantations appears useful as she is a widely recognized resident member of the community who may be easily accessed in time of need.

Personal safety and security

The MoPISE circular pertaining to the personal safety and security of Counsellors while on official duty authorizes home visits only if there is a prior request by the officer or client. It requires visits preferably to be done by a pair of officers to avoid allegations of impropriety and risk of exposure to physical and verbal abuse by perpetrators.

An NGO in the CP related an incident where a WDO who attempted to intervene in a domestic altercation between a couple had been remanded by the Police when the alleged perpetrator had accused her of trespass.

Divisional Officers acknowledged the usefulness of the circular, but felt that being legally empowered (similar to Probation officers) would command them greater respect from the community and facilitate them to more effectively intervene in instances of domestic violence, with safety and security.

Health and Well-being, Work related stress

WPO at the police WC desks and non-medical staff at MP/NP clinics reported that mental stress due to working on a daily basis with victims/survivors has negatively affected their personal and family lives. The service risked losing trained staff as affected officers had requested transfers to more congenial posts but had not sought professional help. MoPISE counsellors reached out to family, friends and colleagues for emotional support and relief from work related stress.

Infrastructure issues

Working environments - Working spaces, Communication and IT facilities

Attitudes of Divisional/ District Secretaries and Hospital administrators appeared to be important determinants of allocation of

working spaces and facilities in institutions. WC and Counseling units reportedly were not routinely entitled to offices, and fixed phones at the district /divisional secretariats.

Physical facility

Most WC Units were too cramped to comfortably accommodate the assigned complement of officers and provide a client friendly environment for discussions.

MoPISE Counseling Units where available, were generally unsuitable for engaging clients with privacy and confidentiality. Counselors reported having to find quiet spaces within the divisional secretariat building or even conduct the counseling sessions outdoors. Those sharing spaces had to take turns to leave the room to give the other Counselor the privacy and confidentiality to engage the client. In the SP sustained advocacy of a District Secretary by MoPISE Counselors has achieved the allocation of separate rooms for establishing counseling units in some divisions in the Matara district.

The MP/NP clinics were generally sited on the ground floor of hospital OPDs where the multiple entrances/exits, and the presence of other attendees reduced the visibility of women victims and facilitated safe access. Access to the few MP/NP clinics situated on upper floors was difficult for women with disability as most OPDs lack an elevator. At DGH Kilinochchi the MP/NP clinic was temporarily accommodated in the Health Education Unit pending the allocation of a suitable clinic room. Refurbishment of most MP/NP clinics would make them more pleasant and client friendly.

The recently established Police WC unit in the Matara division by the MoWCA is a commendable prototype as the well-designed facility has a separate room where victims may record their statements with safety and privacy.

Communication and IT facilities

Working spaces, telecommunication facilities and other amenities at District and Divisional Secretariats appeared to be allocated at the discretion of the DS/DvS. WC and Counseling Units reportedly not routinely entitled to working spaces and fixed phone facilities.[63] Lack of computers and official telephone lines required WDOs to incur out of pocket expenses to use their personal mobiles to link with clients and forward work related emails from internet cafes. MoPISE Counsellors had computers and a select number (84) operated on a mobile phone package subsidised by the Ministry[64] that also incurred some out of pocket expenses. All MP/NP clinics had computers and around two thirds had direct help lines, some with internet facility. The MP/NP clinic at the Teaching Hospital Jaffna is unable to store confidential client data in the computer as the hospital administrator had identified it as a shared resource among many units and prohibited the use of protective passwords.

Travel and Transport

WDOs incurred out of pocket expenses related to official travel as the monthly travel allowance of Rs 2000/= was inadequate to meet the costs of hired vehicles to visit remote impoverished communities, do cover up duties and regularly visit shelters for supervision.

The current mapping indicated that there had been limited progress in implementing recommendations to address the workforce and working environment related gaps and challenges in service delivery identified in previous studies at the divisional level. [65],[66] .

[63] At DS/Divisional Secretariats only the Planning Unit is entitled to have a fixed direct telephone line.

[64] Ibid 17.

[65] Mapping Study on the Capacity and Work experience of Counseling officers/Assistants attached to the Ministries of Social Services and Child Development and Women's Affairs . The Institute of Health Policy 2015.

[66] Mapping study on the capacity and work experience of Counseling Assistants attached to the Ministry of Child Development and

SYSTEM COORDINATION AND ACCOUNTABILTIY

The mapping showed the presence of a multi-sectoral approach to policy formulation and service delivery led by the MoWCA[67] based on collaborations and partnerships with many stakeholders. Collaborations had also been established between stakeholders for the provision of shelter facilities and provision of livelihood opportunities and relevant skills building. District and divisional level coordination mechanisms were available to ensure timely implementation of activities.

National Committee on Women (NCW)

The amendments to the PDVA 2005 are being finalized and a training needs assessment of women counselors in the Local government is currently in force. The Attorney General's approval is pending on the revised draft bill initiated by the NCW for the establishment of the National Commission on Women to realize, protect and guarantee the rights and freedoms of women included in the Constitution, national legislation, and CEDAW. Discussions on microcredit schemes have been scheduled consequent to increased feedback regarding their adverse impact on vulnerable women.

High level stakeholder mechanism

The MoWCA has initiated the establishment of a High Level Steering Committee to support the implementation of the NPA -SGBV[68] and UNFPA is working towards establishing a M & E system at the MoWCA to monitor progress.

System integration

Integration was clearly evident between the legal and law enforcement services in view of their complementary duties. WC Units, Counseling Units and MP/NP clinics were comparatively less integrated with LAC regional centers probably as most women were reluctant to seek legal remedies for their problems. Integration between police and MP/NP clinics were related to referral of women/ couples for counseling related to family problems. NGO links to other services depended on requests for referral made by women within the services they already provided.

