Gender-based Violence

Information booklet for health care providers

2012

Family Health Bureau
Ministry of Health
Sri Lanka

UNFPA

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Information booklet for health care providers

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Contents

I. Message from the Hon. Minister of Health

iii. Message from UNFPA Representative Sri Lanka

v. Acknowledgements

vii. Preface

ix Acronyms and abbreviations

1	Introduction	01
2	Gender-based violence (GBV)	03
3	Gender-based violence as a Health Issue	07
4	Health consequences of gender-based violence	12
5	Non health consequences of gender-based violence	14
6	The survivor(*Victim*)	16
7	The perpetrator	18
8	What health providers could do?	21
9	Guiding principles in providing care for gender-based violence Survivors	26
10	Revictimisation "within" the health care provision mechanisms	32
11	Asking about gender-based violence	33

12	When a woman discloses gender-based violence	37
13	Ways to assist the survivor	38
14	Documentation/data management	40
15	Assessment of danger	41
16	Development of a safety plan	43
17	Supporting those who provide care	45
18	Prevention of Domestic Violence Act 2005	47
19	Violence at work/sexual harassment in health institutions in Sri lanka	49
20	What is being done in the health sector to address gender-based violence	51

Message from the Hon. Minister of Health

Sri Lankan government provides free health care to its public while maintaining high standards and indicators unrivaled in the region.

One of the distinctive features of the health system of Sri Lanka is the equal emphasis given to both curative care and preventive health care, which includes issues such as addressing gender-based violence.

Many policy documents of the government of Sri Lanka, including Mahinda Chinthanaya, and the Health Master Plan of Sri Lanka 2007-2016 iterate the commitment of the state to provide services to women subjected to various forms of violence.

I am very happy that the Family Health Bureau as the directorate responsible for women's health has taken steps to address gender-based violence in the area of prevention as well as in responding to persons who suffer from violence.

Improving knowledge and skills of the health staff is an important step in provision of support and assistance to persons subjected to gender-based violence.

I am confident that the development of these training documents will launch a series of training activities, which will in turn result in bringing together a group of competent, and compassionate care providers to serve the public.

Maithripala Sirisena
Minister of Health

Message by UNFPA Representative

UNFPA, the United Nations Population Fund, advocates against gender-based violence as a human rights violation and a public health priority, in line with the mandate entrusted to us by the Programme of Action of the International Conference on Population and Development (ICPD). As the lead UN agency on sexual and reproductive health, UNFPA plays a vital role in addressing the health consequences of violence against women and girls which often have a long-lasting impact.

In Sri Lanka, UNFPA began its support in addressing gender-based violence within the health sector in 2002. This was through a pilot under the global Programme Guide for Health Care Providers and Managers, developed by UNFPA. With UNFPA support, the Ministry of Health established the first ever government run gender-based violence care centre at the Matara Hospital in 2007.

Taking on from the lessons learnt, UNFPA under its current country programme is working with the Ministry of Health to integrate the prevention and management of gender-based violence using multi-pronged approaches. A key strategy has been to build the capacity of health professionals (with the) knowledge and competency to respond to gender-based violence. To this end, UNFPA has supported the Family Health Bureau of the Ministry of Health, to produce a resource pack comprising of a training manual, an information booklet for health staff and a protocol for service centres.

This resource pack will enable uniformity in training and in the implementation of activities at the hospital care centres and will add to its long-term sustainability as an integral part of health care in the country.

UNFPA is grateful to the Family Health Bureau for their leadership. We sincerely thank Dr.Lakshmen Senanayake and the panel of experts.

Ms. Lene K. Christiansen

Acknowledgements

The Family Health Bureau, as the directorate responsible for women's health, would like to acknowledge all those who contributed towards the development of this module, but they are too many to be identified by name. However we would be failing in our duty, if those central to the activity are not mentioned here.

The initial training programme for establishing the first Mithru Piyasa/ Natpu Nilayam in 2007, conducted at Matara, was the starting point for the evolution of this module and we acknowledge the contribution made by all resource persons who participated at this training.

This facilitator manual would not have been a reality if not for the hard work and the commitment of Dr Lakshmen Senanayake, who compiled the document after extensive review of literature on gender-based violence.

Dr Chandani Galwaduge National Programme Officer RH, UNFPA and Dr Nethanajali Mapitigama National Programme Manager Gender and Women's Health, FHB who took up the challenge of piloting the document and thereafter improving it with constructive suggestions. We thank them.

The piloting was facilitated by the Heads of the Institutions, Consultant Psychiatrists, Consultant Obstetricians and Gynecologists and other staff of Matara , N'Eliya, Dickoya and Batticaloa Hospitals. The assistance given by them is very much valued.

This manual was extensively reviewed by a panel of experts and consensus was reached after many discussions. We are grateful to the members of this panel who contributed time and expertise in no small measure.

We are thankful to Dr Kamal A. Perera for designing a distinctive cover page for documents.

We acknowledge the assistance given by UNFPA the United Nations Population Fund in Sri Lanka, for providing technical and financial assistance and would like to specially appreciate the support given by Ms. Lene K Christiansen, the UNFPA Representative in Sri Lanka.

Dr. Deepthi Perera
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Preface

Family Health Bureau is the nodal organization responsible for Women's Health in the Ministry of Health.

Gender-based violence is now being recognized as one of the significant threats to women's health. In addition, it has been accepted that, domestic violence is a major public health issue affecting mostly women who are at a high risk of multiple negative health outcomes, particularly in the area of reproductive health. Pregnant women undergoing domestic violence are at a higher risk of experiencing many negative health outcomes, affecting the mother to be and the baby.

Although data on gender-based violence became available over the last few decades, impact of domestic violence on health and well being of the women came to be critically evaluated and assessed only in the recent past. It is a tragic situation that the topic is often considered by many health care providers as shameful, irrelevant, and as an unnecessary intervention. Such attitudes leave the abused women uncomfortable to disclose violence and the health care provider uncomfortable to ask, and the health care system unable to use the window of opportunity offered to identify and care for abused women.

Inadequacy of health care provider's knowledge, the societal attitudes towards the subject, and the ensuing reluctance to respond make its detection and management inconsistent, ineffective and sometimes even counter-productive.

A significant step taken by the Family Health Bureau in responding to gender-based violence is setting up of Gender-based Violence Care Centres named "Mithuru Piyasa/Natpu Nilayam" at hospitals, which are dedicated to provide emotional and medical support to survivors of gender-based violence.

Capacity building of health care providers attached to "Mithuru Piyasa/Natpu Nilayam" to respond to survivors of gender-based violence is vital in this aspect.

Resource pack comprising of the training module on gender-based violence for the core staff of the GBV care centre Mithuru Piyasa/Natpu Nilayam, information booklet for health care providers on gender-gased violence, and the protocol for Mithuru Piyasa/Natpu Nilayam were developed to fulfill the above purpose.

We take this opportunity to pay our sincere gratitude and appreciation to all those who contributed to make this endeavour a success.

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Abbreviations and Acronyms

AIDS	–	Acquired Immune Deficiency Syndrome
ANC	–	Anti Natal Clinic
DALY	–	Disability Adjusted Life Years
DDGMS	–	Deputy Director General – Medical Services
DDGPHS	–	Deputy Director General – Public Health Services
DV	–	Domestic Violence
EC	–	Emergency Contraception
FHB	–	Family Health Bureau
GBV	–	Gender Based Violence
GP	–	General Practitioner
HIV	–	Human Immunodeficiency Virus
IASC	–	Inter Agency Standing Committee
JMO	–	Judicial Medical Officer
MCH	–	Maternal and Child Health
MIS	–	Medical Information Systems
MO	–	Medical Officer
MOH	–	Medical Officer of Health
MoH	–	Ministry of Health
MOIC	–	Medical Officer In Charge
MOMCH	–	Medical Officer/Maternal & Child Health
MOO	–	Medical Officers
MRO	–	Medical Records Officer
MS	–	Medical Superintendent
NCW	–	National Committee on Women
OIC	–	Officer in Charge
OPD	–	Out Patient Department
OSCC	–	One Stop Crisis Centre
OSSC	–	One Stop Service Centre
PHM	–	Public Health Midwife
RDHS	–	Regional Director of Health Services
SLMA	–	Sri Lanka Medical Association
SOP	–	Standard operative procedures
STI	–	Sexually Transmitted Infections
UN	–	United Nations
UNFPA	–	United Nations Population Fund
VAW	–	Violence Against Women
WIN	–	Women In Need
ToT	–	Training of Trainers

01. Introduction

The inset shows what Prof. S. M. Buel, Co-Director of the University of Texas School of Law Domestic Violence Clinic and Adjunct Professor at Harvard Medical School wrote about herself, in an article in the International Journal of Obstetrics and Gynaecology, which illustrates the realities of gender-based violence(GBV) and the relative indifference of some of the care providers.[1]

The issue of GBV, changed from the position of obscurity, to such importance to be mentioned in such strong and unswerving terms in the echelons of health circles, only in the latter part of the last century.

