COUNTRY PROFILE ON GENDER - BASED VIOLENCE IN SRI LANKA
Country Profile on Gender-Based Violence in Sri Lanka
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Country Profile on Gender-Based Violence in Sri Lanka.


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Printed in Sri Lanka.
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This work was carried out with the support from the Regional Office for South-East Asia, for documentation on the magnitude of the problem, supportive policy environment and implementation of best practices to prevent and address gender-based violence.

WHO Country Office for Sri Lanka would like to acknowledge Dr Neena Raina, Director a.i. Family Health, Gender and Life Course (FGL), WHO-SEARO for her technical support, Dr Chandani Galwaduge, for the valued contributions on review of available documents, interviews with key stakeholders and documenting it to complete this publication... (Kindly also acknowledge the Ministry and other partners)
DEFINITIONS

- INTIMATE PARTNER VIOLENCE:

  Intimate partner violence includes a range of sexually, psychologically and physically coercive acts used against adult and adolescent women by a current or former intimate partner, without her consent. Physical violence involves intentionally using physical force, strength or a weapon to harm or injure the woman. Sexual violence includes abusive sexual contact, making a woman engage in a sexual act without her consent and attempted or completed sex acts with a woman who is ill, disabled, under pressure or under the influence of alcohol or other drugs. Psychological violence includes controlling or isolating the woman and humiliating or embarrassing her. Economic violence includes denying a woman access to and control over basic resources (1).

- CURRENT INTIMATE PARTNER VIOLENCE:

  Self-reported experience of intimate partner violence in the past 12 months (2).

- SEXUAL VIOLENCE:

  Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person’s sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to, home and work (3).
1. COUNTRY OVERVIEW ON GENDER EQUALITY

1.1 BACKGROUND

Sri Lanka is a fast developing, lower-middle income country with a multireligious and multiethnic population. The country is still recovering from a prolonged civil conflict that ended in 2009. As a result of consecutive governments sustaining welfare policies since independence from the United Kingdom in 1948, Sri Lanka has made good progress in reducing poverty and improving most social indicators (Table 1).

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>SRI LANKA</th>
</tr>
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<tbody>
<tr>
<td>Estimated population (4)</td>
<td>21 203 000</td>
</tr>
<tr>
<td>Male/female population ratio (4)</td>
<td>93.8</td>
</tr>
<tr>
<td>Life expectancy (total population)</td>
<td>75.9 years</td>
</tr>
<tr>
<td>Life expectancy (males)</td>
<td>72.4 years</td>
</tr>
<tr>
<td>Life expectancy (females) (5)</td>
<td>79.6 years</td>
</tr>
<tr>
<td>Infant mortality rate (6)</td>
<td>9.2/1000 live births</td>
</tr>
<tr>
<td>Maternal mortality ratio (6)</td>
<td>33.7/100 000 live births</td>
</tr>
<tr>
<td>Total fertility rate (7)</td>
<td>2.17</td>
</tr>
<tr>
<td>Adolescent fertility rate (7)</td>
<td>32/1000</td>
</tr>
</tbody>
</table>

Sri Lanka records a higher female population (52%) with a longer life expectancy than men. Usually, the maternal mortality ratio can be used as a proxy for the status of women in a country as it reflects a combination of sociocultural factors that affect women's health, availability of health services and the accessibility of health care by women. The maternal mortality ratio in Sri Lanka is one of the lowest in Asia.

The adolescent fertility rate is also the lowest in South Asia; only 2% of females aged between 15–19 years in Sri Lanka give birth to children before the age of 19 years (7). Low fertility in adolescent years is associated with opportunities for educational attainments for young women. Equal access to free education in the state sector up to university levels was made available to both male and female children in the late 1940s. The provision of free state education supported by additional incentives such as free textbooks, free uniforms, scholarships, subsidized transport and school meals for the children of the economically disadvantaged have resulted in a rapid rise in participation rates at school. There are no considerable gaps between males and females in school enrolment and continuation rates.

The adult female literacy is higher than in neighbouring countries. The literacy gap between males and females as well as the gap between urban and rural women have almost closed.

1.2 RIGHTS AND POLICY CONTEXT

Article 12 of Sri Lanka's Constitution of 1978 provides for equality for women and men and nondiscrimination based on the sex (12).


In the year 1993, Parliament adopted the Sri Lanka Women's Charter (13), which is the principal policy statement by the Government regarding the rights of women. This was an adaptation of the CEDAW to local needs and has seven sections: Civil and Political Rights; Rights within the Family; Right to Health; Right to Education and Training; Economic Rights; Right to be not Socially Discriminated, and Gender-Based Violence. The first National Plan of Action for women was adopted as early as in May 1996, based on the Global Platform for action on Women following the 1995 World Conference on Women in Beijing.

As a part of developing the government machinery to ensure gender equity and equality, the Women's Bureau was established in 1978. The Women's Bureau, when it was first created, was placed directly under the Ministry of Policy Planning, but with the establishment of a dedicated Ministry for Women in 1983 was brought
under the purview of the Ministry. The Women’s Ministry was created to promote gender equity. Over time, the subject of women’s affairs has been amalgamated with different ministries and currently makes up one part of the Ministry of Women and Child Affairs.

One of the most significant additions to State policies and mechanisms to work towards the rights of women and gender equality and equity was the setting up of the National Committee on Women (NCW) in 1994\(^{(13)}\). The main objective was to oversee and monitor the provisions of the 1993 Women’s Charter. Although the NCW was first conceived as an independent body, it has to date been functioning under the Women’s Ministry. At present, there is an ongoing process to enhance its autonomy and authority by converting it into a National Commission on Women.

### 1.3 Influence of the Sociocultural Context

Although the Constitution and policies underscore the principle of gender equality, the existing patriarchal culture in the country perpetuates traditional gender roles and stereotyping in which men are regarded as superior to women. Although forms of gender inequality such as female feticide, infanticide, honour killings, neglect of the girl child and dowry deaths are not visible in Sri Lanka, both men and women are influenced by the negative impact of internalization of these gendered norms that are deeply entrenched in the society.

The recent UN multicountry study on men and violence by CARE, Partners for Prevention, and the UN, conducted in four districts covering 1323 households, revealed that a significant majority of men and women in Sri Lanka subscribe to attitudes that perpetuate gender inequality\(^{(14)}\). More than half of all male and female respondents agreed that “a woman’s most important role is to take care of her home and cook for her family”. A majority of men also related manhood to dominance and violence, with 58 percent believing that “it is mainly to defend the honour of your family even by violent means”, and 57 percent agreeing that “to be a man you need to be tough”. A significant majority of men (70%) also accepted masculinity as bringing with it household responsibilities that entailed providing for the family.

These deeply entrenched gendered norms minimize the opportunities for women and girls from effectively participating in the formal economic, social and political system, and expose them to gender-based violence (GBV).

In contrast to the impressive social indicators, Sri Lanka is one of the countries that records very low levels of women’s participation in politics. The 2015 World Economic Forum’s Gender Gap Report ranks Sri Lanka 100 out of 144 countries according to the Gender Gap Index. In terms of political participation, although women have had the right to exercise their vote and participate in political activities for over eight decades, the representation of women in Parliament has never exceeded 6% and has been even lower in elected local Assemblies. Only six out of the 225 seats in the National Parliament are occupied by women. This has given Sri Lanka a rank of 140 out of 153 countries with regard to female representation in Parliament, which is one of the lowest\(^{(15)}\) not only in South Asia but also in the world. On 31 August 2017, the Local Authorities Elections Act that was amended and approved by the National Parliament to ensure 25% female representation in the local bodies\(^{(16)}\).