Coordination; Monitoring

The service sectors relied on monthly, quarterly and annual meetings/reviews to regularly monitor service delivery. It was not possible to access protocols/guidelines relevant to these meetings.

MoWCA divisional officers are monitored through a monthly Progress Review conducted at the Ministry at which attendance is compulsory. The Ministry had assigned officers to conduct the review at the district level to facilitate greater participation of officers from the NP and EP. A report on the status of activities and issues of coordination in each district is submitted to the Secretary/ MoWCA. In addition the MoWCA links with officers through email and fax for monitoring and supervision. The WDO (district coordinator) submits monthly reports to the MoWCA on the discharges from shelters and status of livelihood related activities.

The MoPISE monitors activities through monthly returns from divisional level counselors and quarterly returns from the District Coordinator/Counseling. A quarterly progress review meeting is held at the Ministry for all District Coordinators/ Counseling and attendance is mandatory. The District Secretary convenes a monthly review meeting with the district coordinator/ counseling and counselors. There is no annual review of counseling activities at

Women's Affairs (2015) The Good Practice Group.

67 National Plan of Action to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka (2016-2020). Ministry of Women and Child Affairs.

68 National Plan of Action for Prevention of Sexual and Gender Based Violence. MoWCA 2016-2020

present.

The FHB monitors MP/NP clinics through surprise On-site visits, Annual Refresher Trainings and Experience Sharing Workshops. The Annual Refresher Training is a combined capacity update and monitoring activity where the FHB proves feedback to MP/NP staff based on their data returns and work output. MP/NP staff also forward monthly and quarterly returns through the Reproductive Health information Management System to the Central database at the FHB.

LAC regional centers AAL submit monthly and quarterly returns of all cases to the Chairperson, LAC. At present, the regular conduction of the annual review for officers of the LAC regional centers is challenged by limitation in funds.

The line ministries and Divisional Secretaries provided guidance to officers on administrative and general technical issues. Some officers indicated a preference to discuss more sensitive issues of clients on a one-to one basis with the superior officer as it "allows the issue to be solved more quickly."

The quarterly District Coordination Meeting chaired by the District Secretary is a general review of all activities done by state, INGO and NGO actors in the district. The meeting is convened on a pre-circulated agenda and includes summary presentations by each organization. Attendance at the meeting is compulsory. The opportunity to present SGBV related issues for discussion was variable. The leadership provided by the district secretary determined the efficiency and effectiveness of the meeting.

At community level, the lack of funds to provide travel honorariums and refreshments were cited as barriers to the regular conduction of meetings of Women's Societies and GBV Networks.

All service providers emphasized the need to strengthen coordination between sectors to achieve better outcomes.

The need to improve coordination between sectors was reiterated during the KII with the Police. In the SP, an NGO has recently spearheaded the establishment of a multi-stakeholder Police led Network[69] that relies on case conferencing to collectively respond to issues of sexually abused women and children in the Matara Division. In the EP, an independent initiative has established a District Psychosocial Forum[70] to provide technical support for officers engaged in SGBV prevention activities.

Recommendations

- Advocacy of district officials, strengthening coordination and monitoring mechanisms through the formulation of guidelines, increasing travel allowances and identifying funds for refreshments is likely to enhance service delivery at the district and divisional level.
- Strengthening existing coordination and monitoring mechanisms is likely to give better outcomes instead of establishing multiple coordinating mechanisms at district level that risks overlap and duplication of efforts

Memoranda of Understanding

Shelters in the NP and EP have been established through MoWCA-NGO–District Secretariat collaborations .The Haragama Shelter for sexually abused girls in the CP is a registered Children's Home that has been established through a collaboration

[69] Police Network membership- Divisional Secretary, Officers of the Divisional Women and Child Unit, MoPISE Counselor, NCPA officers, WIN, Probation Officer, Prisons Welfare Officer, Representative from the DGH Matara,

[70] District Psychosocial Forum membership – Consultant Psychiatrist TH, Batticoloa, MoPISE District Coordinator /Counseling, D/CRPO, D/DCPO,D/WDO, D/ECCD O and D/Elders Promoting Officer , Community Correction Officer (Courts & Prisons)

between the WDC Kandy and the Provincial Department of PCCS. (Table 5).

In the NP and EP, 3–year MoUs outlined the separate responsibilities of each partner with respect to shelters and established monitoring committees for oversight.[71] Financing of shelters was on a shared basis of 70% by the MoWCA (utilities, groceries and goods) and 30% by the NGO partner (staff salaries).NGO policy guided the routine management of the shelter. The WDO (District Coordinator) is responsible for local coordination and liaison with the District Secretariat.

In the NP and EP, delays in authorizing transfer of funds between the MoWCA and the District Secretariat had required NGO partners to obtain bank loans at high interest for the routine management of shelters. The direct purchase of goods by the WDO for the Maruthenkerny shelter supported the smooth running of the facility whereas at the Maritimepattu shelter delays in reimbursement of bills for goods and groceries by the District Secretariat required the managing NGO to find additional funds to maintain the facility. The MoWCA is due to assume full administrative control of the three shelters when the MoUs expire in 2021.

The MoU for the Haragama shelter is annually renewed after prior inspection of the facility by the Provincial Department of PCCS. A shelter committee[72] provides oversight and coordination. The shelter is largely self-funded but receives a maximum annual allocation from the Department of PCCS of Rs. 300,000/= computed at the rate of Rs. 30/child/day for girls who complete a full calendar month (from the 1st to the 30th) at the facility. However, admissions take place throughout the month, and the loss of monthly income has required the managing NGO to find alternate funds for the routine maintenance of the shelter.