It is well known that GBV affects mainly women but is not limited to them, and affects men as well.

Emerging research also indicate that men and women in same-sex relationships experience domestic violence at rates similar to that of heterosexual relationships.

Professional organizations including the American Medical Association, American College of Obstetricians and Gynaecologists, Royal College of Obstetricians and Gynaecologists of the UK, Sri Lanka Medical Association and Sri Lanka College of Obstetricians and Gynaecologists have promulgated policy statements, position papers, guidelines and published many research documents on this important health issue, requesting all health care providers to address this issue.

"A pregnant woman presents to her doctor with bruising on her stomach and both sides of her face. The patient says she was clumsy and bumped into a bookshelf, so she is bandaged up and advised to be more careful. The physician notes in the medical record that the patient's injuries are not consistent with her story, but says nothing to her. Believing that such silence reflected that the fault for the abuse lay with her, that woman remained with her abusive husband for another 3 years

I was that pregnant woman," [1]

This has led to a growing recognition, among health care professionals that GBV, including domestic violence is a highly prevalent public health problem which has devastating effects on individuals, families and communities.

The health care setting offers the care provider a vital opportunity for early identification and primary prevention of GBV. Studies show that inquiring for GBV in medical settings has been effective in identifying women who are survivors of GBV and, contrary to the common belief, patients are not offended when asked about current or past GBV including Domestic Violence.[2]

This information booklet, developed to be complimentary to the protocol for the GBV service points in health institutions, provides any reader with an insight in to, and knowledge, on GBV and its effects on individuals, families and the society from the perspective of health care provision. It also provides some practical information, they may be able to utilize in the routine care provision.

This document should be considered as supplementary to other National Guidelines.

2. Gender-based Violence

2.1 Terminology

Gender refers to the social differences between males and females that are, deeply rooted in every culture, forms a part of learned behaviour, are changeable over time, and have wide variations both within and between cultures. **"Gender"** determines the roles, responsibilities, opportunities, privileges, expectations, and limitations for males and for females in any culture or society. [3]

Sex refers to the biological and physiological characteristics that define men and women. [7]

The terms **male** and **female** indicate sex categories, while **masculine** and **feminine** generally indicate gender categories.

Gender Based Violence is an umbrella term used for any harmful act that is perpetrated against a person's will, and is based on socially ascribed (gender) differences between males and females.

Around the world, GBV has a greater impact on women and girls than on men and boys. Therefore, the term "gender-based violence" is often used interchangeably with the term "Violence Against Women."(VAW)

One of the earliest and simple definitions of GBV is from the United Nations in 1993.

"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 private life." [5]

Although the initial definition was limited to women the term GBV at present includes violence perpetrated on persons of either sex based on gender.

GBV shall be understood to encompass, but not limited to, the following:
Physical, sexual and psychological **violence occurring in the family**, including battering, sexual abuse of children in the household, dowry-related violence, marital rape (not legaly recognised in Sri Lanka), female genital mutilation and other traditional practices harmful to women, incest and violence related to exploitation.

GBV also include violence based on gender occurring **within the general community**, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; physical, sexual and psychological violence based on gender perpetrated or condoned by the State, wherever it occurs. [5]

A broader definition of GBV also has been used. "any act of commission or omission by individuals or the State, in private or public life, which brings harm, suffering or threat to girls and women, and reflects systematic discrimination-including harmful traditional practices and denial of human rights because of gender." [6]

Sexual violence is defined as "any sexual act, attempt to perform a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality to coerce the victim, in any setting, including but not limited to home and work."[4]
This term includes rape, sexual abuse and sexual exploitation.

Sexual abuse is the actual or threatened, physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. [3]

Sexual exploitation is any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another.[3]

Sexual exploitation is one of the purposes of trafficking in persons. It includes getting a person into performing in a sexual manner, forced undressing and/or nakedness, coerced marriage, forced childbearing, engagement in pornography or prostitution, sexual extortion for the granting of goods, services, assistance benefits, sexual slavery.

Domestic violence is a pattern of assaultive and coercive behaviours, including physical, sexual, and psychological attacks, as well as economic coercion, that

as noted here, this definition of domestic violence does not include (*but needs to include*) abuse, neglect, or sexual assault on children. However, often children are also victimized by a domestic violence perpetrator in the course of the abuse of an intimate partner. In some families, there may be both domestic violence and child abuse, while in other families there may be only one, or neither.

This definition of domestic violence also does not encompass (*but needs to include*) what is traditionally thought of as abuse of the elderly. [8]

Survivor *(victim)* is the person who has experienced GBV. The terms "victim" and "survivor" is often used interchangeably. "Victim" is a term often used in the legal sector. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.[3] Therefore the term survivor is used in this document.

Perpetrator is a person who carries out an act of gender-based violence using assaultive and coercive tactics against an intimate partner or any other individual.

Intimate partner denotes current or former dating, cohabiting, or marital relationship which could be heterosexual, gay, or lesbian. [9]

2.2 Prevalence of GBV

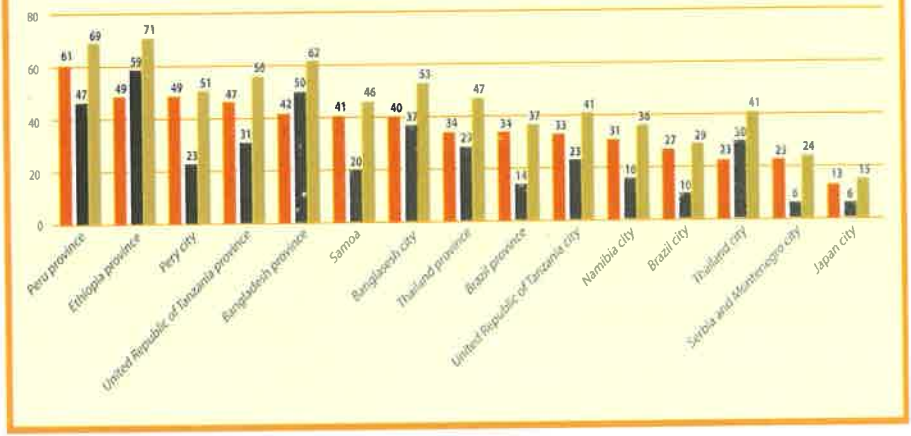
Prevalence of GBV is difficult to measure due to it's sensitive nature but many research and screening programmes conducted at sub national, national and international level have produced prevalence estimates.

2.2.1 Global situation

- At least one in three of the world's female population has been either physically or sexually abused at some time in life. [3]
- It is estimated that one in four women and one in eight men experience sexual assault during their lifetime, although many instances of sexual assault are never reported. It is also estimated that one in three women and one in six men experience sexual assault in their childhood. [11]
- In a worldwide study by WHO on intimate partner violence, the proportion of ever married women, who experienced physical or sexual violence or both, ranged from 15% to 71%. Women in Japan were least likely to be violated and higher likelihood of violence was reported from rural settings in Bangladesh, Ethiopia and Peru. [9]

- In the context of armed conflicts and displacements, sexual violence, including exploitation and abuse, is a well known and a high risk problem. Sexual violence is sometimes used as a weapon of war, targeting civilian women and children.
- The majority of perpetrators of violence are men. Women and girls are at greatest risk from men they know or are familiar with.
- Every week two women are killed by a current or former partner in the U.K.[19]
- Police in the UK receive an emergency call every minute requesting to stop an act of domestic violence.[19]

Figure 1 (9)



2.2.2 Regional situation

- One of the higher prevalence rates of GBV was reported in Nepal where 80 per cent of women reported psychological violence, 32 per cent reported physical violence and 10 per cent reported sexual violence.[11]
- The issue of dowry continues to play a role in GBV in the Asian region despite anti-dowry laws enacted in countries such as India, Bangladesh and Pakistan. Disputes about dowry in parts of South Asia have been highlighted as instigating serious incidents of domestic violence including murder and "forced" suicide.

- The WHO multi-country study on Domestic Violence and Women's Health which was carried out in 2004, showes that among ever married women aged 15-49 years, 40-42 percent reported physical violence and 37-50 percent reported sexual violence by their husbands ever in their lifetime.[9]
- It is significant to note that in Bangladesh, 14 percent of the maternal deaths are considered to be due to violence. The contribution of violence to maternal deaths equals that of abortion and is only surpassed by haemorrhage.[28]
- A national study in Maldives on women's health and life experiences, shows that, 1 in 5 women aged 15-49 (19.5 percent), who have been in a relationship, have experienced at least one form of violence, physical, sexual or both sometime during their lifetime. The study also reports that 12 percent of women surveyed had been sexually abused before the age of 15.[13]

2.2.3 Sri Lankan situation

- Unlike in the rest of South Asia, there are very few reports of large scale trafficking of women for commercial sexual exploitation in Sri Lanka. However, some reports indicate that trafficking for sex and exploitative forms of labour does exist.
- A study by a family practitioner among his clients, (n = 800 women) on domestic violence in 1992 found a prevalence of 27% of physical violence with 9% of them experiencing severe battering.[15]
- In 2000, women attending antenatal and gynaecological clinics of two hospitals in North Central Province were screened for GBV. Out of the respondents, 40% reported that some form of GBV had been experienced some time during their life. Of them 36% had been beaten but had no external injuries and an additional 11% had been beaten resulting in injuries.[16]

There is adequate evidence to show that prevalence of GBV in Sri Lanka is on par with the global situation. Although some forms of GBV such as honour killings and female genital mutilation are not seen in Sri Lanka, the prevalence and severity of other forms of violence, particularly domestic violence is increasing.