A critical consequence of gender inequality is the lack of equal opportunities for women in employment. The Census of 2012 revealed that females perform better at the secondary and degree level in comparison with males but the unemployment rate for women has been consistently double that of men (3% for males and 7% for females) over the last few years\(^{(17)}\). For example, the percentages of those with a degree who were not employed were 18.8% for males and 64.4% for females. The 2016 survey of the labour force annual report states that among the professionals employed in the Government sector, females make up only about 63.8\%\(^{(18)}\), which is again mainly because 100% of midwives, 90.2% of nurses and 71.2% of teachers are women. However, even within these professions, women appear to experience the “glass ceiling” that limits opportunities for career progression. For example, despite being considered a traditionally female profession, only a fifth of all heads of school are women. Within the civil service, only 16% women occupy positions of district secretaries and 31.7% of divisional secretaries\(^{(19)}\). In Sri Lanka only 28.4% of the senior management positions in both public and private were held by females in 2012\(^{(20)}\).

Gender stereotyping has also crept into educational materials\(^{(21)}\). Some of these convey the message that girls are subordinate to boys and more passive whereas boys are to be dominant and aggressive. Such conditioning tends to limit the aspirations and self-confidence of girls and women and creates a scenario where gender-based violence (GBV) is deemed to be normal.

Sri Lanka has ratified the ILO Equal Remuneration Convention\(^{(22)}\) in April 1993, which ensures equal remuneration for males and females in the public sector. Nevertheless, in the private sector, females are generally paid less than their male counterparts. In the private sector, female workers can earn anywhere between 30%–36% less than their male counterparts for doing
Country Profile on Gender-Based Violence in Sri Lanka

Foreign employment continues to be the largest foreign exchange earner for Sri Lanka. The female participation in foreign employment was 34.44%, based on total departures from the country during the year 2015. In 2015, the majority (81%) of female migrant workers were recruited as housemaids. This tendency for Sri Lankan women to be largely employed in low-skill jobs, with low wages and a lesser degree of job security increases their vulnerability towards gender-based violence.

1.4 THE LEGAL AGE AT MARRIAGE

The Marriage Registration (Amendment) Act No. 18 of 1995 recognizes the age of 18 years as the minimum age for marriages under the general law of the country, and is the same in Kandyan customary law. This reflects the principle embodied in Article 16 of CEDAW on minimum age for marriage. However, the customary Muslim marriage and divorce laws do not specify a minimum age at marriage and stipulate that a girl may be married upon reaching puberty, even if she is under 12, with the consent of the quazi. This remains unchanged despite recommendations from the Committee on the Elimination of Discrimination against Women.

Under the Common Law, the age of sexual consent for both males and females is 16 years. The criminal law in the country makes sexual intercourse with a girl under 16 years of age punishable, and this is considered as statutory rape. This poses a contradiction with Muslim customary law, and this has not been resolved till date.

Although the legal age of marriage is 18 years, 2% of females below the age of 15 and 12% of females under 18 years of age are living in cohabitation in the country. This early age for cohabitation and reproduction impedes many girls from fulfilling their aspirations and is also a cause for gender inequality and gender-based violence.
At present, there is no national mechanism for systematic data collection on gender-based violence and as a result, sex and age disaggregated statistics on prevalence, underlying associated factors, and consequences of gender-based violence are not available at the national level. Different service sectors such as the police, Judiciary, women’s bureau, health and NGOs maintain statistics pertaining to their own mandates. Most of these data sources are not available to the public or are not in the public domain and are limited mostly to the individual sectors for their internal use.

To date, no national studies have been carried out about gender-based violence, but there had been several research studies covering various aspects of GBV. These studies vary in population groups, geographical coverage, sample sizes and methodology, and many have not used statistically valid sampling methods. Therefore, the data are not comparable and cannot be generalized, and does not allow any trend analysis. Two publications are available that summarize research studies on GBV in the country (28,29).

Available research data, service records and administrative reports of the relevant service entities and NGOs indicate the prevalence of diverse forms of GBV ranging from rape, sexual abuse, intimate partner violence, domestic violence, violence during pregnancy, sexual harassment in public places, etc. Some forms of GBV such as sex-selective abortion, dowry-related killings and honour killings are not reported in Sri Lanka. The report of the Opposition Leader’s Commission on the prevention of violence against women and the girl child (30), compiled in December 2014, had very succinctly described the diverse forms of violence that exist in the country and the issues related to the response.

One of the least researched areas in GBV is trafficking. Unlike several other Asian countries, large scale trafficking is not reported from Sri Lanka. The Trafficking in Persons Report 2017 released by the US State Department states that trafficking for sex and exploitative forms of labour does exist, especially in cases where Sri Lankan women travel out of the country to West and East Asia to work as domestic helps or in garment factories. Within the country, trafficking of women has been found to take place in situations where women seek work in factories, or in cases where women are lured with the promise of such employment and coerced instead into sexual slavery in the cities. Boys are more likely than girls to be forced into prostitution in coastal areas for child sex tourism(31).

The police reports on grave crimes annually records around 2000 cases of rape(32). However, these numbers only include the reported cases of cohabitation of girls under 16 years as it is considered statutory rape.

A clinic-based study (33) on gender-based violence among pregnant women in Badulla district, Sri Lanka, was one of the earlier studies that used an appropriate sampling method. The main objective was to develop a suitable screening tool to screen GBV during pregnancy. The sample comprised 1200 pregnant women aged 15–49 and their lifetime and current experience of physical and sexual abuse and information on perpetrators were collected.

Out of 1200 women in the sample, 18.3% reported of being ever abused, 10.6% reported being abused during the last 12 months, 4.7% reported being abused during the current pregnancy and 2.7% reported experiencing current sexual abuse.

*Figure 1: Prevalence (%) of physical and sexual abuse*

*Source: Clinic-based study on GBV among pregnant women (33)*

*Figure 2: Prevalence (%) of physical abuse by type of perpetrator*

*Source: Clinic-based study on GBV among pregnant women (33)*
Of the women who reported being physically abused, in the majority of cases it was the husband who had perpetrated the violence, mirroring global incidence patterns. Mothers-in-law and sisters-in-law have also been reported to have perpetrated physical violence, albeit to a lesser degree.

Figure 3: Prevalence (%) of current sexual abuse by type of perpetrator

<table>
<thead>
<tr>
<th>Type of Perpetrator</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>59.1%</td>
</tr>
<tr>
<td>Father</td>
<td>9.1%</td>
</tr>
<tr>
<td>Male partner</td>
<td>22.7%</td>
</tr>
<tr>
<td>Other</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Source: Clinic-based study on GBV among pregnant women (33)

Of the total of 1200 women surveyed, 2.7% reported current sexual violence. Among those, in 59% of cases the perpetrator was the husband while the sexual violence was perpetrated by a male partner in 22.7% of cases. It is noteworthy that in 9.1% of cases the perpetrator was the father, indicating incestuous sexual abuse.

2.1 INTIMATE PARTNER VIOLENCE

There are no national studies on intimate partner violence (IPV) in Sri Lanka. The first published research on intimate partner violence in Sri Lanka was in 1982 on “wife battering”: a hospital-based study on 60 women presenting with history of having been battered by their partners/husbands(34).

Available research studies report a wide range of prevalence rates (from 18% to 72%) for IPV, and cover varied geographical areas, different ethnocultural and religious backgrounds, and also a broad definition of IPV.

A scoping review(35) on intimate partner violence in Sri Lanka, based on both published and grey literature over the last 35 years, reviewed 38 research studies that fit into the selection criteria. Based on the most recent data, the authors concluded that the prevalence of IPV to be 25%–30%, which is lower than the estimates for other Asian countries(2).

For the first time in Sri Lanka, the DHS(7) 2016 included a module with questions on women’s experience of intimate partner violence during the preceding 12 months, their help-seeking behaviour and knowledge on available services. The main objective of collecting this information is to improve the health sector interventions that are being implemented in the country. Furthermore, this information will serve as the basis for the 5.2 indicator of the Sustainable Development Goal 3 as well. The survey covered all 25 districts and included 16,229 ever-married women of the 15–49 age group.