- The periodic upward revision of annual allocations based on the cost of living and other relevant indices; and strengthening coordination between relevant Ministries/Departments and District Secretariats for timely transfer of funds; and underwriting emergency funds for contingency situations is likely to streamline the routine management of shelters and lessen financial pressures on the managing NGO partner.
- The duration of the MoUs provide the MoWCA a window of opportunity to strengthen its capacity to ensure the smooth transition of administrative control of shelters while retaining the option to renegotiate current MoUs for continued management of shelters by NGOs to ensure uninterrupted availability of shelter facilities to women and girls.

Protocols/Guidelines

A detailed protocol of the FHB guides client management and referral and follow up at MP/NP clinics. A work instruction guideline[73] in Tamil and Sinhala on Assessment, Interventions and Referral is available for MoPISE Counselors and MoWCA Counseling Assistants. It was not possible to access a TOR for WDOs and a guideline for the WC Unit and the police women and child desk. At present, no circulars or guidelines are available to formalize the collaboration and coordination of the MP/NP clinics with other health services (medico-legal, psychiatry,

[71] Membership of the Shelter Monitoring Committee - Additional Secretary (Development) and Director of the Women's Bureau, relevant District Secretary (or nominee) Legal Officers of the Managing NGO. The Committee is coordinated by the NGO.

[72] Membership of the Shelter Committee – Provincial Dept of PCCS, Police, Medical officer of Health, WDC representative.

[73] Developed in 2016 as a joint activity led by a Clinical Psychologist) with the assistance of MOPISE District Coordinators and MoWCA Counseling Assistants

etc.) and the police WC desks, LAC and NGOs.[74] Similar protocols and guidelines appeared to be lacking among other service as well.

- The availability of TORs for service providers, guidelines and protocols for client management and circular/ guidelines to strengthen and formalize collaboration between service sectors is likely to support the timely delivery of services for SGBV prevention

Joint training activities among service sectors was not common although the LAC had conducted joint training workshops for LAC legal officers and officers of the police WC desks. Divisional officers identified the need for joint training in addition to sector specific in-service trainings as it facilitated learning through shared experiences, strengthened collaborations between services towards a more cohesive response and is cost effective. Joint training in addition provides insights into service related issues of other sectors that are important when making client referrals.

- Achieving consensus among sectors for joint capacity building activities, developing Guidelines on joint training programmes, identifying core content (e.g. CEDAW, PDVA ,Human rights etc), sensitizing attitudes, and supporting self-care is likely to strengthen the capacities of service providers for better service delivery.

Documentation

Documentation is vital for case management of victims/survivors, referral, follow up, monitoring of services, for leading evidence in Court, research, generating data for trend monitoring and evidence-based policy and programme formulation and implementation and advocacy.

RA & M forms (CIFs) were secured under lock and key in cupboards or in electronic systems where available. Data from the periphery was forwarded regularly through monthly and quarterly returns to central data repositories of ministries by post or through electronic systems for collation and analysis. At the MP/NP in the teaching Hospital Jaffna, confidentiality of client data was compromised as the hospital administrator had identified the MP/NP clinic computer as a shared resource among many units and prohibited the use of protective passwords.

Data from MP/NP clinics is captured in the FHB RHIMS. The MoPISE is currently being assisted by The Asia Foundation to operationalize its central data base to enable evidence based policy and programme formulation. Police data is available on its website.The MoWCA is in the process of establishing a national database on GBV with the support of UNFPA. NGO data was available on organization websites. All service providers disseminated data through annual reports, other publications and on websites but in many instances the data was not complete or current.

SGBV data is not comparable as it is collected by many organisations both state and non-state, primarily from an orgaisational needs perspective and definitions, categories as well as risk assessment formats are different. The establishment of a national database by the MoWCA is a significant step towards providing national level data to strengthen the SGBV prevention response.

- The development of standard operational guidelines based on internationally accepted practices would strengthen the collection, collation and analysis of information to provide national level data for more effective response and permit comparison with data from other

[74] Country Profile on GBV in Sri Lanka . WHO.2018.

countries.

- Protocols/Guidelines are required on mechanisms to ensure security and confidentiality of client data in resource constrained settings.

Rights of women/girls and children

Girls/women in shelters have the right to safety and security, to engage with family, to leisure and recreation, and freedom of movement. The psycho-social well-being of girls is likely to be affected by the absence or curtailing of these rights as well as their retention in shelters beyond the period of temporary residence stipulated by Court for whatever reasons. (Table 8)

Case Story

Two girls from a NP shelter had scaled the parapet wall and run away. The Police traced them to have travelled by bus to Colombo by seeking the assistance of other passengers. They were apprehended in Vavuniya when returning to Jaffna by bus, taken into police custody and readmitted to the shelter by Court order.

The retention of girls in shelters beyond the stipulated period of 3 months was due to a failure of Probation officers to secure their timely discharge through submission of an application to Court, the unavailability of the DNA report for registering the birth of infants prior to their adoption, and lack of a family/relative willing to accept the girl after discharge.

Shelter staff attributed the bickering and disharmony seen among girls to boredom and frustration caused by the following problems

- Shelters have few facilities for leisure and recreation other than reading, watching TV and livelihood activities of sewing or making handicrafts;
- Opportunities for socializing are greatly reduced by the NGO shelter policies on visitors and the location of shelters in isolated neighbourhoods for reasons of security and safety;
- Visits to places of interest and worship are rare as the monthly transport allocation is mostly spent on hiring three wheeler taxis to take girls to hospital for pregnancy related care.
- The presence of male security officers within the compound in NP shelters confined girls and deprived them from enjoying the outdoors.
- Women/Girls are not given money to hand on admission to prevent them running away.