- Another study, done in 2002, on physical abuse among pregnant women in Badulla district found that 18.3 percent of women had been abused sometime during their entire period of cohabitation, 10.6 percent of women had been abused during the preceding year and 4.7 percent of women had been abused during the current pregnancy. [17,21]
- A survey at the Out Patient Department of the Teaching Hospital close to Colombo, covering a semi urban area in the suburbs of Colombo, found that 40.7 percent of women had been abused by their partners. The abuse was physical, emotional, and sexual, and most women reacted in a submissive manner. [14]

.....both her legs were cut with a sword by her husband .....

.....she survived.....legal action followed.....

.....with psychosocial support from many individuals and organisations.....

.....fitted with an artificial limb.....

Presently remarried in to a happy relationship.

3. Gender-based violence as a health issue

In 1996 the World Health Assembly declared that violence against women to be considered a major public health problem that needs to be addressed.

The health policies of Sri Lanka, namely, Population and Reproductive Health Policy of Sri Lanka 1998, Health Master Plan 2007-2016, National HIV/AIDS Strategic Plan 2007-2011 and Maternal and Child Health Policy, recognizes the importance of GBV as a health issue and have identified strategies to address this issue in the health sector.

Mahinda Chinthanaya " which, identifies the state policy recognises the need of services for survivors of GBV

3.1 Reasons why GBV is considered a health issue

- **Gender-based Violence is a major cause of disability and death among women.**
  - The Disability Adjusted Life Years (DALY) s due to GBV in women is more than that due to all cancers affecting women.[4]
- **Gender-based Violence has adverse consequences on sexual and reproductive health of women.**
  - Violence in a relationship can limit the use of contraception or condom, putting her at risk of unwanted pregnancy and STIs particularly HIV, respectively.
  - Childhood sexual abuse leads to high risk behaviours such as drug abuse, alcohol abuse and early and irresponsible sexual encounters.
  - GBV is also linked to unsafe abortions, poor antenatal care seeking behaviour, increased pregnancy complications and low birth weight babies.

- **If they do not ask about violence, providers may unknowingly misdiagnose the condition or offer inappropriate care.**
  - Chronic pain may be a presenting feature of domestic violence and if the provider does not recognize this, he/she will not be able to help the survivor.
  - Healthcare programmes, particularly those concerning reproductive health, give an opportunity for adult women to come in contact with a person outside her family to whom she could confide with.
- **Health professionals are in a unique position to change societal attitudes about GBV.**
  - Health professionals are better equipped to be change agents, because they could identify GBV as a health problem. Individuals with conservative and fundamentalist attitudes are more likely to listen to health professionals and recognize the negative aspects of GBV.
- **Responding to GBV can improve the overall quality of health care.**
  - Providing GBV care while ensuring privacy and confidentiality, gains the trust and respect of care seekers and builds up a positive image of the hospital.
- **Health professionals may inadvertently place women at risk if they are uninformed or unprepared on managing GBV.**

  Health care providers who breach confidentiality, who respond poorly to a disclosure of violence, who blame survivors or who fail to offer crisis intervention, can place women's safety, wellbeing and even their lives at risk.

.....Considered globally....., GBV, despite the evidence that it is a pervasive public health problem throughout the world, it is often ignored by the health sector. Health care professionals often fail to recognize the impact of GBV on health, and many consider it as a social or cultural issue that is not relevant to their work....(4)

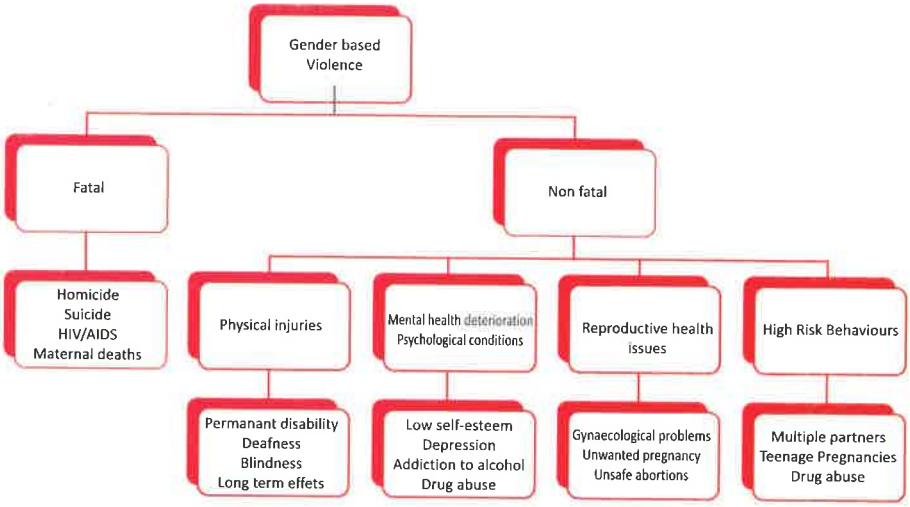
This can happen by:

- Expressing negative opinions to patients about other women who are beaten or raped.
- Discussing a woman's injuries in a consultation room, where it can be overheard by a potentially violent spouse who may be standing outside.
- Breaching confidentiality by sharing information about a pregnancy, an abortion, STIs, HIV or sexual abuse with another family member without the patient's consent.
- Providing inappropriate medical care by misunderstanding/misdiagnosing the reasons/cause behind repeated consultations for symptoms such as vague abdominal pain/backache.
- Not recognising or ignoring warning signs, that a woman is in danger of suicide or homicide.

4. Health consequences of GBV

The common health consequences of GBV as physical injuries such fractures, ruptured ear drums, burns, and internal haemorrhages are well known and often seen by most medical professionals. Summary of health consequences attributable to GBV is given in Figure 2.

Figure 2. Health Consequences of GBV



Some of the negative health consequences linked to GBV, but not often recognised, is given below:

- GBV increases women's risk and vulnerability to HIV/AIDS directly through sexual violence, lack of control over the sexual act (forced anal intercourse) and due to difficulties in negotiating the use of the condom.
- GBV contributes to teenage pregnancies and STIs in adolescents.
- Childhood sexual abuse leads to high risk behaviours such as early sexual encounters and sex with multiple partners. GBV leads to unwanted pregnancy and unsafe abortions.

- Physical and psychological abuse are linked to a number of adverse health effects including chronic neck or back pain, chronic headache, chronic pelvic pain, peptic ulcers, and irritable bowel syndrome.
- GBV, particularly domestic violence can lead to suicidal ideation and suicides.[10]
- GBV in pregnancy is seen more frequently than some of the obstetric complications such as pregnancy induced hypertension and gestational diabetes and leads to adverse outcomes as given in the inset.

Violence leads to negative pregnancy outcomes

- premature labor
- miscarriages/abortions
- bleeding during pregnancy
- low birth weight
- late entry into prenatal care
- increased smoking and substance use

- It is important to recognise that negative mental health consequences of GBV such as regret, loss of self esteem, depression, post traumatic stress syndrome, suicidal ideation are often seen in survivors of GBV and are more debilitating than the physical injuries and often outlasting them and are very difficult to manage without professional emotional support.

Table 1

Effects on the Mental Health of the Survivor [21]

- Incessant fear
- Increasing likelihood of misusing drugs, alcohol or prescribed anti-depressants
- Wanting to commit or actually committing suicide
- Depression/poor mental health
- Sleep disturbances
- Post-traumatic stress disorder
- Anger
- Guilt complexes
- Loss of hope
- Loss of self confidence
- Loss of self esteem
- Panic disorders
- Eating disorders

5 Non-health consequences of GBV

5.1 Effects on the Children: "The Forgotten Victim"

In addition to children becoming the primary victim as in incest or child abuse, they happen to, or are forced to, witness domestic violence and are very often battered in the process.

- One of the studies reported that, in 29% of families where the woman was battered, children were also battered. [23]
- Another study found that a child's exposure to domestic violence (without being directly assaulted) was sufficiently traumatic to precipitate moderate to severe symptoms of post traumatic stress in 85% of the children surveyed. [2]
- Infant and child mortality is more than six times greater if the mother is exposed to physical and sexual violence.
- Children may have difficulties at school and may find it hard to develop close and positive friendships. They may run away from home or even display suicidal tendencies.

