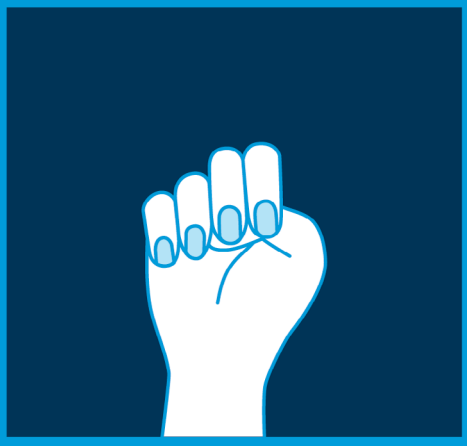
# BEHIND CLOSED DOORS

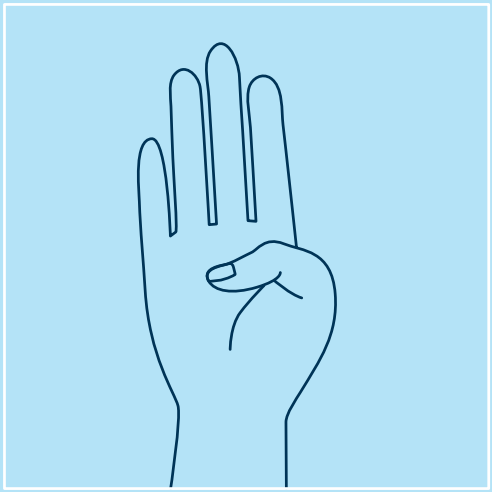


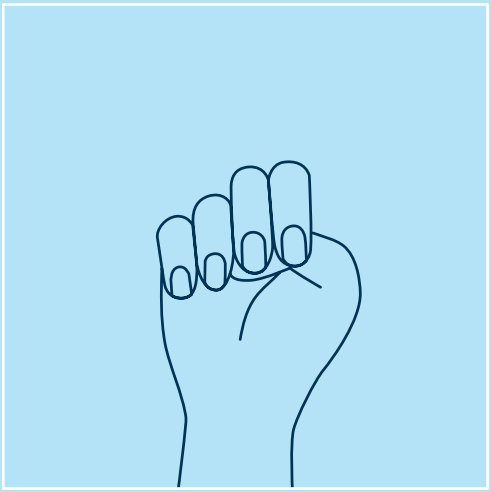
# RAPID ASSESSMENT OF DOMESTIC VIOLENCE DURING THE COVID-19 PANDEMIC

PUTTALAM | ANURADHAPURA | KILINOCHCHI | BATTICALOA | HAMBANTOTA | MONARAGALA

Kingdom of the Netherlands

Centre for Equality and Justice





The **Violence at Home Signal for Help** is a gesture used over a video call or in person by an individual to alert others that they need help.It was originally created by the Canadian Women's Foundation in 2020, to combat the rise in Domestic Violence across the world during the COVID-19 pandemic.

# Behind Closed Doors:
# Rapid Assessment of Domestic Violence during the COVID-19 Pandemic

**Anuradhapura, Batticaloa, Hambantota, Kilinochchi, Monaragala, Puttalam**

**Centre for Equality and Justice**

**August 2022**

# CONTENTS

# LIST OF ABBREVIATIONS

| Abbreviation | Definition |
|---|---|
| CEJ | Centre for Equality and Justice |
| CSO | Civil Society Organisation |
| DV | Domestic Violence |
| FAGBV | Forum Against Gender-Based Violence |
| IPV | Intimate Partner Violence |
| JDC | Judicial Services Commission |
| JSAC | Jaffna Social Action Centre |
| NCPA | National Child Protection Authority |
| PDVA | Prevention of Domestic Violence Act No. 34 of 2005 |
| PHM | Public Health Midwife |
| RPK | Rajarata Praja Kendraya |
| WDC | Women's Development Centre |
| WDO | Women Development Officer |
| WIN | Women In Need |

# 1| INTRODUCTION

The COVID-19 pandemic and the ensuing government-imposed health measures to curb the spread of the virus have had a devastating impact on societies and economies. For example, in early 2020 many countries were compelled to enforce lockdowns or take strict measures to limit the movement of crowds. In Sri Lanka, the Government enforced a curfew in March 2020, and since then has enforced further restrictions on movement at various intervals between March 2020 and December 2021.

Victim-survivors of violence, particularly women and girls, have been among the population groups most severely affected by the restrictions on movement and lockdowns. Global statistics reveal that even in normal circumstances one in three women will experience sexual or physical violence in her lifetime, usually by an intimate partner[1] and 137 women are killed by a member of their family every day.[2] Statistics confirm that women are most at risk from violence by their own family, close relatives or known persons. Research has also shown that fewer than 40 percent of women will seek help when facing incidents of violence.[3] Situations of emergency or humanitarian crisis, such as COVID-19, have compounded pre-existing conditions, putting women and girls at further risk due to increased isolation, lack of access to support structures and services, and delays in service provision.

In Sri Lanka, the Government's COVID-19 response plan did not prioritise the delivery of services to combat violence against women, particularly Domestic Violence (DV). National level hotlines, Police Women and Children's Desks and counselling services established to specifically support victim-survivors of DV were not accessible and have remained inaccessible in certain areas. As in many other parts of the world, women's organisations and women's groups rose to the occasion and attempted to fill the gap in available services for victim-survivors of violence, and community-based responses have proven to be effective. These efforts involved a primary focus on preventative and safeguarding measures to support victim-survivors of violence.

[1]World Health Organisation, 'Violence against women: Key facts' (09 March 2021) <https://www.who.int/news-room/fact-sheets/detail/violence-against-women> accessed 17 August 2022.

[2]UN Women, 'Facts and figures: Ending violence against women' (February 2022) <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures> accessed 17 August 2022.

[3]ibid.

# 2| ABOUT THE RAPID ASSESSMENT

The Centre for Equality and Justice (CEJ), together with district partners, conducted a rapid assessment on DV and related services in the districts of Puttalam, Anuradhapura, Kilinochchi, Batticaloa, Hambantota and Monaragala. This assessment was undertaken as part of a project that aims to facilitate and provide capacity for the advocacy and lobbying skills of member organisations of the Forum Against Gender-based Violence (FAGBV) which works at the local and national levels on the issue of DV within the COVID-19 context. CEJ further looks forward to upscaling the current interventions by the FAGBV by strengthening the lobbying and advocacy skills of its member organisations to empower them to effectively demand that relevant authorities address DV in a more holistic manner.

## METHODOLOGY

CEJ developed a questionnaire which was administered by district partners to key informants. The assessment included qualitative interviews with front-line government officers, including Sri Lanka Police, Women Development Officers (WDO), Counselling Officers, Grama Niladharis, Public Health Midwives (PHM), officers of the National Child Protection Authority (NCPA); health sector professionals including medical and psychiatric doctors, nurses and matrons; and local women's and Civil Society Organisations (CSO) providing services to victim-survivors of violence. The interview guide aimed to understand if key informants observed an increase in the incidents of DV, and violence against women more broadly, to identify issues victim-survivors faced in accessing services and any other challenges, and to make recommendations for strengthening responses and services to DV. Interviews were conducted between August to November 2021 in the local languages.

| Key informant interviews by district | |
|---|---|
| **District** | **# Interviews** |
| **Anuradhapura** | **10** |
| **Puttalam** | **10** |
| **Kilinochchi** | **8** |
| **Batticaloa** | **10** |
| **Hambantota** | **10** |
| **Monaragala** | **7** |
| **Total** | **55** |

Thereafter, the interviews were reviewed and compiled into a brief report which included a desk review of DV incidents during COVID-19, current services available in Sri Lanka to victim-

survivors of DV, and recommendations by stakeholders.