Shelters had attempted to rectify this situation by allowing family members other than males to meet girls at organization crisis centers (shelter in the SP), or in a secluded space in the District Secretariat during working hours on weekdays (shelters in the NP). Staff in NP shelters felt that building a separate facility close to the shelter for families and women/ girls to meet was preferable as there would be greater privacy.

TABLE 8 – PERIOD OF TEMPORARY RESIDENCE OF WOMEN/GIRLS IN SHELTERS

Shelter	Period of stay	Extension of period of stay
NP	3 months	By a Court order issued on an application submitted by the Probation Officer
EP		
CP	Up to 18 years of age	
SP	Average of 2-4 weeks.	At the discretion of WIN
NCP (Kekirawa)	Up to 2 -4 weeks after delivery	At the discretion of RPK

Pre-school classroom at a state shelter in the Northern Province

Girls are allowed to remain in shelters until the DNA report proving paternity is available in order to facilitate birth registration prior to adoption. Access to education for children in shelters is ensured by the recruitment of preschool teachers by the MoWCA (NP shelters). The transfer of school going children to Children's Homes with the assistance of Probation Officers (SP shelter), and enrolling girls in nearby government secondary schools (CP shelter).

- A review of shelter policy/guidelines based on the principle of "the best interest of the child" is likely to identify measures that ensure the right to psychosocial well-being of girls in shelters without compromising their right to safety and security while temporarily in state custody.

The right to freedom of movement of girls may be safeguarded by preventing their institutionalization beyond the stipulated period by the timely action of Probation officers to procure their release through Court, greater availability of DNA testing.

The overall health and well-being of girls/ women may be enhanced by engaging them to identify a choice of recreational activities and increasing transport allocations to facilitate visits to places of interest.

Coverage

An assessment of coverage by services was done to increase the relevance of the use of the generic ESP Module 4 to determine gaps and challenges, and make recommendations on the status of SGBV prevention response in the selected provinces.

Tables 9 -16 indicate how the land size, population density, poverty levels, location of shelters, cadre strengths of MoWCA and MoPISE officers, and distribution of MP/NP clinics, LAC regional centers and Police WC desks impacted coverage of communities for service delivery.

Table 9 shows that with the exception of the districts of Kilinochchi and Jaffna in the NP, and Galle and Matara in the SP, the land area of all other districts exceeded 1250 sq. Km, with the three districts of the EP being the largest. The population density was lowest in the four districts of the NP other than Jaffna. The district of Mullaitivu, Mannar and Kilinochchi in the NP and Batticoloa in the EP reported the highest percentage of poor households.

Coverage by Shelters

Service coverage by existing shelters extended beyond their district of location with the exception of the Kekirawa shelter that restricted its services to the Anuradhapura district (Table 10).

At the Haragama shelter in the CP the managing NGO partner had changed the admission policy to accept abused women in addition to girls.

In the NP, a need for a state shelter in Vavuniya was identified by staff at the MP/NP clinic although two faith based organisations were providing facilities. In Mullaitivu, the request by women ex-combatants for a dedicated shelter for themselves is been addressed through a NPC – NGO collaboration although a state shelter is operating at the Maritimepattu division.

In the EP, divisional officers recommended a state shelter for the Ampara district based on the high levels of violence in some divisions, and the reluctance of women to seek admission to the shelter at Batticoloa due to distance and ethnic polarization of the three communities. A leading Muslim women's NGO in the EP required donor support for an export oriented agriculture project that aims to provide regular employment and a shelter facility for single Muslim women at risk of violence.

Service providers noted that many shelters established by NGOs and faith based organisations during the conflict period had ceased to operate. The establishment of one shelter in each district was recommended to respond to the continued escalation of violence against women and girls in view of the challenges they faced in accessing currently available facilities in time of need.

Coverage by MoWCA Women and Child Units & MoPISE Counseling Units

The MoWCA and MoPISE acknowledged that the current system of appointing staff on the basis of one officer per division is a barrier to achieving service coverage. In the Health sector coverage by public health field staff is achieved through the use of a population based formula that allocates one PHM for every 3000 persons and one PHI for every 10,000 persons.

There were District coordinator /WDO and District Coordinator/Counseling at all District Secretariats. The NPC has recently recruited a cadre of Psychosocial Workers (PSW) to support conflict affected families in the NP as

Table 9 – LAND AREA, POPULATION DENSITY AND PERCENTAGE POOR HOUSEHOLDS IN THE FOUR STUDY PROVINCES

Province	District	Land area Sq. Km	Population density per Sq.Km	Percentage poor households
NP	Jaffna	929	629	6.6
	Killinochchi	1205	94	10.7
	Mullaitivu	2415	38	28.8
	Vavuniya	1861	92	3.4
	Mannar	1880	53	20.1
EP	Batticoloa	2610	202	19.4
	Ampara	4222	154	5.4
	Trincomalee	2529	156	9.0
CP	Kandy	1917	717	6.2
	Nuwara Eliya	1706	417	6.6
	Matale	1952	248	7.8
SP	Galle	1617	658	9.9
	Matara	1270	641	7.1
	Hambantota	2496	240	4.9

Source - Department of Census and Statistics 2012.

there is no cadre of Relief Sisters in the NP.

Tables 11,12 and 13 show that service delivery by the WC and Counseling Units were most affected in the NP and EP. The limited number of women counselors in all districts other than Jaffna, Kandy and Galle, (Table 15) challenged service delivery to the large number of conflict affected women in the NP and women workers in the RPC tea plantations in the Nuwara Eliya and Matale districts in the CP. This was worsened by the lack of a cadre of Relief Sisters in the NP and the high number of vacancies among Counseling Assistants in the CP.