More sinister impact seen in children is violence being a learned behaviour, children are more likely to become abusers or victims of abuse in later life. Children, especially males, subconsciously or consciously learn that violence is a method of conveying a message within a relationship and consider women as physically weaker, submissive, and therefore, to be controlled by men.[24]

Mothers who are living with domestic violence are often unable to protect their children from the direct and indirect effects of abuse, despite their best efforts. As health professionals, we should bear this in mind, when planning for child protection.

Table 2 Effects of Domestic Violence in Children

Deleterious Effects on Children due to GBV [21]	
Physical Effects	*Psychological Effects*
▪ Bruising	▪ Fear, panic, guilt and anxiety
▪ Broken bones	▪ Introversion or withdrawal
▪ Burns or stab wounds	▪ Post-traumatic stress disorder
▪ Death	▪ Anger, aggressive behaviour and delinquency
▪ Neurological complications	▪ Loss of self-confidence
▪ Stress-related illness (asthma or skin conditions)	▪ Hyperactivity
▪ Enuresis or encopresis	▪ Low self-esteem
▪ Running away leading to potential homelessness	▪ Truancy and other difficulties at school
▪ Self-harm	▪ Difficulty in making and sustaining friendships

5.2 Economic consequences

- A study conducted at Rush Medical Centre in Chicago, USA found that, the average charge for medical services provided to abused women, children and older people was US$ 1,633 per person per year. This would amount to a national annual cost of US$ 857.3 million [9] in USA.
- The cost to the National Health Service in the UK, of dealing with physical injuries alone, caused by domestic violence is 1.2 billion sterling, a year. [22]
- Total cost of addressing Domestic Violence to the UK, including legal cost was 123 billion sterling, in 2004 [19]

The economic burden of GBV to any country is immense, when considering the health care costs, the loss of earning by the survivor, legal costs as well as the social services costs for rehabilitation.

6 The Survivor (Victim)

6.1 Profile

GBV is a cross-cutting issue affecting large numbers of women and a lesser number of men. Survivors of GBV come from all strata of society. Although it is possible to identify some groups such as adolescents who are more likely to be abused, such exercise may give an erroneous impression that it is limited to these, so called "vulnerable groups " and also would stigmatize such groups.

The Survivors:

- are often fearful of their partners.
- are often not allowed access to family, friends, or other support networks by the perpetrator.
- often experience reduced freedom, and when they exercise autonomy, there are negative or abusive consequences.
- often feel guilty or wonder if they are to be blamed for their partner's violence.
- can articulate what precipitated specific incidents or the progression of violence if the survivor is given enough time and if the care provider patiently listens.
- Health professionals should be aware that sometimes survivors will make decisions, that they might find hard to understand.

They have their own reasons, which they may find difficult to divulge and may not be apparent to us. Their views need to be respected even if it contradicts with the opinion of the care provider.

6.2 Why do survivors stay / leave and return, to the same relationship?

It is a fact, that most survivors want the **violence to end** but **not end the relationship**. Unfortunately, in practical terms, this does not

materialize most of the time. According to a study done in a semi urban area in Sri Lanka, 79 percent of abused women had stayed in their marriages for more than 10 years. The researchers attributed this to the submissive behaviour of the abused, mainly due to lack of means to leave their husbands and live independently, and to the fact that society looks down upon such women. [18]

- There should be no place for violence in any relationship.
- Violence is always the responsibility of the individual who perpetrate violence.
- Health professionals should never blame the abused individual – not up to them to be judgmental

The commonly mentioned reasons for not leaving an abusive relationship are:

- Fear of further violence on her and her children.
- Lack of options such as safe houses or shelters.
- Lack of continuous and sustained family support.
- Concern about the welfare of the children and their future.
- Social stigma attached to a single parent or a separated woman.
- Lack of economical empowerment and being dependant on the perpetrator.
- She still loves him.
- She thinks that the perpetrator will change one day.
- Feels guilty that she is at fault.

7. The Perpetrator

Perpetrators do come from all strata of the society (similar to survivors). It is difficult to recognise characteristics that could identify an individual who is likely to be a perpetrator or one who is not likely to be one.

Perpetrators of GBV come from every:

- *age group*
- *religion*
- *ethnic/racial group*
- *socio-economic level*
- *educational background*
- *sexual orientation* [9]

Therefore, health care providers can be misled because the alleged perpetrator may not fit the image of a violent person (for instance, unlike what is commonly assumed, the perpetrator may be elderly, sophisticated, upper class, charming, or belong to a respected profession or a priesthood .)

The only defining similarity among perpetrators is their use of tactics for control and abuse of another person and not their visible demographic or personality characteristics.

Both men and women may perpetrate GBV:

- In heterosexual relationships, it is often the male.
- In same sex relationships (MSM, lesbian) it could be either sex.
- Irrespective of whether the perpetrator is a male or a female, the health care professionals need to address this issue seriously.

- When the perpetrator accompanies the survivor to seek care or when the perpetrator is employed in the health system, the clinician may see evidence of denying, minimizing, lying or blaming herself during the consultation.
- There is strong evidence that crime levels and ongoing conflict situations, in a country are causally linked with higher levels of GBV, possibly by "normalising" violence and reducing the threshold for violence in individual relationships.

Table 3

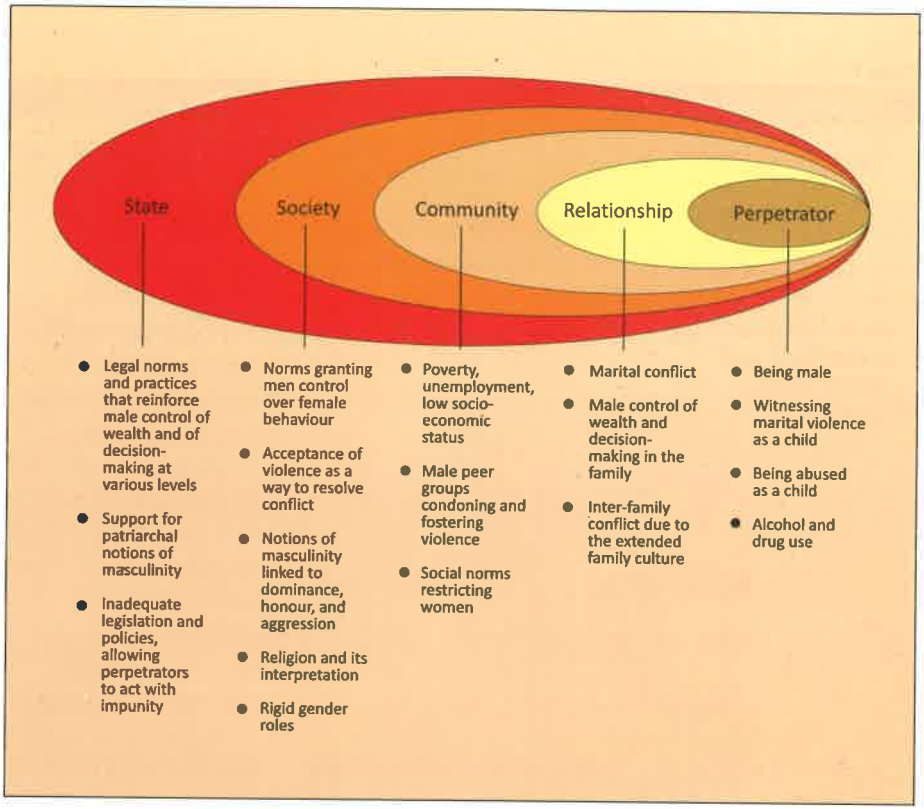
Factors associated with high levels of perpetrating violence

Community Level	*Individual Level*	
	Perpetrator	**Survivor**
Traditional gender norms that support male superiority and dominance and discrimination of women	Witnessing/experiencing violence as a child	In highly traditional settings the woman becoming empowered through education or economic advancement may add to the risk. On the other hand, total dependence on the perpetrator is associated with domestic violenec. Low esteem of the survivor or sometime that of the perpetrator.
Social norms that tolerate or even justify violence against women	Low academic achievement	Previous history of abuse
Weak community sanctions against perpetrators	Alcohol or drug use	Consumption of drugs or alcohol
High levels of crime and conflict in society	Attitudes that justify violence against women	

Figure 4

Model of factors associated with partner abuse[24] Causes of GBV, particularly domestic violence ,are complex and some of these are depicted in the model given below[24]

Figure 1 Model of factors associated with partner abuse(24)



8. What health providers could do to address GBV

8.1 Role of the Health system

The commonly recognised role of health systems is to provide for the needs of women who have been affected by GBV and to assist them in avoiding further exposure to violence, while ensuring their safety.

In addition, the health systems can contribute towards primary prevention (preventing violence before it begins) by providing evidence and conducting sensitisation and advocacy programmes in order to change attitudes and behaviours of the community and individuals.

