



# **Report on the Health and Life Experiences in the Ambagamuwa DS Division**

**A gender-based study**

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**Assisting Communities in Creating Environmental and Nutritional  
Development (ACCEND Project)**



European Union



OXFAM



ADRA

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May 2021

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The editors thank the following people for their feedback and input - Lakmini Jayathilake, Visaka Wickramarachchi, Shafeer Mohamed, Shenal Hettiarachchi and Florentia Amarasinge.

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The information in this publication is correct at the time of going to press.

The views shared in this report do not necessarily reflect the official positions of the European Union in Sri Lanka and the Maldives, Oxfam in Sri Lanka or ADRA.

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# Abbreviations

ACCEND	-	Assisting Communities in Creating Environmental and Nutritional Development
ACE	-	Adverse Childhood Experiences
DRR	-	Disaster Risk Reduction
EMA	-	Estate Medical Assistant
FHB	-	Family Health Bureau
GN	-	Grama Niladhari
HCP	-	Health Care Provider
IPV	-	Intimate Partner Violence
MOH	-	Medical Officer of Health
MOU	-	Memorandum of Understanding
NGO	-	Non-governmental Organization
OCP	-	Oral Contraceptive Pill
RH	-	Reproductive Health
RPC	-	Regional Plantation Company
SGBV	-	Sexual and Gender-based Violence
THP	-	Traditional Health Provider
WHO	-	World Health Organization

# The ACCEND Project

ACCEND (Assisting Communities in Creating Environmental and Nutritional Development) is a 48 month project which has been jointly run by ADRA (Adventist Development and Relief Agency International) and Oxfam since 2017. Funded by the European Union and implemented in the 3 districts of Matale, Nuwara Eliya and Monaragala, the project is to benefit 306,016 persons (including 26,518 individuals from 6314 families) from 30 estates and 22 rural communities.

The goal of the project is to contribute towards the improvement of the health, hygiene, nutrition and sanitation of communities residing in the Uva and Central provinces. Project activities are carried out in cooperation with the Divisional Secretariat and the MOH (Medical Officer of Health) offices. The project's operational areas in the Matale and Monaragala districts consist of 10 and 12 Grama Niladhari areas. 30 estate divisions that belong to 10 tea estates, owned by 3 Regional Plantation Companies (RPC) are the operations areas of the Nuwara Eliya district. The project has signed Memorandum of Understandings (MoUs) with Horana Plantations, Maskeliya Plantations and the Bogawantalawa Plantations.

## Main Outcome

To strengthen communities and public institutions towards an integrated, mutually accountable service delivery system in water, sanitation, health and nutrition. Gender, Disaster Risk Reduction (DRR) and the environment are cross cutting themes that run through all project activities.

## Key Role

To facilitate and assist communities and the government services within the project locations. This is enabled through formation and mobilization of community entities, raising awareness and training, construction and repair of physical structures, piloting of innovative ventures, launching studies based on project priorities and being involved in planning and policy development with the government.

# Introduction

## *Women's Health and Sexual and Gender-Based Violence*

Women's health is affected by many factors, of which Sexual and Gender-Based Violence (SGBV) can play a key role. It has a disproportionate effect on many women and girls, especially among estate populations, and negatively affects their well-being as well as that of their children. Information on the causative and promoting factors leading to SGBV, the magnitude of the problem and seeking to eradicate such behaviours within the estate sector is essential in order to address the issue sustainably. However there exists a dearth in detailed information on areas related to SGBV *specific* to the estate-sector.

To address the gap in data and information within this area of discourse, the study 'Report on the Health and Life Experiences in the Ambagamuwa DS Division - A gender based study' was launched by the ACCEND project in 2019. The study took over six months to complete and was aimed at identifying underlying issues related to Reproductive Health (RH) and Sexual and Gender-based Violence (SGBV) in the estate communities. This qualitative and quantitative study provides significant insight to the lived experiences of women residing within the area.

The results of the study intend to support future planning and strengthening of programmes targeted towards the improvement of the health and well-being of women in the Nuwara Eliya district; inclusive of both estate and rural populations.

## *Ambagamuwa Divisional Secretariat Division*

The Ambagamuwa Divisional Secretary (DS) division is situated in the Central province of Sri Lanka. Located within the Nuwara Eliya District, in the central highlands, it is considered to be an important location for tea cultivation and production.