Table 10 – SHELTERS IN THE FOUR STUDY PROVINCES BY LOCATION, COVERAGE AND CATEGORY OF WOMEN AND GIRL VICTIMS/SURVIVORS

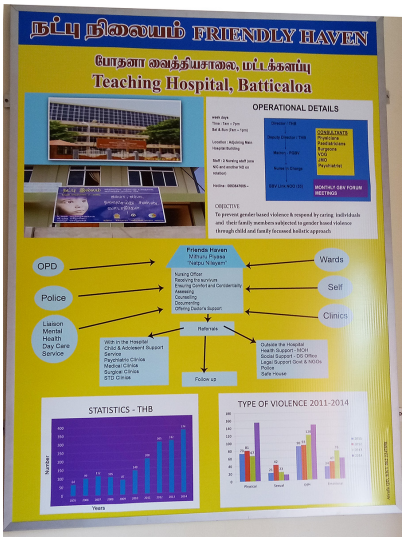
Province	Shelter	Coverage	Category of women/girls
NP	Maruthenkerny, Jaffna	Jaffna, Vavuiya, Mannar	Sexually abused women/ girl victims/survivors other than those who are mentally physically challenged
	Maritimepattu , Mullaitivu	Mullaitivu, Vavuniya, Mannar	
	Vavuniya (Faith based org.)	NP but mostly Vauvniya	
EP	Batticoloa	Batticoloa, Trincomalee, Ampara	
SP	Matara WIN	Matara, Galle, Hambantota,	
CP	Haragama, Kandy	Open island wide for referral. Referrals are mostly from Central, Uva and Eastern provinces.	
NCP	Kekirawa RPK	Anuradhapura district	Physically challenged sexually abused girls (pregnant and not pregnant)

Northen Province: In Killinochchi, one WDO covered up duties in the two divisions of Karachi and Kandavalai and the latter division also lacks Counselling Assistant. In Mullaitivu, there was no WDO in the Oddusudan division and the WDO in Mantivu East also covered up duties of the CRPO and ECDO. In Vavuniya, the District Coordinator/WDO covered up duties in the Vengalacheddikulam division.

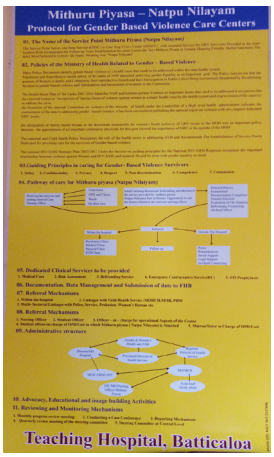
Eastern Province: In Ampara, the WDO/Ampara covered up duties in the Dehiattakandiya division, and there are no Counseling Assistants in 4 Sinhala and 3 Muslim divisions, including the Pothuvil division where over 2000 women are at high risk of migration.

Central Province: Four fifths (81%) of women counselors work in the Kandy district where less than one fifth of the women estate worker population (155,437) resides.

COVERAGE BY MOH MITHURU PIYASA/ NATPU NILAYAM CLINIC[75]



MP/NP clinic linkages for SGBV response



Protocol for Mithuru Piyasas /Natpu Nilayam GBV Care Centers. Teaching Hospital Batticoloa

- No. MP/NP clinics established between 2016-2018. ***(Source: RH Management Information Unit, Family Health Bureau, Ministry of Health)***

Between 2016 and 2018, the health sector achieved considerable coverage of communities of all ethnicities through the establishment of new MP/NP clinics in Jaffna

[75] The Mithuru Piyasa/ Natpu Nilayam (Friendly Haven) is the FHB/ MoH first line stigma free confidential befriending service assisting women with information, crisis counseling, emotional support through active and empathetic listening, and referral for related services

Table 11 - DISTRIBUTION OF MoWCA WOMEN AND CHILD UNIT STAFF BY DIVISION IN THE FOUR STUDY PROVINCES

Province	Total NO. Divisions	WDO %		Counseling Assistants %	
		Occupied	Vacant	Occupied	Vacant
NP	38	81	19	NA	NA
EP	48	91	9	56	44
CP	39	89	11	50	50
SP	50	94	6	90	10

Source – MoWCA. Based on available data from the WB

Table 12 – DISTRIBUTION OF MoPISE COUNSELORS BY DIVISION IN THE FOUR STUDY PROVINCES

Province	Total No. Divisions	Occupied		Vacant	
		No.	%	No.	%
NP	38	18	47	20	52
EP	48	25	52	23	48
CP	39	26	67	13	33
SP	50	43	86	7	14

Table 13 - PREVALENCE OF IPV AND AVAILABILITY OF MoPISE WOMEN COUNSELORS BY DISTRICT IN THE FOUR STUDY PROVINCES .

Province	District	% women reporting IPV (SL DHS 2016)	Women Counselors % occupancy
NP (No. women counselors =10)	Jaffna	41	80
	KIllinochchi	51	20
	Mullaiitivu	32	-
	Vavuniya	20	-
	Mannar	23	-
EP (No. women counselors =11)	Batticoloa	50	45
	Ampara	28	45
	Trincomalee	30	10
CP (No. women counselors =21)	Kandy	26	81
	Nuwara Eliya.	30	5
	Matale	30	14
SP (No. women counselors =39)	Galle	23	90
	Matara	18	31
	Hambantota	6.5	28

(6) and Mullaitivu (1) in the NP; in Ampara (4) and Batticola (3) in the EP, and one each in Teldeniya and Nawalapitiya in the CP, and Tangalle and Elpitiya in the SP (Table 14). Importantly, the new clinics in Jaffna included one at the BH Chavakachcheri where the Psychiatric Unit has a dedicated Alcohol and Drug Rehabilitation Unit.