It is also important to recognise that work place violence based on gender does occur within the health care system, (often in a magnitude more than expected) and needs to be prevented and dealt with, uncompromisingly when recognised. (Discussion in section 19.p49)

Health care providers are in an advantageous position to address the issue of GBV.

Most health care providers' training and practices are based on a medical model that seeks to diagnose and "cure" clients. But there are other areas to be considered under medical treatment. "The 'practice of medicine' can instead be broadly defined as diagnosing, healing, treating, preventing, or removing, any physical, mental or emotional ailment of an individual." (Civic Research Institute, 2000.) The care providers need to have a different outlook that encompasses an understanding of the many psycho social factors that affect someone's life and health, ones such as culture, gender, family, religion, poverty, drugs and alcohol and education. There are many benefits of this broader understanding and they could offer survivors, what they need, i.e., understanding, support, openness and respect then only they can truly provide them the help that they need. [26]

8.2 Health care systems should use a "Systems approach"

A growing body of evidence indicates that the most effective way to improve the health delivery system for survivors of GBV is to make changes throughout the healthcare organization. This approach is called the "systems approach". The idea behind this approach is that GBV has implications in every aspect of health service provision. It has been found that isolated training programmes or single interventions are less likely to improve health care provision for GBV survivors, compared to the "systems approach"[26]. In fact, changing the professional culture of an entire organization may be essential for convincing many health workers that GBV is a health concern that should be part of their routine care provision.

The important issues to be considered when addressing GBV within a health system:

- Support efforts to fully integrate attention to GBV within existing health programs.
- Incorporate programmes addressing GBV into the existing care provision structure.
- The programmes or projects planned must take into account the sustainability.
- Sensitization and training programmes should be conducted as sustained and repeated rather than isolated and single or one off interventions.

On Routine Screening ...

Some researchers have raised concerns that "routine screening" might cause more harm than good, in settings where few referral services exist, where legal systems are weak, and where negative attitudes and lack of training, may prevent health providers from responding compassionately when women disclose abuse.

On the other hand, some argue that "routine inquiry" in selected group such as pregnant women or in identify situation is an essential way to ensure appropriate, high-quality health care for women and to identify women in danger of further violence.

Even in resource-poor settings where referral services are not available, asking women about violence and responding compassionately may have benefits for women, such as reassuring women that they are not to be blamed; raising women's awareness about the health risks of violence for themselves and their children; and helping women and girls to get help before violence escalates. The evidence suggests, therefore, that if the health programs implement the basic precautions to protect women's safety as described under the "systems approach," then it is likely that the benefits of screening will outweigh the risks... [26].

Universal screening for GBV is not always mandatory and is not considered as the gold standard when assessing the health sector response ... [27] *and is not recommended.*

Essential Components of a "Systems Approach"

- An institutional commitment to GBV as a public health and human rights issue
- Sexual harassment policies
- Policies and infrastructure that protect patient privacy and confidentiality
- Awareness of local GBV laws such as the prevention of DV Act 2005
- Ongoing training and support for staff
- Referral networks to help survivors access legal services, counselling, shelters, etc.
- Protocols for the care of survivors
- Emergency supplies such as STI prophylaxis and emergency contraception
- Educational materials on GBV for clients
- Data collection and management system
- Monitoring and evaluation of quality of GBV care

Table 4

Barriers faced by health care providers

Attitude	Barrier/Myth	Truth /Fact
	"This only happens in other places in the world, to other kinds of people. Not in Sri Lanka."	GBV happens in just about every country, to all kinds of people. Sri Lankan statistics prove this.
Denial		It happens to women of all races, ethnic groups and classes.
	"This happened to me or someone close to me but I should not admit it."	It is painful to admit this has happened but you can help others and may need to get help for yourself.
Rationalization	"It is a private matter."	This is a human rights issue.
	"It is not my job".	GBV is a public health problem
	"There is no time".	Addressing GBV takes a bit more time but may save the providers' time in the future.
	"If I ask it could cause me legal problem".	

Contd.....

Attitude	Barrier/Myth	Truth /Fact
	"Victims don't really want to talk about it."	Women do want to talk about the GBV in their lives.
	"Clients will get upset if asked about GBV."	Studies show that clients want to tell their heath care providers about violence in their lives.
	"She must have done something to provoke it."	No one deserves to be hit or sexually abused.
	"There is nothing I can do anyway."	There is much that you can do and asking about GBV is the first step in helping women begin to heal.
	"This happened in the past and could not be affecting her now."	The past, especially one that includes GBV, can affect someone's well-being in the present
Minimization	"She doesn't have a lot of marks so this couldn't have been too bad."	GBV can cause psychological, health and behaviourial damage that may not be visible, yet is very serious.
	"This could never happen to me so it could not be happening to a woman like me."	GBV can happen to any woman although it is hard to think about being vulnerable to this.
Identification	"I could see why her partner would beat her.."	Be aware that men and women can identify/profile themselves with the perpetrator.
Intellectualization	"A woman who is being hit should leave"	This is a complex situation and it may actually be dangerous for her to leave. We cannot make these decisions for clients.
	"People get over these things in a short time."	Even when the physical bruises go away, the survivor is not necessarily over the other effects.
	We only deal with medical problems."	GBV is a public health problem. survivor of GBV often present with physical symptoms such as headaches, pelvic pain, gastrointestinal problems, etc. These are symptomatic of the underlying problem, i.e., GBV.

9. Guiding principles in providing care for survivors of GBV

The goals of providing care to a survivor of GBV are, primarily, providing medical care and emotional support, increasing survivor safety and supporting them in protecting themselves and their children.[9]

This goes well beyond providing treatment for injuries.

In providing care, special attention needs to be given to some aspects of ethical and moral principles, in addition to the clinical aspects of care. This is because, unlike most of the other clinical conditions seen in the routine health care provision, GBV care merges with other dimensions such as societal attitudes, safety issues for the patient and her children, presence of the perpetrator and his pressure on the care provider, as well as the attitudes and the experiences of the care providers themselves.

Therefore, it is important to recognize the value of these principles and ensure that care provision is guided by them, thereby guaranteeing the human rights of the survivor, while ensuring her/his safety.

Points to remember when providing care to a GBV Survivors [9]

- Increase the safety of the GBV survivors and their children.
- Respect the integrity and authority of survivors to make their own decisions over their lives.
- Hold perpetrators, not survivors, responsible for both abuse and for stopping it.
- Advocate on behalf of survivors of GBV and their children.
- Be willing to make changes in both individual practice and in the health care system in order to improve the response to GBV

GBV, violates all, if not most , human rights, in addition, to being a major public health issue.

All individuals, including actual and potential survivors of GBV, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and the security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and most of all to the right to health.

It is the responsibility of the health systems and the individual care providers to make the maximum effort to safeguard these rights.

The following guiding principles need to be adhered to:

- **Safety**
- **Confidentiality**
- **Respect**
- **Non discrimination**
- **Responsibility**
- **Competence**
- **Compassion**

9.1 Confidentiality

All information related to survivors on their medical and health status should be kept confidential and private, even from members of their family. Information regarding the health and the clinical situation may be divulged to the immediate family members or the guardian, but with the permission of the survivor, if she or he is an adult.

However, the legal responsibility of the care provider towards the legal system of the country needs to be fulfilled.

It is important to recognize the value of maintaining confidentiality at all points of care provision pathway, from the point of entry to hospital, at the reception to the point of exit from the hospital. This applies particularly in maintaining documents and records. It is advisable to maintain a filing system which is kept under lock and key and the client identified only by a serial number, with a master list of care receivers kept by one person, the officer in charge.

Although constraints towards providing infrastructure and furniture exist in most of the hospitals it important to consider this area as a priority when planning and implementing a programme for GBV survivors.

Breach of confidentiality, often unintended, could result in a threat to life or limb of the survivor and her/his children.

9.2 Competence

Survivors of GBV are entitled to receive competent, high quality health services, including reproductive health care to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs resulting from GBV.

The care provider should be aware of his or her limitations to knowledge, skill and competence to provide care and if there is any doubt on these, the survivor should be referred to an appropriate level of care.

It is important to realize that the pathway of care and the process of care provision should not traumatize the survivor by repeatedly getting her/him to go through the experience by asking her to repeat the story at many points of the care provision pathway.

In summery...

The safety and security of the survivor is of primary importance;

The wishes, rights, and dignity of the survivor must be respected at all times;

All information regarding the survivor and her/his family must be kept confidential.

Confidentiality means that information is kept private between care provider and the care receiver and divulged to a third party only with explicit consent except to fulfil legal requirements.

Consent is a mutual agreement. **Informed consent** means making an informed choice freely and voluntarily by persons in an equal

It is critical that health services do not "re-victimize" survivors in any way. Competence in building and maintaining referral networks is an important skill of the care providers dedicated to serving survivors of GBV.