### **The DS Division:**

- Coverage: 486 square kilometres
- Grama Niladhari divisions: 67
- Estates: 458
- Population: 205,273 (in 2018)
- **Female population: 108,275**  
(52.7% of the total population).

### **Demographic of the female population:**

- Living in estates: 68.8%
- Living in rural locations: 24.2%
- Living in urban areas: 6%



# The Study

## *Objective*

The overall objective of the study was to assess the general health needs of women and the prevalence of SGBV (including behavioural patterns and other related issues) and analyse the socio-cultural factors which both protect women yet in some cases promote a culture of violence. This study was preceded by a literature survey and consisted of both a qualitative and quantitative component.

A considerable amount of research on GBV in Sri Lanka exists; however research specific to the plantation and/or estate sector is limited. The earliest known research<sup>1</sup> within this subject area was conducted in 1991 and focused on four geographical locations (of which the estate sector was featured as one location). A more recent study<sup>2</sup> in 2018 focuses on pregnant women only, to assess the regional differences in domestic violence situations between the capital city and the tea plantation sector. In comparison, the current study provides a more concentrated perspective on GBV in the plantation and estate communities.

## *Study Methods and the Process*

The World Health Organization's (WHO) study-instrument<sup>3</sup> (2005) in surveying women's health and life events for the purpose of household surveys was used as a primary method in this study. The consultant perused the study-instrument and included additional questions and perspectives related to the estate sector and the estate sector community (particularly in the area of reproductive health) to identify sector-specific issues.

The field work included a household survey by the enumerators, using a questionnaire of 149 questions. This was followed by in-depth interviews, key informant interviews (8) and focus group discussions (8) by the consultant while in the field.

Twelve (12) enumerators were selected through an open invitation, based on the criteria of being female and having had relevant experience in research work related to the estate sector. Two training sessions were carried out for the selected enumerators, prior to engaging in field work. Of them, 9 (73.6%) carried out the data collection in Tamil while 3 (24.4%) worked in Sinhalaese. No translators were used for any interview. Additionally, emotional support and guidance for data collectors was arranged in the case of burn-outs or distress.



<sup>1</sup> Samarasinghe, G. (1991) "Report on some observations on the incidence of domestic violence in four locations in Sri Lanka and the attitudes of women towards violence." Colombo, Women In Need

<sup>2</sup> Muzrif MM, Perera D, Wijewardena K, Schei B, Swahnberg K. (2018) "Domestic violence: a cross-sectional study among pregnant women in different regions of Sri Lanka."

<sup>3</sup> [https://www.who.int/gender/violence/who\\_multicountry\\_study/Annex3-Annex4.pdf](https://www.who.int/gender/violence/who_multicountry_study/Annex3-Annex4.pdf)

Using the accepted standard sampling methods, 12 of the 67 Grama Niladhari (GN) areas were chosen for the study. Likewise 393 households were selected as the minimum sample size for the survey.

### *Ethics and safety consideration of participants.*

The ethics and safety standards outlined by the WHO document: “Putting Women First: Ethical considerations in research on GBV<sup>4</sup>” were practiced throughout the study process. Written authorization from the Divisional Secretariat of Ambagamuwa and from the estate authorities was obtained prior to the survey.

Each respondent was provided with a consent statement prior to the interviews. The consent statement was made available in all three local languages (Sinhala, Tamil, English) and was additionally explained to each participant. Where necessary, verbal consent was obtained and recorded by the enumerator. Participation in the study was voluntary and respondents were allowed to leave the interview or the study at any time as per her requirements. No incentive payment or gift was given at the conclusion of the interview. Instead, educational material on health and GBV was distributed.



All women featured in the study were over 15 years of age.

**30.9%** -- 25-34 of age

**26.4%** -- 35-44 of age

**16%** -- 55 and older.

Most (73.4%) women interviewed were able to read Tamil. **76.9%** -- unable to read English

**74.4%** -- unable to read Sinhalese

**26.6%** -- unable to read Tamil

Of the respondents (women), 9.7% (n.38) declared that they had no formal (school) education.

**14.1%** -- studied until Grade 5

**43.3%** -- studied up to G.C.E. Ordinary Level

**12.8%** -- studied up to or above G.C.E. Advanced Level

**0.3%** -- completed a university degree



Education levels of husbands or partners (of those who were in a relationship) considered to be almost similar.

<sup>4</sup> Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication: “Putting women first: ethical and safety recommendations for research on domestic violence against women.” Geneva: World Health Organization. February 2016.