The average monthly attendance at the clinics was between 35-40 clients at the Teaching Hospital Jaffna to less than 10 at Teldeniya. According to staff, about 90% of women seeking help for DV/IPV at Jaffna and Vavuniya were WW/WHH and while 75% of those seeking similar help at Nuwara Eliya were estate women. The lack of a clinic in Mannar[76] and the temperary discontinuation of the clinic in Trincomalee[77] meant that women had to travel long distances to Vavuniya and Batticoloa respectively to obtain services.

Case Story

Staff at a MP/NP clinic in the NP reported that a DV victim repeatedly visits the clinic and spends many hours complaining and crying about her abusive husband. According to the victim, " visiting the clinic and sharing her problem with the staff gives her relief". The clinic staff have observed that the person who drops her to the clinic and picks her up in the evening is the husband. The victim is a public health midwife (PHM)

-Staff at a MP / NP Clinic in the NP-

[76] The FHB has priority listed the establishment of a clinic at the DGH Manner in 2019 *(personal communication, Women's Health and Gender Unit, FHB)*

[77] The Trincomalee clinic was temporarily discontinued in 2017 due to lack of funds to support the volunteers who manned the clinic.

 # Based on responses from members of the NGBV Forum (3) and NGO respondents met during field visits (4)

NGO .Services

Table 15 shows that the majority of NGOs provided referral (100%), outreach (85%) and psychosocial counseling activities (85%). The high proportion of referrals indicated that links had been established between services, but the lack of feedback made it difficult to assess whether women had actually accessed the other services and received support. Organizational mandates and limitations in capacity may underlie the lesser involvement of NGOs in activities related to the economic empowerment of women (42%) and delivery of hotline services. The reluctance of women to seek legal remedies aligned with less than a fifth of NGOs providing legal representation (14%).

The SGBV prevention response at community level had been diluted by the closing down of GBV networks and the overall reduction in the number of NGOs in the post-conflict period. The NGO consortiums in the NP and EP, mostly engaged in supporting livelihood and income generating activities for women but also provided some SGBV related services. The failure of NGOs to coordinate the selection of areas for outreach and livelihood activities with the District Secretary and WDO had led to poor coverage of communities most in need of support. In the CP, an NGO project[78] had facilitated women's organizations to strengthen referral mechanisms for women victims/survivors, raised aware of national mechanisms to address violence at community level, established district and divisional level SGBV prevention committees, an integrated counseling unit at the district secretariat, and a shelter for sexually abused disabled girls in the NCP[79] among other achievements. In all provinces, the need to strengthen community based response through restoring/establishing networks and GBV fora was highlighted by divisional officers and staff at MP/NP clinics.

The limited response from the NFGBV may have been due to members not currently working in the selected study provinces, or declining to respond due to other reasons, as well as NGOs addressing SGBV prevention in the study provinces not being members of the forum. A comprehensive updated database on NFGBV membership by district was not available for reference.The directory of services in Mannar and Hambantota[80] provides information on services delivered by NGOs, state and other stakeholders in the districts. Similar mappings are likely to be useful in all districts and need to be updated at regular intervals.

Strengthening coordination between the State and NGO sector to sustain a close working partnership is critical to achieving the effective implementation of the planned activities under the Policy Framework of the National Plan of Action 2016–2020.[81]

Overall, the demand for MP/NP clinic services was shown by the increased attendance in all provinces other than in the EP where the decline probably reflects the extended closure of the Trincomalee clinic. The

[78] The Women's Development Center. www.womendev.org
[79] See shelter at Kekirawa the Anuradhapura district.
[80] Mapping Exercise – UNFPA /MOWCA & DZD 2018.
[81] WHO 2018 ibid.

Table 14 – DISTRIBUTION OF MP/NP CLINICS IN THE FOUR PROVINCES; CLINIC ATTENDANCE 2015-2017

Province	No. districts	Number of MP/NP clinics			Annual attendance		
		Before 2016	New ##	Total	2015	2016	2017
NP	5	2	7	9	799	1314	1685
EP	3	5	7	12	751	1481	1127
CP	3	7	2	9	405	539	611
SP	3	3	2	5	995	1367	1231

COVERAGE BY THE NGO SECTOR

Table 15 – SERVICES PROVIDED BY NGOS

Rank	%	Service provided
1	100	Referral
2	85	IEC, Community Awareness , Outreach
3	57	Crisis information, Crisis Counseling, Help Line, Legal advice, Woman centered support, Support for children affected with violence
4	42	Income generation activities for affected women
5	28	Skills training for affected women , Grants, Loans
6	14	Legal representation, Hot line

gradual but steady increase in attendance by family members and perpetrators at clinics is significant as it indicates the acceptability of this service among key individuals whose engagement is vital to address the impact of violence on women and children .

Tables 16 shows that coverage of service was best by the legal and law enforcement sectors and next by the health sector. Coverage by the WC units and Counseling units was challenged by many factors. Counseling services were most affected in the NP, CP and EP and was due to a shortage of counselors and C/assistants. Counselor vacancies were highest in the NP and EP; Counseling assistant vacancies were highest in the CP and EP; and WDO vacancies were highest in the NP.

The mapping showed the need for district level assessment of services towards delivering a comprehensive SGBV prevention response.

Discussion

The mapping showed that the coverage of communities for prevention of sexual and gender based violence was affected by issues of availability, accessibility and sustainability of services delivered through the WC and Counseliing Units, legal, law enforcement and NGO sectors, and to a lesser extent by the health sector. It was seen that the formulation and delivery of interventions at the local level needs to engage local communities, be guided by the ethnic and cultural sensitivities, and overcome challenges posed by terrain and gaps in manpower. For instance, in the NP, Mullaitivu district has the largest land area (2415 sq Km), the lowest population density

(38 /sq Km), and the highest poverty indices (poor households 24.7 %; poverty headcount 28.8) and high vacancy among WDO (43%), and counselors (85%), and no women counselors.