## LIMITATIONS

Due to the ongoing COVID-19 restrictions there were some delays in completing interviews. As such this assessment includes information gathered from 55 interviews from Anuradhapura, Puttalam, Kilinochchi, Batticaloa, Hambantota and Monaragala districts. Furthermore, due to ongoing restrictions, this assessment was unable to include responses of victim-survivors of violence and relies primarily on information provided by the key informants listed above. Due to limited time on the part of service providers, there were constraints in following up and/or gathering more in-depth information. Therefore, it should be noted that this assessment provides only a snapshot of the situation in the various districts and is not a comprehensive assessment of the situation of each district.

# 3| PREVALENCE OF DOMESTIC VIOLENCE IN SRI LANKA

DV refers to *'abusive behaviour (physical, sexual, emotional violence, neglect) that occurs within the private, domestic sphere, generally between individuals who are related through blood or intimacy'*[4] and includes economic or financial neglect and abuse. Within DV, the most prevalent form is intimate partner violence (IPV) against women, understood as *'a pattern of assaultive and coercive behaviours, including physical, sexual and psychological attacks, as well as economic coercion, by a current or former intimate partner'*.[5]

In terms of laws, many countries adopt specific definitions of DV. In Sri Lanka, the Prevention of Domestic Violence Act No. 34 of 2005 (PDVA) defines DV more broadly to include violence *'committed or caused by a relevant person within the environment of the home or outside and arising out of the personal relationship between the aggrieved person and the relevant person'*.[6] This broader definition is significant as it includes protection for violence that can take place between and among children, parents, siblings, spouses, cohabiting partners, and ex-spouses or ex-cohabiting partners. Unfortunately, the PDVA does not extend to non-cohabiting partners. In addition, the PDVA specifically includes emotional abuse as a form of violence, and Section 11 provides a wide range of protection orders that include protection against destitution.[7]

Studies indicate that between 20 to 70 percent of women in different locations in Sri Lanka have experienced DV.[8] The Women's Wellbeing Survey 2019 – the first dedicated national survey on violence against women and girls in Sri Lanka, undertaken by the Department of Census and Statistics - has revealed that women in Sri Lanka are *'twice as likely to have experienced physical violence by a partner (17.4 percent) than by a non-partner (7.2 percent) and found that 24.9 percent of women have experienced physical and/or*

[4]Henrica A.F.M. Jansen, Measuring Prevalence of Violence Against Women: Key Terminology (UNFPA Asia and the Pacific Regional Office 2016), 2.

[5]ibid.

[6]Prevention of Domestic Violence Act, No. 34 of 2005 (PVDA), s 23.

[7]See s 11 (l) PVDA which specifically includes provisions for protection orders against selling, transferring, alienating, or encumbering the matrimonial home so as to place the aggrieved person in a destitute position.

[8]S Guruge et al., 'Intimate Partner Violence in Sri Lanka: A Scoping Review' (2015) 60 Ceylon Medical Journal, 2.

*sexual intimate partner violence or non-partner sexual violence'*.[9] Women have reported experiencing violence in all stages of life, whether as adolescents or elderly women, and even during pregnancy.[10]

During COVID-19 lockdown or curfew periods, victim-survivors of DV were particularly affected, being forced to remain in the same house as the perpetrator with no possibility of accessing support systems or services that they would have otherwise been able to access before COVID-19. The media also reported a spike in the number of calls made to the 24-hour '1938' national women's hotline and other helplines. For example, the national hotline 1938 would previously receive 1000 complaints annually. However, during COVID-19 lockdowns, the hotline received between 100 to 200 calls daily of which more than 70 percent were complaints of DV.[11] In 2020, the national hotline 1938 received 3771 complaints, and between January to June 2021 1791 complaints were received.[12] Similarly, between the 16th of March and the 01st of April 2020, Women In Need (WIN) received approximately 250 calls of which 60 percent were related to incidents of DV.[13] The health sector was the first to raise the alarm with many women being admitted to hospitals for injuries sustained due to incidents of DV.[14] One news report stated that before COVID-19, the Accident Service of the General Hospital would receive at least 300 patients a day of which 3-5 were victims of DV. In contrast, during the lockdown, 10 out of every 100 patients requiring treatment at the General Hospital were victims of DV.[15]

[9]Department of Census and Statistics, 'Women's Wellbeing Survey – 2019: Findings from Sri Lanka's first dedicated National Survey on Violence against Women and Girls: Final Report' (2020) <Women's Wellbeing Survey - 2019 (statistics.gov.lk)> accessed 17 August 2022.

[10]Guruge (n8).

[11]Renishka Fernando, 'Violence against women: Covid-19 breakout sees surge in domestic violence both here and globally' (The Sunday Times, 28 November 2021) <Violence against women: COVID-19 breakout sees surge in domestic violence both here and globally | Print Edition - The Sunday Times, Sri Lanka> accessed 17 August 2022.

[12]State Ministry of Women and Child Development, Pre-Schools & Primary Education, School Infrastructure & Education Services, 'Statistical Handbook' (October 2021), 66 <http://www.childwomenmin.gov.lk/storage/app/media/final-2022-01-11compressed-2-1.pdf> accessed 17 August 2022.

[13]Ermiza Tegal and Ananda Galappatti, 'Unsafe Homes: Sri Lanka's COVID-19 Response Must Address Violence Against Women and Children' (Daily Mirror, 17 April 2020) <Unsafe Homes: Sri Lanka's Covid-19 Response Must Address Violence Towards Women And Children (magzter.com)> accessed 17 August 2022.

[14]ibid.

[15]Minoan Gamage and Rochelle Tummodara, 'A Study on the Rise of Domestic Violence Against Women in Sri Lanka During the Lockdown' (Colombo Telegraph, 12 March 2021) <A Study On The Rise Of Domestic Violence Against Women In Sri Lanka During The Lockdown - Colombo Telegraph> accessed 17 August 2022.

A study by CARE Consortium[16] titled *COVID 19 Impact on Key Populations PLHIV and SR Organizations* revealed that 76.8 percent of the respondents experienced verbal abuse, while 7.8 percent encountered physical violence and 5.6 percent encountered sexual violence. The survey further revealed that the main perpetrators were neighbours (49%), followed by parents (25%) and intimate partners (24%).[17] Niluka Perera, a consultant from CARE Consortium stated that respondents did not seek help as they did not know where to go. Furthermore, she stated that *'there is no safety net when key populations face violence because they cannot go to the police. The violence is based on their identity which is stigmatised and even the police tend not to care.'*[18]

Reports of DV during COVID-19 revealed that many victim-survivors of DV were denied access to timely services, including the ability to report incidents of DV. It was reported that the police were reluctant to accept complaints of DV and advised women to return home to the perpetrator. There were many reasons for this response by the police including the additional duties entrusted on them relating to monitoring quarantine and curfew regulations. Police stations were stretched thin with additional duties, and incidents of DV were not a priority.[19] The directives issued by the Judicial Services Commission (JSC) also did not make cases of DV a priority/urgent matter and therefore, in practice, except in exceptional circumstances, victim-survivors of DV were unable to secure protection orders during COVID-19 lockdowns.