The most recent statistics available from the DHS data, dating from 2016, indicate as shown in Figure 4 that 17% of ever-married women had experienced intimate partner violence during the preceding 12 months (the current prevalence rate of IPV is 17%), with urban women reporting a slightly higher prevalence than rural women and estate sector women. Another community-based study in the Central Province in 2007(36), which used the WHO multicountry study questionnaire, covered 624 ever married women in the 15–49 age group and recorded a similar IPV prevalence rate of 19%.

Figure 4: Current prevalence (%) of intimate partner violence by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Prevalence</th>
</tr>
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<tbody>
<tr>
<td>Urban</td>
<td>19.8%</td>
</tr>
<tr>
<td>Rural</td>
<td>16%</td>
</tr>
<tr>
<td>Estate</td>
<td>17%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: DHS Sri Lanka 2016

The most recent statistics available from the DHS data, dating from 2016, indicate as shown in Figure 4 that 17% of ever-married women had experienced intimate partner violence during the preceding 12 months (the current prevalence rate of IPV is 17%), with urban women reporting a slightly higher prevalence than rural women and estate sector women. Another community-based study in the Central Province in 2007(36), which used the WHO multicountry study questionnaire, covered 624 ever married women in the 15–49 age group and recorded a similar IPV prevalence rate of 19%.

Figure 5: Current prevalence (%) of intimate partner violence by district

Source: DHS 2016
Exploring the differences between districts, the DHS 2016 reported IPV prevalence rates ranging from 5.6% in the district of Hambantota down south to 49.6% in Kilinochchi and Batticaloa (Fig. 5) in the northern and eastern parts of the country respectively. It should be noted that the Northern and Eastern districts were the areas worst affected by the civil conflict that ended in 2009. There are few other reports (37) which record higher prevalence of IPV in the conflict affected areas. On the other hand, the very low prevalence in certain districts needs to be treated with caution as women tend to underreport experiences of violence and there may also be issues with data collection since the questions were administered by an interviewer.

Figure 6: Prevalence (%) of different types of intimate partner violence among ever-married women aged 15–49 years

DHS 2016 revealed that of the women who were subjected to IPV within the last 12 months, 13% were beaten with an object and 15% were forced to have sex by their intimate partners. It is important to note the repetitive occurrence of abusive behaviours against women (Figure 7). Of the women who reported current IPV, 12.7% were subjected to violence on a daily basis, 15.1% weekly, 47.6% monthly and 66.9% were subjected to violence less often. Of the total female population, 2% are subjected to violence on a daily basis.

Figure 7: Frequency (%) of intimate partner violence by type

The first ever largescale community-based study on IPV(38) was conducted in 2005 covering a total of 750 ever-married women belonging to the age group of 18–49 years. The probability proportionate cluster sampling method was used to select the participants and, for the first time in the country, data were collected using the WHO multicountry study questionnaire. Lifetime physical violence was found to be 34%, sexual violence 5%, and emotional violence at 19%.

In 2013, the UN Multicountry Study on Men and Violence(14) surveyed 1658 men and 653 women who are ever partnered and aged between 18–49 years from four locations (Colombo, Nuwara Eliya, Batticaloa and Anuradhapura). This study used innovative methods such as personal digital assistants (PDA) to collect sensitive information to ensure confidentiality. The main focus was to study the male perpetration of violence and the relationship between attitudes and gendered norms on violence perpetration. This is the second IPV study in the country that included men, the first being the “Gender, Alcohol and Culture: an International Study (GENACIS), a multicountry study that used qualitative data collection methodology.

The available research studies do not allow trend analysis as they are limited by being applied to different subpopulations, by the lack of uniform definitions, the use of varied sampling methods and sample sizes, and by the fact that different categories of information...
Figure 8 shows the reporting of perpetration by males and experience of violence by women for each type of violence. Even though the overall reporting of IPV by women was better in this study due to the self-reporting methods that were employed, still males were reporting higher perpetration rates compared with females reporting IPV, with the exception of economic abuse. This indicates the general reluctance of women to disclose violence by their intimate partners, which may propagate gendered norms.

The community study on IPV in 2005 found that only around 2% of women who are subjected to intimate partner violence sought help from health services. Further, they found that women may obtain treatment for their injuries from health facilities without disclosure of IPV. The same study found that women who are exposed to violence by their intimate partners make more frequent visits to hospitals with vague symptoms but withhold information on IPV. The DHS 2016 revealed that of the women who were subjected to violence by their partners, only less than one third (28%) had sought help. Of those who sought help, three out of four women (75%) had turned to family members. Seven per cent of them had sought help from primary health care staff, and 18% of those women who had sought help had approached the police. The Men and Violence study in 2013 found that 32% of women who had sought health care had disclosed the violence to health-care providers. Overall, there appears to be an increase in the number of women seeking services and, more importantly, who disclose IPV than before. However, it is not possible to make direct comparisons as the studies are not comparable in design.

Earlier IPV studies (conducted between 1982 and 1993) reported that 70%–80%(28) of women continue to remain with their abusive husbands or partners for even as long as 10 years, despite the continuing abuse. Several studies have found that some women leave the abusive husband but choose to come back. One plausible explanation is the cultural value that considers motherhood to be the supreme status a woman can achieve and the social expectation from her to maintain the family unit together. One study describes how the women helpdesks of the police and mediatory boards encourage women to remain in a violent relationship in the guise of maintaining the stability of the family(39).

Another reason may be the concerns women have over their own safety and over the welfare of their children as some women (and perhaps children too) may be subjected to more violence by the intimate partner in the event they decide to leave or actually leave the partner. Most recent research studies/surveys have not inquired into this aspect and it is important that more information is gathered on women remaining in abusive relationships. This information will provide directions
for better programming of remedial measures such as provision of temporary shelters and safe houses, etc.

2.2 PREVALENCE DATA ON NON-PARTNER VIOLENCE

There is a dearth of information on non-partner violence in the country. In Sri Lanka, female feticide, honour killings and dowry related killings are not visible and possibly non-existent. Although there is anecdotal evidence of an increased incidence of cyber stalking, no national-level data sources are available.

Recently, a group of women, through an NGO, produced affidavits alleging that they were subjected to female genital mutilation (FGM)(40). The sectoral oversight committee on women and gender of the Parliament of Sri Lanka had initiated action to abolish this practice in the country and had requested the Ministry of Health to take appropriate action. The Family Health Bureau of the Ministry of Health held consultations with the participation of health as well as non-health sector stakeholders, where women deposed about their experiences.

Subsequently, a circular was prepared in consultation with all stakeholders including the Sri Lanka College of Obstetricians and Gynaecologists. A recent discussion with the Gender and Women's Health unit of the Family Health Bureau (FHB) revealed that the Ministry of Health is already in the process of issuing the circular that requests health staff to be vigilant. The circular also mentions that disciplinary action would be taken against any medical professional practising or promoting FGM.

There are three recent studies that collected data on non-partner violence:

**UN multicountry study on men and violence: non-partner violence**

UN multicountry study on men and violence(14) in 2013 collected data on male perpetration of non-partner sexual violence including rape. Of the total of 2656 men aged between 18 and 49 years from four districts who were chosen, 1440 (54%) responded and self-completed the questions on rape/sexual violence using PDAs, thus ensuring confidentiality and anonymity. Of the respondents, 66/1440 (4.6%) men reported having perpetrated sexual violence including rape on non-partners.

This is closer to the WHO estimate of lifetime prevalence of non-partner sexual violence in South-East Asia, which is pegged at 4.9%. More than three fourths (78%) of these men perpetrated the violence as they thought it to be their sexual entitlement, and 15.5% perpetrated the violence out of anger or to punish the woman. Only 2% of men who perpetrated rape on non-partners were convicted, 3.2% were arrested, 6.6% were punished by family or friends and only 33% said that they “felt guilty” about the act, which demonstrates the lack of policing and the level of impunity in such matters that prevails in the country.

**Sexual harassment on public transport**

A study on sexual harassment on public transport(41) was commissioned by UNFPA in 2015. This study had a sample of 2500 women between 15 and 25 years of age from all 25 districts who commuted on public buses and trains. Data were collected using both qualitative (focus group discussions and key informant interviews) and quantitative methods. Of the women who are using public transport, 50% used it to go to work, 28% to study and 20% of the women were using it for other purposes.