The priority needs identified by service providers included:

- The availability of market oriented livelihoods for the economic empowerment of women to break the cycle of poverty and SGBV.
- Establishment of more shelters (one per district was suggested) to provide women and children security and safe accommodation in emergency / crisis situations.
- The strengthening of coordination mechanisms and addressing infrastructure deficiencies to increase the efficiency and effectiveness of services.
- The adoption of an inclusive approach to service delivery in situations of domestic violence to enable engaging perpetrators (for substance use/ abuse, mental health problems) children (mandate mental health and psychological support services) and women in a non-judgmental way.

Coverage of communities was best by the legal, law enforcement and health sectors. Access to fixed facilities and help lines was limited by the routine working days and hours of service organisations. There was adequate staff to sustain legal aid services and the appointment of permanent officers ensured sustainability of services at MP/ NP clinics. However sustaining 24 hour services at police WC desks is likely to require increasing the cadre of WPOs to ensure a roster of two women officers for the night shift. Women were least likely to seek legal services but the increasing trend in attendance among women, family members

Table 16 - COVERAGE OF SGBV RESPONSE SERVICES IN FOUR PROVINCES

Province	District	Shelters State/NGO/ Faith based	MP/ NP	LAC	P/ WCD	NGO ##	MoWCA % Vacancies		MoPISE % Vacancies
							WDO	C/A #	COUN
NP	Jaffna	+	+	+	+	+	-		19
	KIlinochchi	+	+	+	+	+	20		40
	Mullaitivu	+	+	+	+	+	43		85
	Vavuniya	+	+	+	+	+	40		100
	Mannar	_	-	+	+	+	20	80	80
EP	Battiicoloa	+	+	+	+	+	7	7	53
	Ampara	-	+	+	+		5	33	33
	Trincomalee	-	-	+	+		16		66
CP	Kandy	+	+	+	+	+	5	19	9
	Nuwara Eliya	-	+	+	+	+	33	83	66
	Matale	-	+	+	+		8		58
SP	Galle	-	+	+	+	+	5		10
	Matara	+	+	+	+	+	6		23
	Hambantota	-	+	+	+		8		8

Source – MoWCA/MoPISE/Legal Aid Commission/Police Headquarters Colombo. #Based on available data ; ## Based on NGOs respondents.

and perpetrators at MP/NP clinics justifies the continued expansion of the service.

A method that recognizes the relevance of land size, population density, poverty indices and prevalence of SGBV towards achieving coverage of communities merits consideration by the MoWCA and MoPISE as an alternative to the current system of appointing divisional officers.

The hospital based temporary safe space that is being piloted by the MoWCA needs to be closely monitored. This short term temporary option benefits women by circumventing the challenges related to timely access to shelters in times of crisis.

The usefulness of this option is underpinned in data that shows that the majority (63%) of attendees at MP/NP clinics are referrals from hospital wards indicating that women seek hospital admission for care and safety. This facility and may also provide the Ministry with a cost effective alternative to establishing many shelters as building new shelter facilities is costly and needs to recognize the issues of polarization and cultural sensitivities of the three ethnic communities, the burden of SGBV and the geographical distribution of women of higher vulnerability, among other factors.

The termination of the MoUs for shelters in the NP and EP in 2021 provides the line ministry the opportunity in the interim period to strengthen its capacity to assume full managerial responsibility while retaining the option to re-negotiate MoUs for their continued management of shelters by NGOs.

The period of temporary residence in the shelter provides the opportunity to empower women/girls through the provision of counseling, legal advice, guidance, and skills building/education for social reintegration and inclusion. This process may be further enhanced by safeguarding their SRH rights through access to SRH information, and contraceptive commodities for consenting women and girls prior to their discharge from shelters.

Enhancing the role of the PHM who is currently an underutilized trained resource in SGBV prevention is likely to address the gap in delivery of community based services (by divisional officers) and benefit women whose access to fixed service facilities is limited by multiple factors including the risk of provoked violence.

Interventions by the PHM may particularly benefit women in the TSH estates (SP) and pave the way for gathering SGBV related data to advocate the TSHDA to initiate services. Similarly, training the resident PFWO on RPC estates in the CP would provide women workers with a community based person who may be accessed easily in a crisis situation.

Service delivery at the divisional level by officers of the MoWCA and MoPISE is challenged by many staffing issues (maldistribution and high turnover of trained staff) issues of travel and transport, limited technical capacity, lack of TORs, concerns of personal safety and security during field visits and the absence of structured career pathways for professional advancement.

Capacity building in all sectors and particularly in the social services, legal and law enforcement sectors needs to be sustained through regular in-service trainings, The introduction of joint training events having standard core inputs on the PDVA 2005, gender sensitive attitudinal training, self-care and human rights is required for all service sector personnel engaged in SGBV prevention efforts. Court procedures, and preparation and presentation of cases need to be standard inputs of the basic curriculum and in-service trainings of WPO. Joint programme reviews are required to share understandings and address factors challenging the timely delivery of a comprehensive SGBV response. Strengthening skills of women entrepreneurs requires reinvestment in the NCEWHH to fulfill its mandate, provide greater access

to vocational training, and advocacy of the private sector, international agencies and donors for greater funding.

The SGBV response mechanisms needs to be strengthened and formalized through the introduction of protocols and guidelines on referrals, training, monitoring, and for the transparent equitable allocation of livelihood opportunities to impoverished communities, and strengthening inter and intra-sectoral coordination at all levels.