To make up for these deficiencies, by and large, women's organisations and grassroots or community groups stepped up to support victim-survivors of violence, even in a limited way, during COVID-19 lockdowns. These groups contributed by providing advice on steps to report violence, securing emergency shelter where possible, referrals to hospitals, and financial support including food rations. Many women's organisations, however, were unable to provide the full range of services due to the restrictions

[16]A collection of three organisations including Delivery and Solitary Trust (DAST), Young Out Here and National Transgender Network. Out of the 329 respondents, 56 percent were men, 16 percent transgender women, 16 percent sex workers, 32 percent people who use drugs and 3 percent beach boys.

[17]Mantoe Phakathi, 'Gender Violence: Report Shows Sri Lanka has Escalations of Violence During COVID-19 Lockdown' (IPS, 19 August 2020) <Report Shows Sri Lanka has Escalation of Violence During COVID-19 Lockdown | Inter Press Service (ipsnews.net)> accessed 17 August 2022.

[18]ibid.

[19]See Ermiza Tegal (n13); Shreen Saroor, 'Disproportionate Effects of COVID-19 on Sri Lankan Women' (Groundviews, 04 August 2020) <Disproportionate Effects of Covid-19 on Sri Lankan Women – Groundviews> accessed 17 August 2022.

[20]Shreen Saroor (n19).

of movement and lack of transport services in remote locations. Among the services that were in short supply during the COVID-19 lockdown were reproductive health and contraception services.[20]

At a broader level with respect to violence against women, reports also revealed a complete lack of attention on key sectors such as workers in the apparel industry and migrant domestic workers. In addition, there were also cases of trafficking of minor girls and incidents of abuse at police stations that were reported by the media.

[20]Shreen Saroor (n19).

# 4| OVERVIEW OF SERVICES RELATED TO DOMESTIC VIOLENCE IN SRI LANKA

## HEALTH

The main State intervention relating to violence against women, including DV, is the Mithuru Piyasa Crisis Centre, established in select teaching hospitals in the country. The centre provides victimized women with a safe space for befriending, counselling and referral to other support services. The Family Planning Association in Sri Lanka also provides services relating to reproductive health and contraception. In addition, PHMs regularly visit homes of expectant mothers, and often identify abusive situations, referring such cases to the Medical Officer of Health (MOH) and/or other officers based in the Divisional Secretariat, Women and Child Development Unit.

## LEGAL

Any person experiencing DV can make a complaint at the nearest police station. Each police station has a Women and Children's Desk, which is a designated specialized unit trained to accept complaints relating to violence against women and children. If a police station refuses to accept a complaint, victim-survivors can directly report the violence to the Head Office of the Police Women and Children's Bureau in Colombo or to their hotline. In addition, the PDVA allows victim-survivors of DV to make a direct application for a protection order to the Magistrate's Court within whose jurisdiction the 'aggrieved person' or victim-survivor temporarily or permanently resides or where the act of DV has been or is likely to be committed.[21]

Sri Lanka passed the PDVA in 2005 which included a broad definition of DV and provided for victim-survivors of DV to be able to petition the Magistrate's Court for protection orders. Section 11 of the Act provides a wide range of protection orders that the Magistrate can make, including prohibiting the respondent from entering a shared residence, place of employment or school.[22] The Act provides for interim protection orders to be granted forthwith if the Magistrate is satisfied that it is necessary to do so.[23] Closely linked to incidents of DV are maintenance orders which are granted by the Magistrate's Court. Monthly maintenance payments can be paid

[21]PVDA (n6), ss 2(1) and 3.

[22]ibid, ss 11(1)(a) and (b).

[23]ibid, s 4(1)(a).

in person at court or deposited to the applicant's bank account. Many women prefer to accept the monthly payment in court as many husbands fail to make maintenance payments otherwise. In the case of the Maintenance Act No.37 of 1999, the Magistrate is empowered to remand any respondent who fails to make a monthly payment. In the case of the PDVA, if a protection order is breached, the Magistrate may order the respondent to be remanded for up to one year and/or to a fine of Rs. 10,000.[24]

Victim-survivors of DV may freely access legal advice from any Legal Aid Commission Centre in Sri Lanka. Generally, households receiving less than Rs. 25,000 a month are entitled to free legal representation, but in cases of DV the Legal Aid Commission does make an exception. Legal Aid Commission Centres are located in District / High Court premises. In addition, Sri Lanka has several women's organisations and CSOs that provide legal advice and representation for cases of DV. This includes, for example, WIN based in Colombo, Jaffna, Matara, Batticaloa and Badulla; Women's Development Centre (WDC), Kandy; Suriya Women's Development Centre, Batticaloa; Legal Action Worldwide and Sisters at Law.

## COUNSELLING

Several hotlines are available for victim-survivors of DV who seek counselling. This includes the national hotline by the National Committee of Women – 1938; WIN – 0775676555; Sumithrayo – 0112682535; Family Planning Association – 0112555455; and Shanthi Margam – 0717639898. Special counselling services for adult children are also available at reachsamana@gmail.com. In addition, many women's organisations provide counselling across the country.

Moreover, each Divisional Secretariat in Sri Lanka includes a Women and Child Development Unit with frontline government officials to help address issues relating to women and children. The Unit includes the WDO, counselling Officer, Probation Officer, NCPA Officer, Early Childhood Development Officer, and Child Rights Promotion Officer. The Ministry of Child Development and Women's Affairs also have counselling centres in seven provinces.[25]

## SHELTERS

At present, nine districts[26] have shelters or crisis centres aiding victim-survivors of DV. These shelters have historically

[24]ibid, s 18.

[25]'Counseling Centers of the Ministry of Child development and Women's Affairs' <http://www.childwomenmin.gov.lk/storage/app/media/pdfs/counselling_Centers_of_the_Ministry_of_Child_development_and_Women.pdf> accessed 17 August 2022.

[26]A national shelter assessment is being carried out by UNFPA as at 13.12.2021 and the actual numbers of shelters as well as district needs will be identified by this exercise.

been supported by non-governmental organisations but over the last five years some of these shelters have evolved into a collaboration between the State Ministry of Women and Child Development, Pre-Schools & Primary Education, School Infrastructure & Education Services.