About 90% of the women reported having undergone sexual harassment in buses and trains. Only 4% sought help from the police; and 82% of women had seen others being subjected to harassment but had not spoken up or reacted in consequence. About 44% of the women who were harassed said that their personal life had been affected by it and 54% of the women had moved location within the same bus to get away from the harasser (for example, shift seats) or had taken an alternative bus or train to get to the desired location as a result of the incident. Some women were subjected to harassment repetitively; 24% monthly, 16% weekly and 12 % of women reported that they were subjected to daily harassment.

**Violence and coercion within romantic relationships among university students**

Violence and coercion within romantic relationships were studied(42) in 2011 using a sample of 283 female university students. Both qualitative (FDG) and quantitative (self-administered) method were used to collect information. Thirty six per cent of students surveyed reported instances where girls were forced to commence a romantic relationship and 73% of girls said they were forced to continue relationships. A fear of being physically harassed by males and a fear of lack of social acceptance

If the relationship was discontinued were the reasons cited the most. Verbal abuse in romantic relationships was reported by 57% of students while 23% reported physical violence in such relationships.
Furthermore, 64% reported knowing females who had unwillingly agreed to sexual relationships due to the fear of losing the relationship and 21% knew of instances where violence was used by male partners to coerce females into sexual activities.

Although conducted in three different settings, the presence of non-partner violence in all these three studies are clearly indicative of the existence of gendered norms that treat males as superior, including in the sexual arena, and reveal the low levels of empathy felt towards females.

As revealed in the 2013 UN multicounty study on men and violence, impunity (only 2% of those males who had perpetrated rape had been convicted) is another deterrent to addressing these issues effectively. The submissive behaviour of female students of the university also reveals how girls, irrespective of their educational attainment, conform to the social expectations of being docile and unquestioning. These standards continue to perpetuate GBV.

2.3 VICTIM/SURVIVOR AND PERPETRATOR PROFILE

Victim/perpetrator profiling is important to plan the programmatic interventions for preventing similar occurrences. In Sri Lanka, individual state departments (prisons, police, health, the Women’s Bureau) and NGOs maintain statistics pertaining to the services under their purview, and the majority of these statistics are not in the public domain. Even these statistics that are maintained are restricted to sociodemographic information and not learned behaviours and societal beliefs on gendered norms that really have an influence on the perpetration/experiencing of gender-based violence.

In line with the global picture, husbands and male partners in Sri Lanka are also the most common perpetrators of intimate partner violence. In the domestic sphere mothers-in-law were found to be perpetrating violence against women too, albeit to a lesser degree. Sexual violence was mostly committed by husbands and male partners. Fathers and other male relatives have also been found to be perpetrating sexual violence.

Several research studies attempted to profile the perpetrators and survivors, but the findings are contradictory. For instance, several research studies on IPV found young women to be more vulnerable. But the DHS 2016 findings revealed that women in the older age group of 45–49 had experienced a greater degree of IPV. Similarly, several studies identified women enjoying lower socioeconomic status and having lesser educational attainment to be more vulnerable to IPV, though the recent UN multicountry study on men and violence revealed that education attainment did not have any significant association.

Therefore, it is evident that perpetrators/victims of IPV/GBV are a heterogeneous group and there is no one profile that easily identifies them.
3. SOCIAL ATTITUDES AND ASSOCIATED FACTORS

3.1 SOCIAL ATTITUDES

Social attitudes of victims and perpetrators towards gender, gender norms and gender-based violence have a strong link with prevalence, consequences and outcomes of violence as well as interventions which are directed towards prevention and response.

Many social attitudes on gender are constructed upon deep-seated sociocultural norms and religious beliefs. An in-depth understanding of positive as well as negative attitudes will be of immense help in the planning and implementation of prevention and response programmes.

Social attitudes have been studied in several research studies/surveys in Sri Lanka and the 2013 UN multicountry study on men and violence also collected salient information on the views and attitudes of both men and women regarding gender roles, gender relations, sexuality and violence against women.

The community-based IPV research study in 2005(38) stated “that the majority of women surveyed, both in the abused and non-abused groups, believed that a ‘good wife’ obeys her husband even if she disagrees with his view; that it is important for the man to show he is the ‘boss’; and that a wife is obliged to have sex with the husband even if she doesn’t want to”. More than 50% of the women in this study also believed that disobedience, refusal of sex, asking the partner about relationships with other women, and the partner “suspicions” of infidelity are “good” reasons for a man to abuse his partner. Some survivors (8%) accepted violence as normative behaviour, and this was reinforced by family and friends. Although this was a community-based survey limited to the western province, it represents the gender norms and perceptions instilled in Sri Lankan society, which perpetuates not only overt violence but also norms that promote men’s extreme control over many aspects of women’s lives.

In the 2006–2007 Demographic and Health Survey(43), women were asked whether they thought that a husband is justified in beating his wife in each of five scenarios: if she burns the food, argues with him, goes out without telling him, neglects the children, and refuses sexual relations with him. Less than half of the women stated that none of these reasons would justify physical abuse of a wife by the husband 47%. Wife beating was justified by 42% of women for neglect of children, 41% women for arguing with the husband, slightly more than one third 35% for going out without telling the husband, and 21% of the women believed that it is justifiable for the husband to beat a woman for refusing sex. Almost one in five women 18% accepted burning the food while cooking is a justifiable reason for men to beat their wives. Although women’s education was significantly associated with their attitudes towards IPV, many (43%)

Figure 9: Male and female attitudes towards gendered norms

- it is manly to defend the honour of your family even by violent means
- Changing nappies, giving kids a bath and feeding the kids are the mother’s responsibility
- To be a man, you need to be tough
- A woman should tolerate violence in order to keep her family together
- It is a woman’s responsibility to avoid getting pregnant
- There are times when a woman deserves to be beaten
- A woman’s most important role is to take care of her home and cook for her family
- Percentage of women who agree or strongly agree with the statement
- Percentage of men who agree or strongly agree with the statement

Source: UN multicountry study on men and violence
women with higher educational attainment (who had secured the GCE Ordinary Level certificate or higher qualifications) accepted that wife beating is justifiable. This indicates that even the educated women in Sri Lanka subscribe to gendered norms that place women at a level inferior than men in intimate relationships.

A study involving undergraduate male medical students revealed attitudinal barriers that could potentially affect prevention and response to IPV; 33% of students surveyed believed wife beating was justified, 63% blamed women for instigating the violence, and 23% stated that occasional violence by a husband against his wife could help maintain the marriage.

A community-based study in the Central Province found that obeying the husband was associated with a lower risk of IPV, demonstrating how the gender norms have assigned a subordinate status to the woman as well as the vulnerability of a women to abuse if she chose to challenge the gender norms.

The UN multicountry study on men and violence indicate, as shown in Figure 9, that 74% of men do not approve beating women. The same study found that three quarters of men (75%) did not approve acts of a teasing nature with sexual connotations. However, the majority related manhood to dominance and violence, with 58% believing that "it is manly to defend the honour of your family even by violent means", and 57% agreeing that "to be a man you need to be tough".

The same study found that a high proportion of men (78%) subscribed to the view that a woman should obey her husband, and more than half of them (58%) agreed with the view that "a woman cannot refuse to have sex with her husband". These attitudes are reflected in the actual behaviour towards control over their intimate partners that men exercise and are accepted and perpetuated by society.

As shown in Figure 9, it is noteworthy that more women than men contribute to propagate these gendered norms that place a woman in a subordinate position within the intimate relationships.

The majority (men 70%, women 68%) of men and women think that women subjected to rape should not to be blamed for putting herself in that situation. However, both men and women, and more so women, hold very negative attitudes on other aspects related to rape. These attitudes serve as barriers to the prevention of sexual violence and ensuring empathetic care for survivors.