9.3 Ensuring safety

Ensuring safety of the survivor and her/his children should be a prime concern of the care provider, and all interventions should take this into consideration. The facility providing services should have a room with a door that could be closed and locked prior to discussing issues with the survivor in safety.

In addition, in order to make clients feel safe in disclosing GBV, there needs to be a clearly stated clinic policy that ensures privacy and confidentiality when women are being asked about GBV. That means one's partner cannot be allowed in the room while a consultation is going on, unless the survivor specifically requests otherwise.

Asking a survivor of domestic violence about GBV in front of her partner can put her in danger. If the necessity arises this policy could be explained to the partner or the person accompanying the patient that each client is seen alone for part of her visit.[26]

When a male health care provider is attending to a female survivor, it is essential that there is a female chaperone unless the survivor specifically declines it.

9.4 Being non- judgmental and non -discriminatory

Every survivor of GBV has the right to receive respectful and high quality health care, regardless of their race, sex, age, national or social origin, marital status, tribal identification, religion, or socioeconomic status.

All members of the society including doctors and other health professionals have past experiences, established opinions, views and attitudes towards gender and GBV already implanted in their mind. This is a baggage that we subconsciously carry with us. Often this makes us judgmental on issues such as GBV.

It is very important to ensure that these should not interfere with the way we look after the survivors of GBV, by making a special effort to dissociate from such notions when providing care.

Common expressions coming from care providers such as "no wonder you get molested when you wear such clothes", "if you go around at night you are inviting trouble", "If she was out late she may have been a prostitute" indicate a judgmental attitude.

It is the right of each and every individual to receive non-judgmental care irrespective of the providers' personal values.

9.5 Ensuring privacy at all points of care provision

Every survivor has a right to privacy. A survivor's privacy should be maintained by caring for her in a separate room where she cannot be seen or overheard by those not involved in her care. She should not be required to move from room to room in the hospital for different stages of care provision such as history taking, internal examination, collecting samples or counselling.

Understandably, all services may not be available in every facility at one point but the pathway of care should be developed while attempting to make it as comprehensive as possible to ensure privacy and to prevent traumatizing her in this process.

She should not have to interact with people other than the trained staff who are caring for her directly.

9.6 Respect

Every GBV survivor has undergone very traumatic, degrading and humiliating treatment from the perpetrator, often over a long period and inflicted deliberately to "break her" self-esteem. Treating her with respect and dignity is very important for her recovery, apart from being her right.

The words used by the care provider, and her/his body language is very important to gain the confidence of the survivor ,which is essential in order to help her/him. Whatever the background or the values of the survivor or the views and values of the care provider, it is essential to show respect to her and to her views in providing care and never to ridicule client's view.

It is important for the care provider to realize that every survivor has a right to make decisions. She or he may decide to stop telling her story or stop the examination at any time. She or he has the right to choose what kind of care she wants. The survivor has the right to decide whether she wants or not, legal or any other services the health facility offers, excluding the legal obligations that the care provider is bound to fulfil by the law.

Health care workers should not exert pressure on a survivor to do anything she/he does not wish to do.

Every survivor needs to be provided with information in a language she understands.

She/he has a right to know about:

- the right to privacy, confidentiality and self-determination
- the details of the examination
- treatment options available to her/him
- the effects and side-effects of prescribed medications
- available referral services

9.7 Compassion

It is essental to treat survivors with kindness, that they have lacked over the period of abuse, which is often months or years.

It is important to distinguish kindness or compassion from sympathy. The survivors do not wish for sympathy, and in most instances they actually resent it. Sympathy enhances the helplessness of the survivor, particularly when the care provider offers it while being in a higher and a less stressful position.

The empathetic, kind and understanding attitude not only helps the survivor to open up but also builds up her confidence, in the health care system and strengthens the decision-making, self-esteem and self-confidence which are key elements essential to her recovery.

Table 6

Barriers faced by survivors in seeking care [8]

- Fear of the perpetrator escalating violence and imposing controlling tactics.
- Possibility of losing custody of children.
- Lack of options for financial resources, housing, employment, safety, health care, etc.
- History of having received inappropriate and victim blaming responses from others, such as law enforcement officers, health care providers, counsellors, clergy, family and friends.
- Fear of third parties getting to know, such as police ,insurance companies, mandatory health care provider reporting requirements.
- Language issues such as the use of an interpreter.
- Cultural or religious issues such as cultural rejection of certain medical procedures, fear of revealing sexual identity.

10. Revictimisation "with in" the health care provision mechanisms

"Violence" within the care provision[29] system

Any situation of power and control may result in violence. Such situations could exist in any health system between health care providers and the care receivers, especially women.

- ***Violating confidentiality:***
  Asking women's health concerns especially related to sexual health in front of family members or other patients.
- ***Not maintaining privacy:***
  Performing examinations especially related to reproductive health e.g. vaginal examinations in the presence of other patients or in a place where there is no privacy.
- ***Using abusive language:***
  The health care providers may use abusive language, incriminating words or make judgmental comments.
- ***Failing to maintain minimum health standards:***
  If minimum standards, especially related to asepsis and personal care are not met.
- ***Failing to diagnose women's illness:***
  Often, women due to socio-cultural barriers fail to directly communicate their reproductive concerns to health care providers, e.g. a woman may complain about headaches, but on deeper probing one may discover the problem of domestic violence, which may go unnoticed.

11. Asking about GBV and domestic violence

Many factors have contributed towards the silence that has long surrounded GBV. Many people believe that GBV is a "private" matter, one that should not be discussed in public. GBV has even been rationalized as something that is acceptable, under certain conditions, for men to inflict upon women in some communities.

Survivors of GBV have been silenced, by themselves by their feeling of guilt and remorses, secondary to the societal norms set by the patriarchal societies in which they live in.

They are made to believe that it is their fault, that they must have done something to deserve it, that no one will believe them if they do tell or else they are frightened into silence by threats of more harm.

This frame of mind should be recognised by the care provider, and she/he should understand and tolerate the reluctance of the survivor in divulging information about GBV and develop the skill of communicating with them.

Table 7.

The mindset of the survivor [30]

What a perpetrator tells..	*What it communicates to the survivor..*	*How it affects the survivor..*
"I hit you because I love you"	"This is what love is"	Confusion, re-victimization
"The abuse is your fault"	"I'm bad and to blame"	Self-blame, confusion, helplessness
"No one will love you like I do"	"Without this person I'm alone forever"	Dependent, fearful of leaving
"This is for your own good"	"Other people know what's good for me"	Doubts about herself Loss of confidence
"No one will believe you if you tell"	"I'm all alone and no one cares"	Silence

Despite all these pressures, most survivors do want to break the silence about the violence in their lives, if given a chance within a suitable environment.

Few women might be able to speak out on their own, but most need to be encouraged and asked about it. But, unfortunately, providers even when they are aware that GBV is prevalent, rarely ask their clients about it.

In a study which asked women whether they would disclose information on sexual assault to their provider, if they were asked about it, 70 prcent confirmed that they would. The study also recorded that, only 6 per cent of the women in this study had ever been asked by a care provider while 90 percent of the women said that they felt their physicians could help them with their problems.[30]

Two good opening statements to inquire about GBV

- "Because violence is so common in women's lives, we have begun asking all clients about abuse. So I would like to ask you ...."
- "I do not know if this is a problem for you, but many of the women I see, are dealing with tensions at home, sometimes leading to conflicts and even violence. Some are too afraid or uncomfortable to bring it up themselves, so I have started asking about it routinely."

11.1 Asking a patient directly

- "As you may know, it is not uncommon these day, for a person to have been emotionally, physically, or sexually victimized at some time in their life, and this can affect their health many years later. Has this ever happened to you?"
- "Sometimes when I see an injury like yours, it is because somebody hit them. Did that happen to you?"
- "Has your partner or ex-partner ever hit you or physically hurt you?"
- "Has your partner ever forced you to have sex when you did not want to?"
- "Did you ever have any upsetting sexual experiences as a child?"

...The common scenario is a deadlock, where two people remain silent about GBV, one person, the survivor, afraid to tell and the other person, the care provider, afraid to ask ... [30]

11.2 Asking a patient indirectly

- "Your symptoms may be related to stress. Do you and your partner tend to have difficulties? Or have conflicts ? Have you ever gotten hurt? "
- "Does your husband have any problems with alcohol, drugs or gambling? How does it affect his behaviour with you and the children?"
- "When considering which method of contraception is best for you, an important factor is whether you can or cannot anticipate when you will have sex. Are there times when your partner may force you unexpectedly?

11.3 When it should not be asked:

- If provider cannot secure a private space in which to conduct the inquiry it should not be asked (but move to an appropriate place even at a later time).
- If there are concerns that inquiring from the patient is unsafe for either patient or provider.
- If provider is unable to secure an appropriate interpreter.

11.4 If a patient says "no" to the inquiry about GBV

- Respect her/his response, say that it is o.k. and do not challenge her.
- Let the patient know that you are available, should the situation ever change.
- If patient says "no" but you firmly believe she/he may be at risk, discuss the specific risk factors and offer information about the available options in general terms.