1. **Colombo, Matara, Batticaloa:** WIN and collaboration with the State
2. **Jaffna and Mullaitivu:** Jaffna Social Action Centre (JSAC) and collaboration with the State
3. **Matara:** Sambol Foundation
4. **Anuradhapura:** Rajarata Praja Kendraya (RPK)
5. **Kandy:** WDC
6. **Ratnapura and Gampaha:** Women's Bureau of Sri Lanka[27]

## COMMUNITY-BASED SUPPORT AND OTHER LOCAL MECHANISMS

In all districts that were part of this assessment, key informants described a range of activities that are undertaken to support victim-survivors of violence. This includes regular awareness-raising programmes in schools for children, teachers, and parents, mobile legal clinics, community-based awareness-raising campaigns, and regular gatherings of women's groups convened by the WDO or other rural organisations. In addition, women's organisations also assist women and children who experience violence.

In many districts and divisions, monthly coordination mechanisms referred to as District/Divisional Coordination Meetings are also held between CSO officers responding to violence against women and children. These meetings provide a platform for collective identification of issues and trends in violence, information sharing, strategy and coordination, referrals, case management and follow-up.

## DISRUPTION TO SERVICES DUE TO COVID-19 RESTRICTIONS AND LOCKDOWNS

After March 2020, many of the services described above came to a complete or partial halt, largely due to curfew and travel restrictions. Both private and public sectors were requested to reduce the presence of staff and adopt a staggered basis of attendance to maintain social distancing. Therefore, even in government institutions such as the Divisional Secretariat staff only reported to work based on a roster with some others not reporting to work at all due to distance and interprovincial travel bans. Meanwhile, the police were

[27]Statistical Handbook (n12), 67.

required to report for duty, all leave was cancelled, and their full attention was required to monitor quarantine and curfew regulations.

CSOs and women's organisations were unable to operate as usual, and instead adapted to providing support remotely via telephone. For victim-survivors of violence, therefore, there were very few opportunities to report violence, either due to difficulty in accessing services or because they were unaware of where to seek help as most mass-scale awareness raising had halted.

# 5| KEY FINDINGS

This section discusses the findings relating to reporting of DV and other forms of sexual and gender-based violence (SGBV), types of perpetrations of violence against women and girls, and aggravating factors that have led to an increase in DV during the COVID-19 lockdowns. This section will also describe the nature of services available to victim-survivors during this period, challenges faced and any adaptation of existing services by service providers and women's organisations.

## 5.1. REPORTING OF DOMESTIC VIOLENCE (AND OTHER SGBV INCIDENTS)

In general, all districts reported an increase in incidents of DV, but not necessarily an increase in formal complaints. This was mostly because women were unable to reach service providers due to travel restrictions and the lack of transport services, especially in remote areas. Interviews revealed that where women were able to report, some would directly report violence to the police. However, most incidents of DV were reported by relatives, neighbours and community leaders informing the Grama Niladhari, police hotline - 119, 1938 hotline, WDOs, local women's organisations and CSOs, or by women and children being admitted to hospitals for injuries. In Hambantota, a counsellor stated that women would on occasion get their young children to call and ask for help. On the other hand, in Monaragala, a counsellor stated that third parties are often reluctant to get involved in such cases, even to report to relevant Authorities, because they apprehended further trouble from the same perpetrators, for reporting them.

Health sector interviews revealed that very often women were reluctant to admit that they sustained injuries due to DV. Furthermore, women were also reluctant to pursue action against their husbands. Key informants stated that many women did not want to report their husbands because they were mostly violent when they were drunk during the night and not violent during the day, and therefore they did not wish to report the abuse. In many cases, however, there appears to be a normalisation of violence with many women not recognizing or considering their experience as violence. Government officials in Anuradhapura revealed that when they would visit homes to conduct further investigations women would deny any violence. In Kilinochchi, a key informant described how even in a very serious case of DV where the husband set fire to the wife, she refused to name her husband as

the perpetrator for fear that if she were to die her children would be left without any parent to care for them. She eventually succumbed to her injuries and her husband continues to neglect the children.

All interviews expose the stigma attached to reporting DV which prevents women from seeking assistance at an early stage. Women most often sought help only when they faced aggravated violence, often requiring them to seek medical treatment. Similarly, even if women wished to seek help, they were unable to do so at the early stages due to the imposition of travel restrictions. Therefore, these women were often subjected to severe forms of DV as they were forced to be confined for prolonged periods in their homes with the perpetrator. Furthermore, a doctor from Anuradhapura observed that many women would seek medical attention for high blood pressure, a possible result of experiencing DV. Similarly, in Hambantota a counsellor stated that many victims would come to hospitals with various physical and psychological problems and, although, DV was often the root cause for these conditions, women were unable to openly express this.

The interviews revealed that the main perpetrators of DV included husbands, partners, mothers, fathers, brothers, step-fathers, grandfathers, brothers-in-law, mothers-in-law, uncles, neighbours, young men involved in drug and alcohol usage, essential service providers, religious leaders and tourists. In Monaragala, a civil society activist highlighted the case of a young girl, who had barely come of age, who was repeatedly raped by a labourer who visited the house. The girl's mother had kept the case concealed until the girl was compelled to be hospitalized in the third instance of experiencing DV. It was only at this point that her case was reported to the police. There was also one reported case of abuse by a samanera (junior priest).

## 5.2. FORMS OF VIOLENCE AND RISK OF VIOLENCE DURING COVID-19

Key informants reported instances of aggravated forms of DV with higher incidents of sexual violence intensifying due to the use of alcohol and abuse of drugs as well as stress caused by the debilitating economic conditions. Many women were forced to share a home with their husbands or partners who were heavily under the influence of illicit alcohol, brewed locally due to the closure of bars. Key informants in Kilinochchi highlighted that many women attempted suicide, mostly due to partners having extra-marital affairs or having other intimate partners, and some attempted suicide due to violence. Informants in Kilinochchi also reported one case of murder where a husband set fire to his wife.

A counsellor from Hambantota stated that emotional violence was the most prevalent form of violence reported during the COVID-19 pandemic. For example, this included cases where the husband would forbid the woman from speaking to or maintaining any contact with friends or family to isolate the woman. In addition, instances were reported where women who were unable to bear children were belittled by the husband and his family causing emotional distress and leading to depression. A counsellor from Monaragala reported a case where a husband prevented the woman from maintaining contact with the neighbours or villagers , which resulted in her not being able to receive monetary subsidies *(samurdhi)* or grocery packs to which she was entitled. Women have also been restrained by their spouses from seeking economic or psycho-social support.

The rapid assessment also revealed that children were left particularly vulnerable to violence inflicted by the father, mother, step-father, uncle and neighbours. It was reported that children were subjected to verbal and physical violence by parents due to frustration, intoxication, and neglect. In Hambantota, key informants stated that household expenses increased exponentially because the entire family was forced to remain at home.[28] Many parents were unable to cope with this increased financial burden and often reacted in anger toward their children. In Anuradhapura, a case was reported where a 14-year-old girl was raped by her stepfather while her mother was in quarantine. Likewise, in Monaragala, case was reported of a 14-year-old girl who was raped by her father who took revenge on his wife for migrating overseas for work. In Puttalam several cases were reported of young girls facing sexual abuse inflicted by parents, close relatives, and neighbours. In such instances, the police would refer children to probation homes or juvenile centres.