Attitudes of frontline workers in health and related services would have a direct influence on the service uptake by the survivors as well as on the outcomes. However, there have been no recent studies conducted on this.

**3.2 ASSOCIATED FACTORS**

The recent UN multicountry study on men and violence revealed that men who had experienced physical, sexual or emotional abuse during their childhood are

![Figure 10: Male and female attitudes to sexual violence (inclusive of rape)](image)

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think that some women ask to be raped by the way they dress and behave</td>
<td>79.1</td>
<td>75.1</td>
</tr>
<tr>
<td>I think that in any rape case, one would have to question whether the victim is promiscuous or has a bad reputation</td>
<td>55</td>
<td>67.3</td>
</tr>
<tr>
<td>I think that if a woman doesn’t physically fight back, it’s not rape</td>
<td>43.2</td>
<td>44.3</td>
</tr>
<tr>
<td>I think that when a woman is raped, she is usually to blame for putting herself in that situation</td>
<td>29.8</td>
<td>31.9</td>
</tr>
</tbody>
</table>

*Source: UN multicountry study on men and violence*
1.7 to 2 times more likely to perpetrate violence against their partners than men who did not experience such abuse.

Perpetration of physical partner violence, engaging in transactional sex or sex with a sex worker, experiencing childhood emotional or sexual abuse, and having multiple sexual partners were all associated with men's perpetration of non-partner sexual violence.

Several studies have linked alcohol either as a cause or as an associated factor for the perpetration of violence (35). There is an ongoing debate about alcohol as an excuse rather than a cause/associated factor. One argument is that “not all perpetrators of violence use drugs or alcohol, and not all those who use drugs or alcohol perpetrate violence”.

A study conducted by FORUT (44), an NGO that addresses alcohol and substance abuse issues in Sri Lanka, found that violence under the influence of alcohol is excused and more or less accepted by the local communities. Further violence is justified by the consumption of alcohol. The study asserts that “what is condoned when one is intoxicated spreads over to be a norm when sober. When a father’s alcohol abuse leads to a lack of care for the children, it is often considered more of an unfortunate circumstance rather than an issue that demands more concern and attention”.

Women abused by their intoxicated husbands are common, however the general consensus is that this is due to fate or an “accident” related to alcohol. This implied consent for misbehaviour under the influence of alcohol leads to the severe disruption of norms and standards. Alcohol consumption affects behavioural patterns and cultural norms making violent behaviour while being intoxicated acceptable.

The findings of the UN multicountry study (14) that covered four districts in the country reported that most men who reported perpetration of sexual violence had done so because they thought that it is their sexual entitlement. Alcohol was the least reported motivation/excuse. This further supports the argument that alcohol is an excuse rather than a cause or an associated factor for the perpetration of violence against women. Therefore, it is important to address these myths linked to alcohol in GBV interventions in Sri Lanka to deter the social acceptance of violent behaviour while intoxicated.
The scoping review 2011(35) asserts that “physical health consequences of IPV in Sri Lanka have been documented, including head injuries, black eyes, contusions, abrasions, lacerations, and burns. A number of studies were conducted in medico-legal settings, where physical injuries are more likely to be reported, than other consequences of IPV.

Only a few studies documented the psychological and mental health consequences of IPV: lowered self-esteem, suicidal ideation and suicide attempts. In one study, 12% of women reported IPV as the main reason for attempted suicide”.

The UN multicountry study (14) found that over a quarter of the women who were subjected to physical violence by their intimate partner had to stay in bed, 16% had to take days off work, and 32% had to seek medical attention, because of injuries relating to the physical violence. Further, 25% of the women who had experienced IPV reported having suicidal thoughts, compared with 7% of women who had never experienced IPV. The same study reported higher abortion rates (7%) among women who experienced IPV compared with women who never experienced IPV (0.7%).

A study on female deaths due to unnatural causes (deaths not caused by disease or ageing but by external causes such as injury/trauma or poisoning, etc., where the manner/circumstance could be homicidal, suicidal or accidental or undetermined), commissioned by UNFPA in 2015, retrospectively analysed 243 female homicides that were reported during three years (from 2013 to 2015) in five provinces in the country. The analysis revealed that just over one third of the homicides of the females were perpetrated by intimate partners. (45) This figure is on par with the global estimate of 38% of all murdered women (in contrast to 6% of all murdered men) having been killed by an intimate partner. However, these estimates are lower than the corresponding estimates (40%) for the South-East Asia Region (2).

It could be assumed that in Sri Lanka, the health impacts of GBV are similar to those that are reported in the global context(2).
5. COSTS OF GENDER-BASED VIOLENCE

A small-scale pilot study on a presenting sample of 15 survivors was conducted in 2015 in Sri Lanka (46). The analysis focused only on the cost borne by the survivor. The direct as well as indirect tangible cost component was taken into account. The cost was estimated to be under five categories: i) health costs related to pain and suffering, ii) costs associated with the loss of productivity/livelihood, iii) costs associated with damage caused to and liquidation of assets and settlement of debts, iv) second generation cost: private and public health costs associated with childcare, changing schools, counselling, and v) cost of obtaining support service: include legal/forensic services, temporary accommodation, paid care and counselling.

The study findings cannot be generalized due to its small sample and because the institutional costs were not included. Nevertheless, this report highlights the constraints in carrying out such analyses in the current context in Sri Lanka.
6. LEGAL FRAMEWORK, POLICY, PREVENTION AND RESPONSE

6.1 LEGAL FRAMEWORK

In Sri Lanka, the legal system addresses GBV through the provisions of the Penal Code (codified in 1883) and the Prevention of Domestic Violence Act (2005).

The amendment to the Penal Code in 1995 (47) broadened the definition of rape to introduce the term “with or without her consent”. The amended laws carry a mandatory minimum sentence of seven years with enhanced punishment for gang rape, custodial rape, rape of a woman of unsound mind, rape of women in a state of intoxication induced by alcohol or drugs administered to her by the man or by some other person, and of pregnant women. The law also recognizes statutory rape at 16 years.

This amendment introduced sexual harassment and incest as crimes. Sexual harassment constitutes: “harassment of a sexual nature using assault, criminal force, or words or actions which causes annoyance to the person being harassed”. If the perpetrator is convicted, the penalty for such an act is imprisonment up to five years and/or a fine. The perpetrator may also be ordered to pay compensation to the aggrieved person.

Marital rape is not a punishable offence in Sri Lanka except in the instance where the man is judicially separated from his wife pursuant to a court order.

Trafficking is recognized as a criminal offence and carries a term of imprisonment of not less than two years and not more than 20 years by the provisions of the Trafficking Section 360C of the Penal Code (Amendment) Act No. 16 of 2006.

The law of the country also considers a homosexual relationship to be a criminal act punishable by imprisonment.

The Prevention of Domestic Violence Act number 34 of 2005 (48) provides a civil remedy through the issue of interim orders and protection orders by the courts in cases where it is deemed to be necessary to prevent an aggressor from inflicting further harm to persons within the home environment. A protection order may prohibit the aggressor from committing acts of domestic violence and entering into the victim’s residence and may also impose other prohibitions. The Act gives paramount importance to the safety of the victim as opposed to punishing the perpetrator and, therefore, where an offence has been committed, the normal criminal justice process of investigation and prosecution is followed.

6.2 NATIONAL POLICIES AND STRATEGIES AIMED AT ADDRESSING GBV

There are numerous policies and strategies in the country to address GBV. Some of these national policies that incorporate strategies on GBV include: the National Health Policy; Population and Reproductive Health Policy; National Policy on Youth; National Family Policy; Plan of Action Supporting the Prevention of Domestic Violence Act; the National Mental Health Policy; Policy on Anti-trafficking; National Action Plan for the Protection and Promotion of Human Rights; and the Guidelines for a Code on Sexual Harassment. The Policy Framework and National Plan of Action to address Sexual and Gender-based Violence (SGBV) (49), which was a collaboration between nine sectoral ministries over 2016–2020 and which laid out the roadmap of planned activities until 2020, was approved by the Cabinet in 2016.