Engagement with child rights and legal experts is required to develop rights based guidelines to safeguard children accompanying women to shelters, review NGO policy and shelter MoUs to ensure these align with the "best interest of the child" as well as to safeguard the right to psychosocial wellbeing of girls/women in shelters without compromising their safety and security while in state custody.

The MoWCA needs to lead discussions with mental health professionals to clarify the role of hospital and community based MH services for women victims and their families, and with the Disability Secretariat, NGOs and people with disability to ensure the right of access of women and girls with disabilities to all SGBV prevention services.

An option for affordable DNA Testing at hospital and university laboratories needs to be negotiated with relevant authorities. The NCEWHH needs to be revitalised through the allocation of adequate financial resources, and the adoption of a working classification for WHH to fulfill its mandated role.

Media and community awareness programmes need to emphasize the benefits of freedom from violence for families and the right of women and girls to be free from violence. Advocacy of the Ministry of National Planning and other relevant state ministries is required to address the funding constraints. The judiciary needs to be advocated to foster greater use of the PDVA to provide relief to abused women. The UN agencies INGOs, donors and the private sector need to be engaged to obtain increased funding support for sustainable livelihood programmes for impoverished women, media sensitization and public awareness programmes.

The highest prevalence of domestic violence is found in the NP and EP followed by the CP. The mapping found that coverage of communities was most challenged in the NP, EP and CP. This is due to the lack of MoWCA and MoPISE staff at the divisional level, and difficulties in responding to specific needs of local communities. It was further seen that the MoWCA had achieved much by way of policy and programme formulation but was likely to benefit by guidance and oversight to provide leadership for a stronger, coordinated multi-sectoral response to strengthen and sustain programme implementation at national and subnational levels.

The findings of this rapid mapping need to be strengthened with in-depth studies in the different provinces to obtain insights to strengthen policy and programme formulation for equitable service delivery.

The UNFPA –ESP Module 4

The mapping showed that module 4 may be enhanced by including the item of Coverage as a standard component.

Recommendations

- Establish a high level mechanism to provide guidance and oversight to the lead ministry to strengthen implementation of the multi-sectoral NAP-SGBV, WHH-NAP, and NAP-PDVA; Operationalize the NCEWHH to fulfill its mandate as the national hub for economic empowerment of WHH/WW; and develop/implement multi-sectoral subnational action plans relevant to the needs of communities in each area.
- Develop protocols/guidelines/ standard operating procedures to

strengthen all inter and intra-sectoral activities to achieve equitable service coverage of communities.

- Expedite recommendations on strengthening service delivery through MoWCA and MoPISE made in previous studies.
- Develop a system of appointment of divisional officers based on land size, population density, prevalence/ incidence of SGBV and poverty indices.
- Monitor the temporary safe space being piloted at the DGH Moneragala in the Uva province by the MoWCA for wider implementation.
- Conduct in-depth studies is are required in each province to strengthen the findings of this rapid mapping.

Limitations

Time constraints restricted the study to four provinces and selected districts within these provinces. In all four provinces, at least one or two districts could not be visited. Field visits had to be planned around Wednesday, the official public day to ensure meeting public officials. The response from the NGBVF was less than anticipated and NGOs could not be identified for discussions ahead of the field visits. Meetings with service providers in the North and East required facilitation by Tamil/ English translators. Time restriction function constrained the ability to conduct additional visits to service providers.

Legal officers of LAC regional centers in the four provinces and the single Faith based organization in the NP were interviewed by phone. Medical officers of Heath and Public Health Midwives were not interviewed as referrals to MP/NP clinics from the preventive health services is reportedly only 6% at present. It was not possible to interview Medico legal officers and Probation officers due to time constraints.

There was no opportunity to engage in discussions with women seeking services at the Mithuru piyasa /Natpu Nilayam clinics, women ex-combatants, women /girls with disability LBT women. Shelter facilities provided by the faith based organization in the Northern province and by the Sri Lanka Bureau of Foreign Employment at the Katunayake Airport could not be inspected for assessment. Discussions with women and girls victims in shelters required translation.

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- Director, Counseling, Ministry of Primary Industries and Social Empowerment
- National Commissioner of Probation
- National Focal Point and Consultant Community Physician, Women's Health and Gender Unit, Family Health Bureau, Ministry of Health
- Assistant Provincial Commissioner of Probation Kandy, Central Province.
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- Consultant Psychiatrists and staff Mental Health Units at the Teaching Hospital Batticoloa, District General Hospital Killinochchi and Medical Officer, Psychiatry Base Hospital Akkaraipattu
- Medical officers, Nursing officers and Volunteers at Mithuru piyasa/Natpu Nilayam Clinics
- Chairperson Legal Aid Commission and officers at LAC regional centers
- Inspector of Police, Women and Child Abuse Prevention Bureau, Matara and Women police Officer, Police/ WC Desk Weligama
- District and Divisional Secretaries/ Government Agents, Assistant Government Agents, Hospital Directors/ Deputy Directors in the four study provinces
- Director, Health and Health Manager The Plantation Human Development Trust
- Manager, Tea Small Holdings Development Authority
- Staff at shelters in all four provinces
- Women and girl victims/survivors in shelters.
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- The Asia Foundation

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NGO

- Women in Need, Colombo and Matara
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- Institute for Social Development, Kandy
- Women and Media Collective Colombo
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(Footnotes)

1 This overseas crisis support and suicide prevention counseling service is accessible in Sri Lanka. It provides support for DV among other problems. The service was identified through a NGO respondent in this study but there was little awareness among other service providers of this service. Available at www.lifeline.org.au