Key informants also reported many incidents of underage marriage, cohabitation and sexual relationships where the girl was a minor. In certain cases, this included situations in which the young girl wanted to elope or get married, but was faced with significant opposition from her family, thus leading to DV. In Hambantota cases were reported where young men coerced underage girls into marriage, in order to overcome restrictions preventing them from meeting during the lockdowns. In Puttalam and Kilinochchi cases were reported where parents were forcing young daughters to get married due to economic hardships. All districts reported that women were forced to have sexual relations with their spouses or partners and, often, contraception was not available. It was reported

[28]Increased expenditure relating to food and increase in utility bills such as water, electricity etc.

that in some cases women refused sex because they did not have access to contraception. All districts report the issue of underage and/or unplanned pregnancies, while in some cases husbands or partners forced women to undergo an abortion.

Other forms of violence were also reported in several districts. This included incidents of rape, sexual abuse, kidnapping and trafficking of young girls, violence to factory workers, sex workers and technology-facilitated violence that included blackmail and extortion, involving minors as well. Puttalam, Kilinochchi and Monaragala, in particular, reported incidents of sexual bribery. Puttalam also reported incidents of sexual abuse and harassment of female government officers. Additionally, a women's organisation in Puttalam reported the incident of a woman stranded in Colombo who had sought shelter with a Puttalam family living in Colombo. The male in the household subsequently raped the woman and continued to harass her until she was forced to seek accommodation in a lodge. Consequently, the woman was suspected to be a sex worker. Fearing for her safety she reached out to a women's organisation in Puttalam that ultimately helped her return to her home in Galle.

## 5.3. AGGRAVATING FACTORS

There were several aggravating factors that led to an increase in DV during the COVID-19 pandemic, which can be broadly categorized as economic, social, cultural, psychological and institutional.

### ECONOMIC FACTORS

The rapid assessment revealed that in all districts financial difficulties due to loss of employment and income resulted in increased anxiety and stress. Many families were already in debt, and the additional loss of income caused them sink into further debt. Microfinance-related debt was highlighted as an issue in Kilinochchi. Families were unable to pay monthly instalments and were compelled to take additional loans to settle existing loan repayments. Both men and women lost employment. Interviews in Monaragala district highlighted that the plantation sector and labourers who are daily-wage earners were especially vulnerable. Similarly, interviews in the Hambantota district revealed that the fishing community was vulnerable. The inability to afford necessities, especially for children, led to stress and caused men and women to react with anger and frustration. Families were forced to sell various possessions to access a source of income, and this often led to violence. In some instances, husbands who were addicted to alcohol or drugs

would sell household items or children's jewellery, and this led to disputes and subsequent violence. Monaragala district reported that during the pandemic women migrated overseas for work due to loss of employment and economic means within Sri Lanka. In their doing so other family members, including children were left behind and made susceptible to violence.

It was further revealed that, government support unfortunately did not reach everyone in need. Key informants stated that victims did not have money to purchase reloads for their phones, or even if they had money, were unable to leave their house to get a reload. This also meant further isolation and barriers to reaching out for help. For example, in Hambantota, a counsellor stated that the biggest challenge encountered during these situations was reaching out to women who did not have a mobile phone, in order to offer them the necessary support. Furthermore, all districts highlighted that the difficulties in securing basic needs directly contributed to an increase in incidents of DV.

## SOCIAL FACTORS

The COVID-19-related lockdowns forced families to live in close and confined quarters with little or no privacy, particularly in the case of extended families. Several men who were generally used to going out for work, lost their employment or income sources during the lockdown and spent long hours at home which they were unaccustomed to. Meanwhile, women bore the bulk of all household responsibilities including cooking, cleaning, caring for children. These women lost access to their coping mechanisms and pre-existing support structures as they were unable to interact or meet with friends and family or take part in social and religious gatherings due to travel restrictions imposed during the pandemic.

Interestingly, key informants from Anuradhapura and Puttalam were of the view that higher incidents of violence were reported in predominantly urban settings compared to rural areas. They stated that in rural areas, particularly agricultural households, it was quite normal for men to remain at home and families were used to being in each other's company. The tension during COVID-19 took place mostly in households where the men would normally spend a significant amount of time away from home due to work.

Similarly, in Hambantota and Kilinochchi, key informants explained that women were also cut away from support structures. Generally, women would be very active in attending various committees or social events, where they would meet friends and have an opportunity to share their grievances and receive support and encouragement. However, due to COVID-19-related restrictions, women

lost access to these support structure and this, in turn, left them more vulnerable to violence.

In addition, it was reported that children were bored at home, with no school or extracurricular activities and classes to keep them occupied. Children would spend long hours on phones, playing games or watching television and rarely help with household work. Interviews conducted in Puttalam revealed instances where children were subjected to violence by mothers due to this frustration. In Anuradhapura, an incident was reported where a husband beat his wife because he blamed her for their (14-year-old) son's drug abuse. The issue of neglect was a significant factor that placed children at risk of violence. This issue of neglect was influenced by situations where there was a lack of proper child protection guidelines and considerations by the State when a parent was required to quarantine. Additionally, special attention was needed to ensure safety and protection for children with disabilities.

All districts reported extra-marital affairs as being a reason for increased DV. Often, this meant that the husband had another family living in another area/location, who he was unable to visit due to restrictions imposed on travel/movement due to the COVID-19 pandemic. Incidents were reported where such extra-marital affairs were exposed and led to violence. As with pre-COVID-19 situations, suspicion and a lack of trust between parties were also aggravating factors that led to DV.

All districts reported an increased consumption of illicit alcohol, a kind of alcohol considered to be highly toxic. It was reported that this type of locally brewed alcohol was particularly potent and led to men behaving more aggressively than usual.

Kilinochchi reported being isolated from government services, even before COVID-19. COVID-19 lockdowns and travel restrictions further exacerbated this situation as many communities could not access transport facilities during the lockdown. Interviewees reported that government officials did not accept complaints of DV. Further, many officials were working from home and could not be reached at the office. Key respondents from Monaragala stated that services offered by the Divisional Secretariat office were unreachable due to the closure of offices and shortage of staff. A counsellor from Monaragala illustrated difficulties in reaching out to women in the field, owing to the shortfall of resources. It was further divulged that mobilising people to provide support services such as the distribution of ration packs were done by women's organisations and CSOs. Kilinochchi interviewees also revealed that neighbours were very reluctant to offer any help. It appears that in Kilinochchi, the Grama Niladhari was the first point of contact in many

cases of DV. Even in such cases, however, interviews revealed that the Grama Niladhari was often overworked and could not take action immediately. In addition to the Grama Niladhari, in Monaragala, Samurdhi Development officers and PHMs were also among those identified as first responders to DV.

The districts also report that during this period gendered distinctions were being reinforced by men. Several men spend their days in the home, while many had lost their employment or were unable to go out to work. In these circumstances, men would expect the women to do all the household work, take care of children and meet their demands to have frequent sex. Additionally, these men became more demanding and demeaning if women refused. Key informant interviews suggest that men and women had different expectations and needs when it came to sex, and this triggered violence. This issue may have been aggravated further due to the fact that women were significantly overburdened with household work and experienced added stress, while the men were often under the influence of alcohol.

