Short communication

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

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

Introduction

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

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

Methods

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

Results

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

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

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

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

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

The way forward

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

Conflicting Interest

None declared

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