Think of the possibility of domestic violence when patients present with... [22, 29]

- Chronic, vague complaints that has no obvious physical cause.
- Injuries inconsistent with the explanation of the cause.
- If the patient tries to hide injuries or minimize their extent.
- In the presence of a male partner who is overly attentive, controlling, or unwilling to leave the woman's side.
- When woman is reluctant to speak in front of the partner.
- Attempts of suicide.
- History of repeated miscarriages, terminations, still births or pre-term labour.
- Repeatedly presenting with depression, anxiety, self-harm or psychosomatic symptoms.
- Non-compliance with treatment or frequent missed appointments.
- Multiple injuries at different stages of healing.
- Patient appears frightened, overly anxious or depressed.
- Patient is submissive or afraid to speak in front of her partner.
- Partner is aggressive or dominant and answers instead of the woman or refuses to leave the room.
- Late entry for antenatal care and poor or non-attendance at antenatal clinics.
- Isolated injuries to the breasts or abdomen.

None of the above automatically indicates domestic abuse but they should raise suspicion and prompt one to make every attempt to see the woman alone and in private to ask her if she is being abused.

12. When a woman discloses violence

Prior to making inquiries about violence, it is mandatory for the care provider to be well aware of how to respond to, if the patient answers in the affirmative.

If the woman reveals that she is being abused, particularly if there is domestic violence, it is important to provide support and relevant information, so that she could be given the assistance she needs, assess the risk to her and the children and help her to develop a safety plan.[22]

Never advise a woman to leave her partner because....

- Women are at high risk of injury or murder when they leave a violent partner, so leaving immediately might not be the best option.
- She alone has to face the consequences of leaving the relationship.
- Supporting her, assessing whether she's in immediate danger and referring her to other sources of help are the best things you can do for her.[22]

- **Never make decisions on her behalf.....**
- It's crucial that she decides for herself, what she wants to do next, and you only should help her by identifying the available options.[22]

These should be done in addition to, assessing the injuries and providing the necessary clinical care and fulfilling legal obligations.

13. Ways to assist the survivor

Provide validation:

Let the survivor know that you believe her/him.

The fact that the care provider empathetically listens, would build up the confidence and develop the trust in the care provider and the health system. This is a very important initial step in providing care and in the recovery process. Omission of this step is one of the common reasons for non-continuity of attendance of the survivor at the hospital and for creating a negative image for the health facility. [2]

Listen non-judgmentally

Use supportive phrases such as:

- "I am concerned for your safety (and the safety of your children)".
- "You are not alone and help is available".
- "You don't deserve to be abused and it is not your fault".
- "Stopping the abuse is the responsibility of your partner not yours".
- "We are there to help you."

Unfortunately, patients who experience domestic abuse have limited options. [22]

Opportunities that are available to them are limited by:

- their personal circumstances.
- the risks they face.
- availability and the capacity of governmental and non governmental agencies providing assistance to survivors of domestic violence in the country.

Options might include:

- Seeking advice from a help line, such as Women in Need (WIN).
- Contacting the police.
- Getting legal advice about obtaining a restraining order according to the Prevention of Domestic Violence Act 2005.
- Taking additional safety measures (such as changing locks) to make her home more secure. (if the abuser has left).
- Developing a safety plan.
- Seeking emergency accommodation in a shelter.

It's important that the survivor makes her/his own decision about what she does next.

14. Documentation and Data management

Documentation is very important but often a neglected area of care provision for survivors of GBV.

Presently, medical records of patients reveal only very limited information regarding GBV. Since such records may be the only documentation, about the patient's injuries, they should contain all key facts, including the use of weapons and whether there are injuries from their use.[1]

As health records play an important role in addressing GBV, it is necessary to keep clear, accurate and detailed notes on the injuries to indicate the harm caused by the acts of violence. This may help the woman to live in a safer environment later on.

Documentation includes, clearly and specifically recording the history, details of the incident and description of injuries, preferably diagrammatically. (body maps)

To ensure consistency, uniformity and completeness, it is necessary to use prescribed formats for documentation. These formats must be made available to the care providers.

It is advisable to use:

- patients' own words when recording the details of the incident
- use body maps and diagrams
- maintain separate notes rather than on other hospital records such as ante natal clinic records in order to ensure confidentiality

Data management refers to the collection, safe storage and collation of data on information such as the number and type of GBV cases presenting at health institutions. This information needs to be included in the national health information systems, and published in relevant reports.[31] Data collection and transmission formats have been developed by the Family Health Bureau.

The data collected through the MIS could also be analyzed and used for evidence-based advocacy within and outside the heath care system.

15. Assessment of the Danger

Table 8

Risk Factors for Danger
▪ If the perpetrator is unemployed.
▪ If the perpetrator has access to lethal weapons such as guns.
▪ Recent threats of deadly violence such as shooting, throttling.
▪ Escalation of severity and frequency of violence in the recent past.
▪ History of inflicting severe injuries, fractures and stab injuries.
▪ Severe abuse of alcohol or drugs.
▪ Threats or actually having battered or harmed the children.
▪ Recently separated or divorced.
▪ Recent activities of stalking or closely watching the survivor.
▪ Pregnancy or recent birth.

Analytical studies on GBV show that, of the women who undergo violence, particularly domestic violence, only a small percentage decide to present themselves to a health institution.

Often, it is the group who undergo more serious form, those with obvious potential serious health effects or those who fear for their life ,who would come to a health institution.

Therefore, it is mandatory that the care provision system should include an assessment of the danger to the life of the survivor and the children in all survivors of GBV who present to the health system.

It is essential to find out whether the woman or her children are in immediate danger.

If the care provider feels that there is immediate danger, it is essential to help her to consider all options and courses of action available to her:

- Is there a relative or a close friend who could help her at this crucial time?
- Is there a shelter for survivors available? (unfortunately this is a very weak area of care provision in Sri Lanka and only very few shelters run by NGOs such as Women in Need are available).
- Is there a possibility of admitting her to the hospital to pass the immediate danger period?
- Should she get the assistance from law enforcement authorities such as Police ?

The most dangerous moment for a survivor, according to some authorities, is when she leaves or announces that she intends to leave the abusive relationship.

16. Development of a safety plan

Most survivors have not foreseen a dangerous situation that may threaten her/his life or the lives of the children and therefor are not prepared to respond.

Wherever there is a significant potential for danger within a relationship, the health care provider can help the survivor to plan how to avoid or escape from such a situation. This is all the more important, when the abuser and the abused live together, then the safety plan actually becomes a life saver.

The safety plan needs to be developed according to the needs of the individual survivor while considering the existing domestic circumstances in order to provide, practical guidance which will be useful at the time of crisis.

The provider can only assist in developing the safety plan, but ultimate decision be that of the survivor.

Care providers can help by prompting them to think about what they can do to reduce the risks in emergency situations. (22)

When survivors have a personal safety plan, they are better able to deal with violent situations and stay alive. [27]

However, they need not have a written plan, because in many instances, it is not safe for the survivor to have such a document at home and be found out, thereby risking her/him further.

Providers can consider the options given below when developing a safety plan:

- Identifying one or more neighbours, the survivor can call about the violence, and asking them to seek help from police if they hear a disturbance in her/his home:
- Trying to move towards a room or an area of the house where the survivor can be seen by others, and leave easily, if dangerous situation arises.
- By staying away from any room where weapons such as sharp knives are stored.

- Deciding where survivor could go to, if she/he has to leave home in a hurry, and have a plan to get there (money for transport etc.).
- Devising a way to indicate (code word) to use with children, family, friends, and neighbours when the survivor needs emergency help or want them to call the police.
- By practising how to get out of the home safely. It is useful to identify which doors, windows, or stairs would be best in such a situation.
- Don't take on the sole responsibility for creating the plan or create the plan on behalf of the survivor as it should be her/his plan.
- You can help them by prompting them to think about what they can do in a hypothetical situation.
- It's important that her plan is based on her needs, and these will change depending on her background and circumstances.

The care provider needs to be on the lookout for evidence of suicidal or homicidal ideation. If there are indications of such a risk, following questions may help to validate the concern.

If the care provider feels that it is indicated he/she may proceed to ask questions such as:

- Have you ever felt so bad that you didn't want to go on living?
- Have you ever attempted or thought about suicide in the past?
- Are you thinking about killing yourself? Do you have a plan? Do you feel this way now?
- How do you perceive your options for safety?
- Have you ever attempted or thought about homicide in the past?
- Have you thought about how you would do it? Do you have a homicide plan?
- Assess if the patient is expressing anger or a genuine intent to kill.

If the care provider feels that there is significant suicidal or homicidal ideation the patient should be kept safe till counselling and or psychiatric evaluation can be obtained.