Women were also experiencing stress and disappointment during this period as many of them had lost their source of extra income which they earned through activities including sewing or preparing food packets and short eats. Women reported being overwhelmed and exhausted due to all the housework they were required to do alone, and without any support from their partners. As a doctor in Anuradhapura observed, many women complained of high blood pressure during this period and DV was an underlying issue for this. Likewise, a counsellor in Hambantota echoed these sentiments.

## PSYCHOLOGICAL FACTORS

Counsellors revealed that men, women and children needed counselling and psychosocial support to help deal with stress, anxiety and depression resulting from the immediate impact of COVID-19 and its related restrictions and complications. Linked to this was the difficulty in meeting basic needs and the uncertainty brought about by COVID-19. This led to increased irritability within family members, and with no coping mechanism to help process their feelings, many resorted to violence.

In addition, counsellors from Hambantota stated that certain individuals with serious mental health problems were unable to receive medication or did not continue with medication regularly and this induced violent episodes, sometimes leading to death threats to other members of the family. Counsellors stated that they did not have access to transport facilities to ensure follow-up treatment or to visit urgent cases. A counsellor in Monaragala stated that clients who

needed to be followed up were checked upon through channels such as the Grama Niladhari. Moreover, providing these services by telephone had proved to be unsuccessful for various reasons. Counsellors from Hambantota attested to the same. Key informants from Hambantota noted that another aggravating reason for DV was that husbands suspected their wives to be engaging in extra-marital relationships. This led to them confining women to the boundaries of their home and inflicting physical and psychological violence upon them.

## CULTURAL FACTORS

Interviews conducted in Anuradhapura, Puttalam and Monaragala revealed that women were extremely reluctant to report DV primarily due to fear of social shame and stigma. Women feared criticism from relatives and neighbours if they pursued legal action against their husbands. They also anticipated further violence from their husbands or partners. A doctor from Anuradhapura expressed that he could not understand why women would not report violence. However, at the same time, he stated that this could be due to the social stigma and shame that would arise if the wife were to leave the family. He stated that, very often, women do not directly report violence but report it to family or neighbours, and when officials visit their homes to investigate, they deny any violence.[29] As discussed above, in Kilinochchi, a woman who was set on fire by her husband refused to identify him to the police as the perpetrator because she feared for her children's future.

However, these observations do not suggest that women never want to report incidents of DV. It merely exposes the strong socio-cultural pressure placed on women that make it increasingly difficult for them to decide whether or not to report incidents of violence. Many women did try to report violence, but interviews and desk review of reports during COVID-19 reveal that the police themselves appear to have discouraged women from reporting and often attempted to resolve conflicts informally and directed women to return to the perpetrator. One activist reported incidents where women who were injured and requiring hospitalisation were also advised to reconcile with their husbands.[30]

In Kilinochchi, it was reported that women who had settled there after marriage would seldom report violence as they did not have any support mechanism and feared backlash. On the other hand, local women who reported violence were able to receive some assistance and counselling, while

[29]Reported in both Anuradhapura and Batticaloa.

[30]Reported at a meeting of the FAGBV held on 01 October 2021.

some were reunited with their spouses. Interviews in Kilinochchi also reported that some women left their husbands during this period.

## INSTITUTIONAL FACTORS

The main aggravating factor for the rise of DV cases during the pandemic was the lack of available and accessible services during the lockdown period. As described, the police were preoccupied with addressing curfew and quarantine violations and hospitals having reached full capacity discouraged people from seeking medical attention unless it was critical. Women's groups and interviews revealed that the police refused to accept complaints from victim-survivors and they were often told to return to their homes.

It has been reported in Puttalam, Kilinochchi, Hambantota and Monaragala that the lack of a shelter/ safe space to house victim-survivors in these districts was a significant barrier in offering them support. Some key informants from Hambantota stated that they were able to direct women to the WIN in Matara. However, this not the most feasible option given the distance and logistical constraints. Due to COVID-19 restrictions, informal mechanisms of providing emergency shelter were also unavailable. Interviews from Monaragala revealed the dire need of having a shelter. For instance, a Counsellor emphasised that the lack of safe homes to shelter women drove them to resort to suicide as the last course of action. It was revealed that temporary shelter were available only for minors and elderly, but not for women affected by violence. Key informants mentioned steps taken by women's organisations and CSOs to create volunteer groups and links that would provide temporary shelter to women in need. For example, efforts to direct women affected by violence to seek shelter at their relatives' was highlighted as the main action taken by them. A shelter available within the District General Hospital was discussed by a key informant, however it was reported to be unsuccessful in catering to women's needs. A shelter operated within the police was also mentioned. However, the informant demonstrated a lack of confidence among women in seeking shelter within the police station, owing to the fear of further violence being committed against them, by police officers themselves. In Anuradhapura, women's organisations reported being able to support certain victim-survivors because there was a shelter within the district.

Similarly, the lack of staff also led to delays in responding to cases of DV. In Kilinochchi, women's groups reported that officials were not reporting to work and did not accepting cases. Most cases were reported to the Grama Niladhari who was already overburdened with additional duties related to monitoring quarantine regulations.

Due to travel restrictions, public transport was scarce and even in an emergency people found it difficult to access transport. There were no provisions for making transport services available in cases of emergency and people had to depend on the goodwill of other individuals. Similarly, government officers helping victim-survivors of violence were not provided with transport facilities, hampering their ability to respond in a crisis and access victims.

## 5.4. SERVICE PROVISION DURING THE LOCKDOWN AND COVID RESTRICTIONS

After March 2020, many institutions increased the number of hotlines and their staffing capacity to ensure 24-hour access to hotlines.

In all six districts, it appears that both government officials and women's organisations were mostly able to provide assistance over the phone. In the case of government officials, victim-survivors were able to report incidents to WDOs over the phone, mostly because they had formed pre-existing relationships. WDOs facilitate women's societies or groups at the village level where they discuss issues affecting women and also function as a savings group. Where these groups existed, women would report incidents to the WDO who would thereafter liaise with the Police or hospitals to provide assistance. Further, key informants from Monaragala revealed alternate methods deployed by women's organisations and CSOs, by which women can reach out when they need assistance, including reporting and lodging complaints. For example, groups of close families were created for women to discuss their issues in confidence, and the leads of these groups would relay the information to the coordinators of the women's organisations and CSOs. A civil society volunteer from Hambantota described a similar mechanism followed to provide services for women where volunteer coordinators connect women societies made up of small groups of 2 - 5 women with the women's organisations and CSOs. These coordinators were trained and experienced to intervene as necessary. Counselling officers also reported that they provided counselling services mainly over the phone. Therefore, if women did not have access to a telephone, it was extremely difficult to provide them with any support. Counsellors further stated that it was very difficult to provide appropriate advice and care for victims when they were unable to visit the individual in person and observe the situation on the ground for themselves. Moreover, it appears that in most cases, frontline government officials, particularly the Grama Niladhari, became the focal point for most services and follow-ups. Furthermore, in Kilinochchi, CSOs encountered difficulties with language

barriers as many government officials spoke the Sinhala Language and were therefore unable to communicate with the predominantly Tamil-speaking populations. This situation was made worse particularly when the only means of access was via telephone. In Monaragala and Hambantota, civil society activists and volunteers pointed out that government officials in Divisional Secretariat and District Secretariat offices were inactive or passive in providing services during the pandemic and the ensuing lockdowns. A key informant from Hambantota also highlighted the need for State officers to maintain continuous relations with women affected by violence to ensure optimal services are provided.