6.3 PREVENTION AND RESPONSE

There are several ministries and civil society organizations that are engaged in GBV prevention and response programmes across the country.

6.3.1 Ministry of Women’s Affairs

Eliminating gender-based violence is clearly identified as a specific objective of this Ministry. The Ministry focuses on formulating, implementing and monitoring policies, programmes and projects for the empowerment of women and combating violence against women in collaboration with the government, NGOs/INGOs, UN agencies, media and donor agencies.

The Ministry has established Women and Children’s Units at the divisional level, staffed by field officers working at the grassroots, to provide protection, care and guidance, and to resolve issues related to GBV and provide emotional support and counselling. In addition, the field officers collaborate with other state agencies...
such as hospitals, and community service organizations to form the crucial link between the grassroots and the state machinery designed to empower women.

The Complaint Centre of the National Committee on Women located in the Ministry premises provides onsite legal and psychosocial support to survivors and facilitates action by other agencies in response to complaints made. The helpline (number 1938) for women established two years ago is supported by a team of trained staff.

The Ministry, in partnership with nine sectoral ministries, took the lead in developing the Policy Framework and National Plan of Action to address Sexual and Gender-based Violence (SGBV) 2016–2020 that was approved by Parliament in 2016. This framework is very comprehensive and has laid down the planned activities with regard to prevention, interventions and policy advocacy and asserts that: “Prevention is aimed at taking measures before GBV occurs and addressing the underlying causes of GBV, as well as eliminating or modifying factors that support or condone GBV at the individual, family, community and societal levels”.

Interventions include responses to issues faced by survivors of GBV. These include: establishing service points and temporary shelters to provide services and protection for the survivors and their children; holding the perpetrator to account; and providing psychosocial and other support to the survivors and others affected.

Policy advocacy involves bringing about policies, laws and regulations, and establishing practices and standards to address the issues of GBV. Activities include those that ensure effective implementation of the laws and policies and strategies that strengthen the management information systems and information sharing. The National Plan of Action also proposes to strengthen the research on GBV and to review the current policies and laws to harmonize jurisdictions and to explore the gaps and areas that need strengthening.

Effective implementation and a sustained monitoring system is required in order to realize the objectives of this National Plan of Action. While each ministry may need constant guidance, there is also need for proper coordination. The Ministry’s capacity also needs to be reviewed and strengthened if needed.

6.3.2 Police Department

Survivors who seek legal action are compelled to go through a long process through the police, health (medico-legal) and the judicial systems that involves lawyers and attending courts. In order to improve the police response, women and children’s desks have been established in 43 main police stations with the support (for infrastructure development and capacity-building of officers who are the first contact points for most survivors seeking legal redress) of the Ministry of Women’s Affairs. They attempt to function as coordinating offices, bringing together data on incidents of violence against women and children, and feeding this to the Central Police Bureau. Personal communication with the Assistant Superintendent of Police attached to the Police Child and Women Bureau in Colombo revealed that all 480 police stations in the country have women police officers to function as frontline contacts at the desks for women and children.

Table 2: Crimes against women and cases solved by the Police Child and Women Bureau

<table>
<thead>
<tr>
<th>YEAR</th>
<th>REPORTED CASES</th>
<th>NUMBER OF CASES RESOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>7798</td>
<td>2062 (26.4%)</td>
</tr>
<tr>
<td>2013</td>
<td>8320</td>
<td>4672 (56%)</td>
</tr>
<tr>
<td>2014</td>
<td>8434</td>
<td>4399 (52%)</td>
</tr>
<tr>
<td>2015</td>
<td>8288</td>
<td>4579 (55%)</td>
</tr>
<tr>
<td>2016</td>
<td>9042</td>
<td>4976 (58%)</td>
</tr>
</tbody>
</table>

Source: Annual performance report: Police Department 2014 (50)

Table 2 indicates the total number of crimes reported and the number of crimes “solved” as reported in the 2015 Annual Performance Report of the Police Department. According to this report, over 50% of reported cases of crimes against women have been resolved. It will be interesting to know how these cases were solved.

The 2005 community-based study on IPV revealed that those women who seek the services of the women’s desks at police stations are often encouraged to continue with the abusive relationship without being offered client-centred services, and thus the case is marked as resolved. Another study describes how the women desks of the police and mediatory boards encourage women to continue to remain in a violent relationship on the pretext of maintaining the stability of the family. Therefore, it is important to review the functionality of these women and children police desks, including the skills and attitudes of frontline officers, which may be impacted by societal norms. All these frontline officers require training to ensure that they really respond to the needs of the clients, ensure their safety, and hold the perpetrator accountable in as many cases as possible. Furthermore, it is very important that these desks function round-the-clock so that women can have easy access at all times.
6.3.3 Nongovernment organizations

In the years before the ministries took up the issue and at a time when there was resistance to taking steps to end violence against women, the nongovernmental organizations took the lead in implementing prevention and response activities against GBV in Sri Lanka.

NGOs set up shelters for women, GBV desks were opened in hospitals and counselling centres were started. NGOs still play a key role in the national response, and contribute immensely to policy advocacy for law reforms and for strengthening the accountability of the State actors. Several NGOs have conducted important research studies to provide evidence-based data for policy dialogue and programme reorientation. Some manage shelters for the Government and run hospital GBV desks in several hospitals.

There is a need to strengthen the coordination between the State sector and the NGOs working with GBV in order to maximize their inputs and sustain partnerships. NGOs are key to the effective implementation of the planned activities under the Policy Framework of the National Plan of Action 2016–2020.

6.3.4 Judiciary

The judiciary plays a key role in ensuring perpetrator accountability.

According to the annual grave crimes reports of the Police Department (32) only a handful of reported rape/incest cases end up in conviction during the same year. For example, as indicated in the above table, of the total reported cases in 2014 only one case led to a conviction that same year.

Similarly, only seven cases in 2013, two in 2011 and only three in 2010 ended up in conviction during the same year, demonstrating the long-drawn judicial processes that survivors have to go through.

Prison annual reports (51) provide information on the prison inmates who have been convicted for rape/incest, and also reflect the considerable volume of pending cases.

These pending cases are to be found lying at different stages: the investigation stage, at the Attorney-General’s Department, and in court. According to the report of the Leader of the Opposition’s Commission on the Prevention of Violence against Women and the Girl Child of December 2014, sexual abuse cases sometimes take up to 15 years for a resolution.

The judicial system in the country is very formidable and the average citizen often feels quite overwhelmed and alien when dealing with the system. These long-drawn judicial processes may lead to revictimization and discrimination and have serious psychosocial implications for women.

6.3.5 Ministry of Health

Policy response from the Ministry of Health

The policy response from the health sector to address GBV is strong, with many health sector policies having

<table>
<thead>
<tr>
<th>DETAILS OF RAPE/INCEST CASES</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape/incest cases reported</td>
<td>1854</td>
<td>1870</td>
<td>2212</td>
<td>2181</td>
<td>2008</td>
</tr>
<tr>
<td>Number of cases with evidence to prosecute</td>
<td>1847</td>
<td>1864</td>
<td>N/A</td>
<td>2175</td>
<td>2008</td>
</tr>
<tr>
<td>Number of cases disposed/acquitted</td>
<td>53</td>
<td>43</td>
<td>N/A</td>
<td>56</td>
<td>36</td>
</tr>
<tr>
<td>Number of pending cases at the end of the year</td>
<td>1794</td>
<td>1819</td>
<td>N/A</td>
<td>2119</td>
<td>1972</td>
</tr>
<tr>
<td>Number ended in conviction in the same year</td>
<td>2</td>
<td>2</td>
<td>N/A</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Number of plaints filed</td>
<td>167</td>
<td>275</td>
<td>N/A</td>
<td>234</td>
<td>249</td>
</tr>
<tr>
<td>Number of admissions to prisons convicted for rape/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incest per prison’s annual report</td>
<td>169</td>
<td>167</td>
<td>274</td>
<td>245</td>
<td>282</td>
</tr>
</tbody>
</table>

Source: Annual grave crimes report of the Police Department 2016 and Prison’s Annual Report 2015
included the subject. The National Policy on Maternal and Child Health 2012 under the Policy Goal 8 pledges to “promote the reproductive health of men and women assuring gender equity and equality”, and identifies a strategy to “ensure an effective response from the preventive and curative health sector for the prevention and management of GBV”.