17. Supporting those who provide GBV care

When providing care to survivors of GBV, health staff is likely to be affected by what they see and hear. This is further complicated by the fact that they themselves may have undergone similar or related experiences in their personal relationships.

In addition, individuals who volunteer to serve in such services and provide warm and empathetic care are sensitive and easily moved. Therefore, care providers themselves are likely to suffer from emotional exhaustion, when caring for survivors over a period of time , resulting in, "burn out".

This is mostly due to the experience of listening to testimonies of human pain and suffering on a daily basis over time. As a result, providers need to use their own emotional resources to face and optimize the interaction with the clients as well as, to protect themselves from the related emotions. [9]

This needs to be taken into consideration and programme planning should include making services for emotional support available for individuals in the health care team.

Consequences of not taking this step include somatic manifestations of anxiety, recurrent thoughts about work or the clients' stories, projecting this anxiety in personal spaces (with partners, family, other work spaces, etc), loss of capacity to enjoy or take pleasure in work, generalized irritability and loss of motivation for work. Furthermore, providers can lose sensitivity in their work which results in the loss of a professional who had become a part of the fight against gender-based violence. [9]

Sensitization of the staff on the possibility of a "burn out" or what is sometimes called "professional stress syndrome" and the availability of a supportive mechanism is an important initial step when establishing a service centre.

Holding a separate and regular meeting where providers can discuss specific cases of gender-based violence, which is termed a case conference, helps care providers in sharing the responsibility for difficult and emotionally stressful decisions they have to make. This type of meeting is not the same as having an emotional support group for providers; but it focuses more on the technical and professional aspects of providing adequate care for survivors of violence. One provider should volunteer to make a presentation of a case, keeping the identity of the client anonymous. The presentation can then be followed by a group discussion about the nature of the case, the way that providers could handle similar situations and the appropriateness of the intervention carried out.

18. Prevention of Domestic Violence Act 2005

What the care provider should know:

18.1 Legal Options

In general, all laws specified under the Penal Code of Sri Lanka, in relation to violent acts such as stabbing, battering, shooting, carried out against an individual, though carried out within a domestic environment are applicable and can be applied in cases of domestic violence.

The Prevention of Domestic Violence Act 2005, specifically provides an opportunity to the survivor or the police to obtain a protection order against the perpetrator, to prevent continuation of violence or stop violence that is likely to be inflicted.

Marital rape is not recognised as an offence in Sri Lanka as at present except when the couple is legally separated.

18.2 The Prevention of Domestic Violence Act of 2005

This is a landmark legislation aimed at providing relief to survivors of domestic violence by providing a provision to obtain a Protection Order(PO) from the Courts against the perpetrator, thereby ensuring her/his safety.

The Act does not provide a provision to inflict punishments on the perpetrator except when the Protection Order has been violated.

Few of the important facts regarding the Prevention of Domestic Violence Act 2005 are:

- *The sole objective is the prevention of further acts and possible acts of Domestic Violence, thereby ensuring safety of the individual.*
- *It is only a civil remedy.*
- *The law is gender neutral and both men and women could go before a magistrate and seek protection from violence.*
- *The law accepts emotional abuse as a form of violence.*
- *The law includes the abuse of the elderly in a domestic environment.*
- *Any person against whom an act of violence has been committed or likely to be subjected to violence can make the application. In case of a child, parent or guardian, the person with whom child resides, the National Child Protection Authority or a police officer may make the application on behalf of the child.*
- *The application can be made against spouse, ex-spouse, cohabiting partners, persons in close relationships, parents, grandparents, siblings, child or sibling. referred to as the relevant person*
- *The application should be made to the Magistrates Court within whose jurisdiction the aggrieved party resides, relevant party resides, or the act of violence has been or likely to be committed.*
- *Once the application is made:*
    - *Step 1. Court shall forthwith consider the application and when the court is satisfied that it is necessary to issue an interim protection order will proceed to issue one.*
    - *Step 2. An interim order will remain in force till court proceeds to inquire into the application and consider evidence. Thereafter if the court is satisfied, will issue a Protection Order which is effective for 12 months.*
- *The Interim/Protection Order prohibits the commission of acts of domestic violence. It may also contain other prohibitions to ensure the safety and wellbeing of the aggrieved person or her / his children such as limiting access to common bank accounts or access to shelters.*
- *The perpetrator has the right to appeal to higher courts against the I/PO.*
- *Violation of the Protection Order makes perpetrator, liable for a fine of Rs. 10, 000/= or imprisonment, not exceeding one year or both.*
- *The Court may punish a person who prints or publishes the names of parties or any matter other than the judgment.*

19. Violence at work

Sexual harassment in health institutions in Sri lanka

Violence at work can take a number of different forms. When considered at global level ,work place violence is widespread in the health sector. Sexual violence is one of the common, demeaning and offensive forms of violence experienced at work and is more important in the health sector, as most categories of service providers are comprised predominantly of women.

The issue of sexual harassment, has gradually become recognized worldwide as a serious matter. It is a human rights issue, a labor relations issue and a legal issue going way beyond the simple notion that it is "just a women's problem".

Great majority of survivors are women and most perpetrators are men. The risk is higher for working women who are especially vulnerable, such as those in temporary employment, younger and recently employed and having low-status jobs.

However, men occasionally may be affected, particularly by homosexual employees .

Sexual Harassment is defined as "unwelcome verbal, visual, or physical conduct of a sexual nature that is severe or pervasive and affects working conditions or creates a hostile work environment" and may be inflicted in many different forms and often repetitively.

It includes uncalled for remarks or sexist jokes, vulgar or embarrassing comments, unwanted invitations, showing pornographic images, groping, unwarranted touching, advances accompanied by promises or threats of reprisal, other acts of sexual aggression such as rape which goes against the individual's wishes and could harm her/his dignity, or physical or psychological integrity.

The difference between sexual harassment and acceptable conduct resides in the unwelcome reaction of the person to whom it is addressed and not in the intentions of the person responsible for the act.

When women are harassed (which happens often) it is commonly commented that"they were asking for it" or "they enjoy it." Such comments are a classic way of deflecting responsibility on to the victim, who is then harassed twice and may even be accused of provoking the behaviour in question.

Negative effects of sexual harassment are seen at individual, institutional and national level and damage the image of the health care provision system.

The morale of the harassed employee is affected and her/his work output is diminished which is compounded by absenteeism. In some instances, the employee may even decide to leave the job leading to break down of services.

Unfortunately, no research data is available on the prevalence of sexual violence in Sri Lanka's health sector, but anecdotal evidence and experience of many health administrators indicate that the shameful and humiliating practice of sexual harassment is widespread. This was brought to notice by the Hon. Minister of Health, who called for urgent and effective action to curb this menace.

While recognizing that strong action is needed against those who perpetrate sexual harassment, it is necessary to understand that prevention is the more efficient and cost-effective way to address this issue .

20. What is being done in the health sector

With much forethought, the health sector of Sri Lanka has implemented some activities as a response to the issue of GBV.
Identification of Family Health Bureau as the state agency responsible for the health of women and the appointment of a consultant community physician (CCP) as the programme manager for women's health, inclusive of GBV, has helped much, in implementing many policies and conducting multiple activities to address GBV in Sri Lanka.

Following policy documents clearly recognise that addressing GBV is well within the mandate, and is the responsibility of the health care system.

Population and Reproductive Health Policy of Sri Lanka 1998: The policy recognised that "the position of women in family and community, their reproductive health and their participation in public life is being increasingly threatened by the alarming increase in gender based violence and intimidation and harassment of women in the community". [29]

Health Master Plan of Sri Lanka 2007 - 2016 : Developed by the Ministry of Health, the Plan identifies that GBV and intimate partner violence as important issues that need to be addressed. It mentions that the expected output as "recognition of various forms of violence against women as a major health issue by the health system and improvement of the capacity to address the issue". [30]

Maternal and Child Health Policy 2012 : Clearly identifies the measures to be taken to provide care for survivors of GBV, including the establishment of the dedicated service points within the health institutions.

The Family Health Bureau has already launched many innovative initiatives to address GBV.

Development of training modules for the field health staff and completion of training MOMCHs as trainers is one of the earliest interventions.

Conducting training by them, to train the field health staff including the relevant field staff is underway.

Development of a care package for the newly married couples with an accompanying information booklet, which includes sensitization on GBV issues, has been launched. GBV has been included in the curriculum of the public health midwives. Efforts are being taken to formally include the subject in the curricula of nursing officers and medical graduates.

A national pool of expert trainers on GBV has been created after a national level Training of Trainers held for specialists from different fields.

Establishment of dedicated centres for providing care for GBV survivors within the health institutions utilizing the existing facilities of the health care system has been started from the Matara Hospital. The centre is named "Mithuru Piyasa/Natpu Nilayam" has been planned in the manner of one stop crisis centre and open for any survivor of either sex seeking care.

Similar service points have been established in hospitals such as Nuwaraeliya, Dick Oya Thambuttegama, Kandy Vauniya, Batticaloa.

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