Women's organisations were constrained by COVID-19-related restrictions, particularly, the lack of transport facilities. Even where staff were willing to assist in person, they had no access to public transport. Private transport was also scarce, especially during lockdown periods. In as many cases, however, local women's organisations attempted to visit the victim-survivor in person to evaluate the situation and to provide assistance. Interviewees in Batticaloa also reported that many cases of DV were resolved through interventions by the Grama Niladhari, community groups such as women and youth groups, and interventions by religious leaders.

Notably, referral systems appear to have provided some relief in Anuradhapura. It was reported that government officers of the Horowpathana Divisional Secretariat coordinated with each other to collectively respond to reported cases of DV. Their efforts included coordination between the Grama Niladhari, WDOs, the police, counselling officers and hospitals. Additionally, counsellors would refer women to WIN, hospitals and the police to seek assistance. This coordinated response was also reported in Puttalam, Anuradhapura and Batticaloa, reflecting the benefits of a coordinated response to address DV. However, there were also some key informants in these districts who stated that the system of coordination could have been better.

Informants in Kilinochchi, Batticaloa, Anuradhapura and Puttalam districts reported dissatisfaction with the legal response to DV. For instance, the JSC issued a circular restricting court work to urgent matters only. Urgent matters mostly included bail hearings. DV or maintenance cases were not considered 'urgent'. Therefore, apart from exceptionally serious cases, the police did not file any new DV cases or follow up on breach of protection orders. It was also reported that the police would refuse to accept complaints and request women to return to the perpetrator. At a meeting of the FAGBV on 1st October 2021, it was reported that a woman who was cut by her husband and had to be admitted to the hospital was

asked to reconcile with her husband. At this same meeting, however, practical difficulties experienced by the police were also highlighted. For example, Police were required to prioritise COVID-19-related duties, and very often, only one female police officer was responsible for looking into all complaints relating to women and children. The Hambantota police stated that it was difficult to maintain officers in the station as police were required for various other special duties. On the other hand, key informants from Monaragala pointed out the gender insensitivity and harassment (mainly verbal) encountered by women who reached out to the police to make complaints. They stated that this was a key feature that discouraged victim-survivors from seeking legal redress. Moreover, a lack of adequate resources and training, especially for the Police Women and Children's Desks, had a negative impact on service provision during COVID-19.

Informants had also observed that where a good rapport had been built between the police and local women's organisations, the police provided them with a number they could be reached at for any emergency. Police also reported that they would conduct regular police monitoring or patrolling of the area. This mainly included actions toward curbing the distribution of illicit liquor and drugs which were aggravating factors in the prevalence of DV. This was the case in Monaragala. In Anuradhapura and Puttalam, the police referred women to counselling services and filed action in courts in very serious cases.

In Anuradhapura, doctors spoke of how they advised women if they suspected a case of DV, or if the women reported violence. Doctors would inform other officials like the police or women's organisations in the area and share contact details of local organisations with the women so that they could seek further assistance. Many health professionals also conducted media awareness programmes and collaborated with the police to raise awareness via television and radio on the increase of DV and the available services for victims to seek relief. One PHM in Hambantota stated that officers were unable to follow up and provide regular services as they were also directed for special duties such as vaccination programmes. Where possible, she stated that she would connect with the victim-survivor via a telephone call to offer some emotional support but indicated that this did very little to resolve the larger issue.

Informants in Batticaloa and Anuradhapura reported that they were able to assist with providing shelter for victim-survivors of DV. Meanwhile, informants in Puttalam, Kilinochchi and Monaragala reported facing many difficulties due to not having shelters. At a meeting of the FAGBV on 1st October 2021, one shelter operating in the Central province reported that during

this period women would seek shelter with their extended family and shelters were expected to provide for additional individuals despite the high demand for shelters.

Civil society and women's groups in all six districts reported distributing dry rations and food to families to help ease the financial burden on them and to help them meet their basic needs. In Batticaloa, this was a joint effort by CSOs.

## 5.5. ADAPTATIONS OF SERVICES DURING LOCKDOWN AND COVID RESTRICTIONS

Adaptations of services mainly related to remote services via telephone or mobiles, increasing the number of hotlines, and the engagement of media to raise awareness. During COVID-19 lockdowns, most individuals were able to receive advice and counselling by contacting national hotlines such as 119 and 1938. Additionally, the National Committee on Women extended the functioning of their 1938 hotline to 24 hours and WIN established district hotlines in addition to their main hotline.

Television and radio outlets were used by the government and civil society to raise awareness on the increase in DV cases, to create awareness about the repercussions and impact of violence and to raise awareness about the numerous services and hotlines available for victim-survivors to reach out to.

In Horowpathana, the police stated that teams including Divisional Secretariat staff, Public Health Officers and the police would visit villages to raise awareness. Government officers based in hospitals, for example, relied on field-level officials such as Grama Niladharis to monitor the situation on the ground and to ensure follow-ups. The same was reflected in Monaragala, as well.

One youth organisation in Anuradhapura reported using Facebook to raise awareness among the youth. Their Facebook page was used to receive complaints and to publicise hotlines and services. A counsellor in Hambantota stated that they would also share positive messages to victim-survivors who had access to their services. A civil society activist from Monaragala stated that Zoom was used as a platform to conduct programmes and lectures to raise awareness on cases of DV.

## 5.6. CHALLENGES AND GAPS IN SERVICE PROVISION

The main barrier to service provision during COVID-19 was the restrictions on travel and staffing which limited capacities within both government and civil society to adequately respond to increasing requests for support. Service

providers were further constrained by a lack of resources to consider alternate methods of service provision which required funding to hire and train staff and finance data packages. Providing services remotely, especially through mobile technology, would include ensuring privacy and confidentiality and 'do no harm' approaches as many victim-survivors were unable to get away from the perpetrator.

As discussed above, the JSC did not consider DV cases as an 'urgent' matter which should have been taken up in courts during periods of lockdown. Under normal circumstances, victim-survivors would approach courts if a protection order was breached. However, during COVID-19 lockdowns, they were unable to seek any assistance from courts. In turn, police stations also discouraged women from making complaints relating to DV or filing new cases of DV. This 'blindness' to recognising DV as a critical issue during COVID-19, as well as the attitude of the police towards women reporting violence, demonstrates a further need for sensitisation and a deeper understanding of the root causes of violence and risk factors that make women and children vulnerable to such encounters.

Furthermore, social stigma remains a critical barrier to women seeking help. Often, this is linked to the lack of support structures within society and the financial dependence of the woman on her spouse or partner who is often the perpetrator. All interviews revealed a need to raise awareness among communities on the laws relating to DV as well as the services. Many communities were not aware that they were subjected to DV or to whom they could report such violence.