The National Health Development Plan 2013–2017 under the main Strategy C has identified the Specific Objective No. 8, to be “to promote the reproductive health of men and women assuring gender equity and equality”. The National Strategic Plan Adolescent Health 2013–2017 discusses the vulnerability of adolescents to teenage pregnancies, HIV/STI and violence, all of which are interconnected with issues related to GBV.

Health system

Although there is a fast-growing private health-care system, with a few private hospitals in Colombo and main cities and other privately-run clinics throughout the country, the health-care system is mostly run by the government.

Sri Lanka has a robust state health system (52) that is extensively spread throughout the country. The system has two arms: curative and preventive, and the community health services. State health care is free of charge at the point of delivery for both curative as well as preventive services.

The curative health services comprise a strong network of 1104 health institutions, of which 140 are hospitals providing specialist services and a further 969 are non-specialist health facilities, which include divisional hospitals and primary medical care units.

The preventive health services comprise 340 health units (each health unit with a medical officer) and each Medical Officer of Health covers a population of approximately 60,000. Public health midwives are the health personnel at the grassroots, and on an average each one looks after a population of 3000.

A public health midwife is responsible for all reproductive, maternal, newborn, child care and adolescent health issues in her location and provides domiciliary care to mothers and children. The public health midwife works to an advance programme drawn up every month and is the link between the health system and the community, especially women and girls.

Preventive health units (under the Medical Officer of Health) and curative health facilities (hospitals) are well linked and are headed by medical graduates.

Medicolegal services

Medicolegal services in the country are well established within the curative health services. Forensic medicine is a specialist discipline, often headed by personnel who are medical doctors with a postgraduate qualification. Personal communication with the Professor of Forensic Medicine at Kelaniya University revealed that there are 79 board-certified specialists in forensic medicine in the country, of which 60 are in active service. Twenty specialists are attached to universities.

In addition to these board-certified specialists, there are around 150 medical officers who have undergone legal training. These are medical graduates who have taken up in-service training. By the end of 2014, there were 76 medical officers working in the capacity as Judicial Medical Officers (JMOs) in the Health Department. Currently, all districts are covered by the forensic specialist services. Forensic medicine specialists attached to universities also conduct medicolegal activities.

All admissions to hospitals with injuries due to GBV or with a history of sexual violence including rape are reported to the police if the survivor discloses the incident and/or desires to take legal action. Once these incidents are reported to the police, it is the responsibility of the JMOs or the doctors who are dealing with medicolegal cases to record the incidents and appear in the courts as expert witnesses.

There is no system within the Ministry of Health to collect data on the medicolegal aspects of cases and, as a result, information on survivors who have sought medicolegal services are not available. It is important to review the present status of medicolegal services that are provided to survivors of GBV and sexual violence to gauge the coverage as well as the quality.

The National Guidelines on Examination, Reporting and Management of Sexually Abused Survivors for Medico-legal Purposes targeting the Judicial Medical Officers (JMOs) were developed by the Sri Lanka College of Forensic Pathologists in 2015.

These guidelines, which were developed in line with the WHO Guideline on Management of Rape Survivors, introduces a rights-based approach and emphasizes a survivor-centred medicolegal response. The non-specialist medical officers in four out of nine provinces have undergone training on the guidelines.
Health sector activities on the prevention and response to GBV

The health system has a unique opportunity to identify and respond to survivors of GBV, since health staff are very likely to come across survivors of GBV during their day-to-day work.

Accordingly, the Ministry of Health has taken steps to address GBV as a public health issue and has applied a systemwide approach to integrate the services for GBV into existing programmes in a phased manner.

In 2004, the Ministry of Health identified the Family Health Bureau, which is the implementing arm of the reproductive and MCH programme in the country, as the nodal agency for gender and GBV issues within the Ministry. Subsequently, in 2005 a dedicated unit for Gender and Women’s Health headed by a public health specialist was established within the FHB.

Interventions in the preventive health sector

There are a few interventions that have been implemented in order to strengthen the preventive health sector towards prevention and response to GBV.

A targeted module was developed for the pre-service curriculum of midwives which includes knowledge-building on GBV as well as skills development on preventing and addressing GBV in the community. An ongoing, cascade in-service training of five days’ duration, using a pre-designed interactive training module for preventive health staff is being conducted by the Family Health Bureau (FHB) on a regular basis to cover all preventive health units, and especially targets all midwives and medical officers of health in the country.

A further training module on GBV has also been integrated into the orientation programme for the medical officers of health.

A unique programme targeting newly married couples is being implemented throughout the country, with the assistance of Registrar of Marriages, by preventive health staff. In this programme, the newly married couples are given an open invitation and an opportunity to discuss issues related to family health and welfare, including GBV.

Marriage registrars encourage the couples to liaise with the field health staff and utilize this opportunity. In addition to the two mandatory discussions, the newly married couples are provided with a comprehensive information booklet.

Public health midwives during their domiciliary visits are expected to identify issues related to GBV within families and report through the Reproductive Health Management Information System. However, this report only contains aggregated numbers of identified issues and the number of survivors referred to other services.

On a positive note, all previously mentioned interventions are delivered at low cost, and this will ensure sustainability of the programme. As public health midwives and other health staff delivering services are also part of the community, it is necessary to acknowledge that they themselves may be suffering from IPV/GBV.

Therefore, it will be helpful if the training is made a mandatory requirement and materials are reviewed and updated to include more interactive sessions on gendered norms, myths about alcohol and drugs, as well as how the health staff could address and seek services in case they themselves are subjected to violence.

Curative health sector interventions

Hospital admissions are sought by a very few women who are subjected to IPV/GBV in the country. This should be viewed in the light of the fact that not all survivors who have undergone physical and/or other forms of violence sustain physical injuries that warrant hospital admissions.

Furthermore, as indicated in research, the majority of women do not want to disclose the cause or extent of the violence mainly due to shame, concern about the family name, and fears for themselves or other loved ones being subjected to violence again.

Recognizing this, and in order to allow the survivors to have easy access to services without being stigmatized, a network of dedicated service points – Mithuru Piyasa/ Natpu Nilayam (Friendly Haven) – tailormade to the needs of Sri Lanka was instituted within the government hospitals.

The first Mithuru Piyasa/Natpu Nilayam was established in the Government Hospital in Matara in 2008. These centres are usually placed within the outpatient departments of hospitals or in places with easy access, and are managed by hospital staff who are specifically trained to provide first-line support that includes active listening, emotional support and referral to medical and other services.

This programme was gradually expanded, and by the end of 2016, 56 such centres had been established including at military hospitals and hospitals within the Free Trade
zone of Board of Investment (BOI) Out of 25 districts, 21 have at least one hospital with a Mithuru Piyasa/Natpu Nilayam (Figure 11).

Figure 11: Distribution of Mithuru Piyasa/Natpu Nilayam centres in Sri Lanka

A protocol has been developed to guide the functioning of the centres, which collaborate with other service providers in the locality such as the Women and Children’s Development Unit at the district/divisional Secretariats, units of the Legal Aid Commission, police and probation services, etc.

Figure 12 shows the increase in the number of clients over the years that is directly linked to the increase number of Mithuru Piyasa/Natpu Nilayam centres. Also, it is important to note the subsequent visits made by clients and as well as the visits by family members and perpetrators.

As shown in the figure 13, the majority of the referrals are from within hospitals. This is an indication of the acceptance of Mithu Piyasa/Natpu Nilayam centres by the hospital system and the medical specialists. Referrals from the police are also an indication of the collaboration that these centres have developed with outside stakeholders. It is encouraging to note that almost one fifth (19%) of the clients come on their own, showing that people are identifying these centres as helpful.

The proportion of referrals from the preventive health units (Medical Officer of Health areas/public health midwives) remain low at only 6%. This may be due to the field health staff attending to the needs of clients as and when they are identified in the field and only referring those survivors with more acute needs to hospital centres, but this needs further analysis.
The Demographic Health Survey 2016 included one question to gauge the knowledge of women about the available services. This question was directed to all women and almost 50% said they knew about the Women’s Bureau and 26% knew about the helpline that is operated by the National Committee on Women. It is also encouraging to note that more than one fourth (26%) of all women acknowledged the public health midwife, 13% the Mithuru Piyasa/Natpu Nilayam, and almost 10% the Medical Officer of Health as being a potential service provider, thus demonstrating growing confidence among women with the services provided by the health sector.

Despite the impressive progress made by the health sector, there are few aspects that need attention. Currently, staff (doctors and nurses) at the Mithuru Piyasa/Natpu Nilayam centres are selected from among the staff who volunteer to serve at the Centre. This is very strategic as only the health-care providers who are committed to the subject of GBV/IPV are working at the hospital centres. The Ministry of Health had taken steps to advertise 16 positions designated as medical officers for the Mithuru Piyasa/Natpu Nilayam as special posts. When the officers are appointed by formal methods such as from annual transfers, the personnel appointed might not have the same motivation on prevention and management of GBV as those who volunteer themselves for the post. On the other hand, this is a clear indication of the intention of the Ministry of Health to sustain the programme.

Collaboration and coordination between the Mithuru Piyasa centres and other stakeholders within (medicolegal, psychiatry, etc.) and outside the hospitals (police, Legal Aid Commission, NGOs, etc.) are not yet formalized. The process needs to be formalized by issuing circulars and guidelines and also strengthening advocacy and monitoring.

Perceptions and attitudes of the health administrators and the health staff who are involved in service provision influences the quality of the services provided, and it will be helpful to have this information for the future.

Health staff who are potential first-line contacts, for example, staff working in emergency treatment units and accident services, also need their skills and knowledge enhanced to identify and respond to survivors of GBV. Guidelines and standard operating procedures need to be in place.

At present the Mithuru Piyasa centres are not opened round-the-clock and many are not functional during weekends and at night, and this can have an impact on the uptake of the services. Therefore, it is important to explore the possibility of having these centres functional (even by covering up by trained staff from other units) round-the-clock and seven days a week.

As the training programmes for Mithuru Piyasa/Natpu Nilayam staff and the preventive health staff have been ongoing for several years, a review of these will be of immense help to further strengthen them in order to ensure that knowledge and skill levels can be maintained.

It may be a wise approach to undertake an independent review of the health sector response to identify the gaps and strategize the interventions for this to be optimal and be aligned with the National Plan of Action.
7. DISCUSSION

Sri Lanka is performing very well on social indicators such as education and health in comparison with other South Asian countries.

There have been many positive steps taken in the country to prevent and manage GBV. Enactment of key international conventions and covenants, law reforms, introducing favourable policies, and integrating prevention and management of GBV into the policies and strategies of many government ministries are commendable.

Several ministries and departments have taken very crucial steps such as establishing women and children’s police desks in order to attempt to reorient the services to be more survivor-friendly.

The health sector deserves to be congratulated for its system wide approach in implementing activities both in curative as well as the preventive sector that are low-cost, thus ensuring future sustainability.

Nevertheless, there is a huge challenge ahead as the country needs to address the deeply entrenched gendered norms in all spheres - home, education system, health care and the workplace. These gendered norms had resulted in low political participation by and low leadership positions being held by females in the country.

Further, the gendered norms perpetuate the male dominance over females, which in turn leads to IPV/GBV. In addition, there are gaps in information due to the absence of a systematic data repository at the national and subnational level on the prevalence and consequences of GBV/IPV. There are gaps in the judicial processes and in implementation of the legal enactments and planned programmes.
8. RECOMMENDATIONS

Priority should be given to proper implementation of the National Plan of Action 2016–2020. As proposed a high-level committee needs to be appointed to monitor the implementation.

It is important to provide continuous guidance to partner ministries. A review should be undertaken of the capacity of the women’s ministry – which is the lead ministry – and if need be steps should be taken to strengthen and augment the capacity of officials or make alternative arrangements enabling continuous stewardship.

8.1 HEALTH SECTOR

A review must be undertaken of the health sector response in order to identify the gaps and strategize the interventions so that these are optimal and aligned with the National Plan of Action.

The review should include the assessment of current medicolegal services and Mithuru Piyasa/Natpu Nilayam centres including survivor perceptions; coordination within hospital and with outside partners; and of the knowledge, skills and perceptions of the service providers, managers and administrators. Protocols and guidelines also need to be reviewed and to updated if needed be.

This review also should include laying down of criteria for selecting staff for Mithuru Piyasa/Natpu Nilayam centres and their training, refresher training, and stewardship.

It must be ensured that all frontline health staff in emergency treatment units, accident services, etc. as well as those who are working in the periphery have the necessary skills, knowledge and attitudes to identify and respond to the survivors, especially those who have been subjected to sexual violence. This may need developing additional protocols and training.

Preventive health interventions need further strengthening. It is also imperative to review the perceptions of the frontline health staff, especially public health midwives. The health sector needs to work more with the youth to nurture healthy attitudes, practices and relationships for a future without violence and discrimination.

The programmes need to change the belief that manhood is defined by being tough. Alternative versions of manhood that are non-violent, gender-equitable and encourage empathy and respect should be portrayed as the norm.

The Early Childhood Care and Development Programme must be strengthened to protect children from violence and nurture healthy childhoods by working with parents and caretakers.

The Health Ministry should take necessary steps to address within the MCH and school health programmes the harmful effects of gendered norms as well the myths associated with alcohol.

8.2 POLICE AND JUDICIARY

It is recommended that the present functioning of children and women desks be reviewed, including the attitudes of frontline staff (managers and decision-makers must also be included), with a view to take steps to make these desks become more survivor-friendly and perpetrator accountable.

Delays in judicial processes need to be looked into and court procedures expedited while ensuring confidentiality and safeguarding the dignity of survivors.

8.3 SUPPORT SERVICES

More shelters need to be established. This may be one area that needs to be explored with funds mobilized from private sector firms.

8.4 NGOs

It is also important to assess the best modalities of working in partnership with NGOs to reach the common goal.

8.5 POLICY LEVEL

The establishment of a National Commission on Women is to be considered urgently with carefully selected membership in order to ensure that the Commission is technically competent and politically independent.

A review of laws on marital rape, same-sex relationships and related marriage laws, and statutory rape needs to be undertaken and relevant amendments lobbied for.
8.6 RESEARCH

The research on national prevalence in the pipeline should be expedited. It is important to establish a multisectoral technical expert committee to oversee the process.

More operational research is necessary in all sectors in order to improve the quality of the services. It is also important to conduct research on not-so-visible issues such as trafficking, FGM, female feticide, etc.

8.7 LOBBYING AND ADVOCACY

Lobbying and advocacy on interventions in all sectors are necessary. It is important to have uniform messages that are tailormade for various audiences in order to trigger the appropriate responses from a variety of stakeholders.
9. REFERENCES


20. ILO. Key Indicators of the Labour Market (KILM) [Internet]. Available from: http://www.indexmundi.com/facts/sri-lanka/indicator/SG.GEN.LSOM.ZS


39. Hussain A. Sometimes there is no Blood, Domestic violence and Rape in Rural Sri Lanka. ICES. 2000;

40. Thomson Reuters Foundation. Whether knife or blade, Sri Lankan FGM survivors just want it to stop. 2017.

41. Gunawardena N, Weerasinghe M, Rajapakse L, Wijesekara P. Sexual harassment on public trains and busses.