The lack of shelter and protection services for children and women was a challenge during COVID-19. Shelter services are a considerable commitment with many women requiring protection for at least a few months before they can move out. Financial dependency is once again a critical factor that prevents women from seeking help. A shelter is therefore a critical lifeline in times of emergency. At present, Batticaloa has a shelter run by WIN in collaboration with the State, and Anuradhapura has a shelter run by a local women's organisation, RPK.

Lack of adequate thought towards protection for children was a significant issue highlighted in all districts. The State did not have a concrete plan for how they would ensure the protection of children in the event parents had to be quarantined. Similarly, there was no proper plan of action to support children with disabilities, or issues faced by people who identify as LGBTQI+.

Another significant finding was the general need for psychosocial support to ensure that individuals were able to develop positive coping mechanisms,

individually and collectively as families. Counsellors further stated that even in considering trauma counselling, women who experience violence require adequate time to consider all possible alternatives and process their own decisions. Unfortunately, the present system doesn't afford ample time or opportunity for this considered reflection.

Access to sexual and reproductive health and contraception was also lacking during this period and, as described above, contributed to DV in all districts.

# 6| RECOMMENDATIONS FOR SERVICE PROVISION FOR DV DURING TIMES OF RESTRICTED MOBILITY AND IN EMERGENCY CONTEXTS

## 6.1. DISASTER RESPONSE AND MANAGEMENT[31]

1 Develop guidelines to ensure the needs of women and girls are incorporated into disaster management plans, with a special focus on violence against women.

2 Ensure equal representation of women in relief committees and ensure women's groups and CSOs are well represented.

3 Classify sexual and reproductive health services and gender-based violence services as essential services and allow such service providers free movement to deliver services to affected persons.

4 Provide financial support to low-income families, female heads of households, families with higher caregiving needs eg. with disabled, sick or elderly persons, and families who may have lost employment and/or lack a regular source of income.

5 Urgently adopt social protection measures to ensure an adequate standard of living including income supplementation, rent subsidies and eviction moratoriums, food subsidies, free clean water and hygiene measures, including menstrual hygiene.

6 Include mental health services and mental health wellbeing as a priority focus area, especially through public messaging and outreach by State officials.

## 6.2. JUSTICE SECTOR

1 The JSC should recognise DV and maintenance cases as priority cases during any crisis or emergency.

2 Invest in and adopt digital technology to encourage remote hearings and reduce delays in taking up cases of DV and maintenance in Courts.

3 Provide sensitisation training for police officers to ensure a supportive and enabling environment for

[31]See Shreen Saroor (n19).

[30]Reported at a meeting of the FAGBV held on 01 October 2021.

victim-survivors to report violence, including language sensitisation.

4 Adopt Standard Operating Procedures (SOP)[32] relating to complaints of SGBV and, particularly, DV that includes provisions for emergency situations.

5 Provide adequate resourcing for Police Women and Children's Desks in terms of cadre, training, transport and other resources required to investigate complaints of violence effectively.

6 Ensure prompt response to complaints of DV to ensure victim-survivors are not burdened or re-victimized.

7 Coordinate efforts between the police, hospitals, Divisional Secretariat structures, shelters and civil society to ensure timely assistance for victim-survivors, especially in relation to medical attention and examinations by Judicial Medical Officers (JMO).

8 Urgently review shortcomings and delays in relation to enforcing PDVA protection orders and adopt a mechanism to better monitor and respond to breaches of protection orders. For example, adopt digital technology where possible.

9 Allocate adequate resources towards the implementation of the PDVA, especially to monitor breaches of protection orders.

10 Provide pro-bono legal aid services for victim-survivors.

11 Create safe spaces for women and children within the institutions of the redress mechanism, including within court houses.

12 Enable police to conduct risk assessments and evaluations at the point of receiving complaints, in order to provide a rounded and sensitized service.

## 6.3. SERVICES AND AWARENESS

1 Adopt Standard Operating Procedures (SOP) for addressing violence against women, and referral pathways to emergency preparedness plans and/or COVID Task Force procedures. These should include special measures to respond to the needs of LGBTQI+ persons, and persons with disabilities, including mental health issues.

[32] 'Domestic Violence Complainants during Pandemic Related Travel Restrictions: Statement by the National Forum Against Gender Based Violence' (June 2021) < https://gbvforum.lk/doc/dv-complainants-during-covid-restrictions-english.pdf> accessed 17 August 2022.

2 Stronger considerations of child protection in emergency response plans.

3 Designating minimum resources for first responders / Government services – telephone and data facilities, printers, transport – to ensure effective response and follow-up for victim-survivors.

4 Provide comprehensive services that includes access to food and essentials, counselling and psychosocial services, health and sexual and reproductive health services, and shelter. Recognise that access to food and essentials is not merely welfare but a life-saving measure.

5 Provide adequate resourcing by the Government to establish shelters in each district to ensure resourcing for qualified and trained staff and a sustainability plan.

6 Set up an emergency fund to support services and outreach during emergencies.

7 Strengthen existing hotlines by the government and NGOs, and ensure language accessibility in both Sinhala and Tamil.

8 Raise community awareness targeting children, youth, parents and teachers to identify DV, services and reporting mechanisms, ideally through television and radio, which are more accessible.

9 Increase investment in public messaging and community awareness on gender and power dynamics, and bystander interventions.

10 Strengthen the coordination between state institutions working as responders to DV.

11 Capacitate the Divisional Covid Recovery Committee to be sensitive to issues faced by women.

12 Provide comprehensive training and knowledge to handle cases of DV to all first responders (State and otherwise), including gender and language sensitivity.

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# 8| LIST OF INTERVIEWS

| District | Number of interviews |
|---|---|
| Anuradhapura | Police Officers (Police Women and Children's Desk) - 2<br>CSO representatives - 2<br>Counsellors - 2<br>WDO - 1<br>Hospital Medical Staff - 1<br>PHM - 1<br>Grama Niladhari - 1 |
| Batticaloa | Counsellors - 2<br>Police Officers (Police Women and Children's Desk) - 2<br>Hospital Medical Staff - 2<br>Women's organisation representative - 1<br>Grama Niladhari - 1<br>CSO representative - 1<br>WDO - 1 |
| Hambantota | CSO representatives - 3<br>Counsellors - 3<br>Police Officer (Police Women and Children's Desk) - 1<br>PHM - 1<br>Grama Niladhari - 1<br>Hospital Medical Staff - 1 |
| Kilinochchi | CSO representatives - 2<br>WDOs - 2<br>Hospital Medical Staff - 1<br>Grama Niladhari - 1<br>Counsellor - 1<br>Police Officer (Police Women and Children's Desk) - 1 |
| Monaragala | CSO representatives - 7 |

| District | Number of interviews | |
|---|---|---|
| Puttalam | Counsellors | - 3 |
| | Police Officers (Police Women and Children's Desk) | - 2 |
| | Hospital Medical Staff | - 2 |
| | Grama Niladhari | - 1 |
| | WDO | - 1 |
| | CSO representative | - 1 |

CENTRE FOR EQUALITY AND JUSTICE

16/1, Maurice Place, Colombo 05.
Tel/Fax: +94 11 2055404

www.cejsrilanka.org | srilanka.cej@gmail.com

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