## Challenges and limitations

An electoral registry was meant to be used in sampling the households for the study but accessing it proved to be a major difficulty. As a result, the study team resorted to using limited available household data, via Google Maps. While the government officials in the area agreed on the importance of such a survey, acquiring a formal letter of authority to conduct the study led to a cumbersome process of bureaucracy. Additionally, the unforeseen and devastating Easter bombings on April 21, 2019 upset the social milieu throughout the country and had an impact on the conduct of the survey.

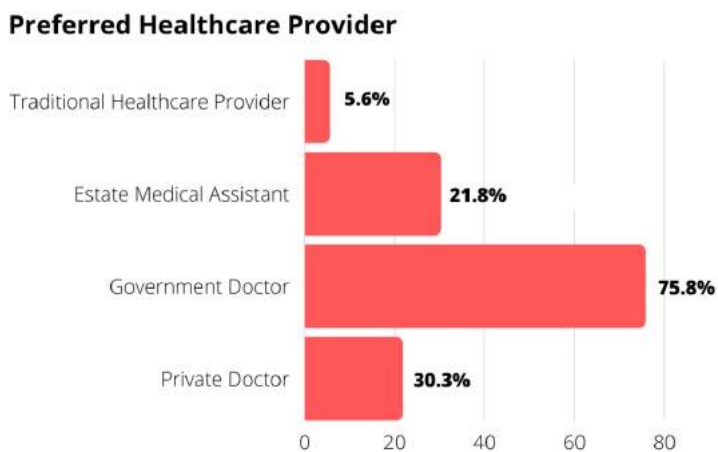
## Health and Well-being

An individual's perception of his/her health is an important component in recognizing one's health problems as it influences health-seeking behaviour. This was an element investigated within this study<sup>5</sup>. The results indicated that nearly 70% of the participants consider their existing health status as either excellent or good. Only 5.6% considered themselves as having poor health. However, this was contradictory to the findings of how nearly one fifth (17% to 23%) of them "slept badly", had "shaking hands", would "feel nervous and tense", "have trouble thinking clearly", "feel unhappy" and "feel worthless". Nearly one third (29.1%) answered "Yes" to the question "In the past 4 weeks did you have problems with performing usual activities, such as work, study, household, family or social activities?" as indicative of poor health either physical, mental or both.

*This contradiction is worth noting as it may be due to lack of awareness, overworking, and/or not caring about themselves, and should be addressed through relevant health programmes.*

### Care seeking pattern

Forty four percent (44%) of the women participating in the survey had visited a Health Care Provider (HCP) within the four weeks preceding the survey; either a



<sup>5</sup>13 objectively phrased questions focusing on symptoms related to general health were asked. While the intention of these symptoms do not diagnose a particular medical condition, They are collectively or individually related to the poor health status of the individual.

government doctor or MOH, private doctor, Estate Medical Assistant (EMA) or a Traditional Health Provider (THP).

*This indicates that many women access HCPs often; which provides a good portal for awareness raising, screening and service provision for survivors of SGBV.*

## *Suicidal ideation*

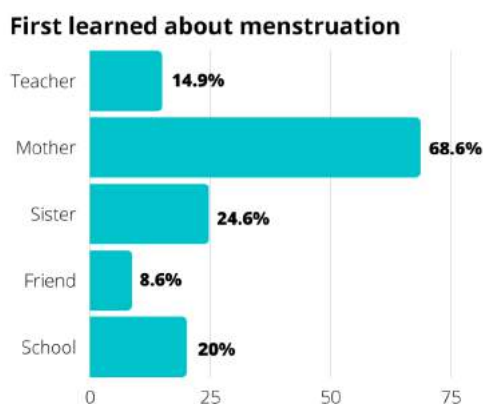
Suicidal ideation (also known as suicidal thoughts) can be defined as thinking about, considering, or planning suicide. The range of ideation varies from fleeting thoughts, to extensive thoughts, to detailed planning.

Although this study was not designed to focus particularly on suicidal ideation<sup>6</sup> two questions attempted to retrieve information in this area.

It was noted that nearly one third (27.0%) “had thought of ending (their) life being on their mind”. However, when the question was more focused on “(At) Some point in your life, have you ever thought about ending your life?” only 10% answered in the affirmative. This compares well with another study<sup>7</sup> done covering four other DS Divisions which found that 7% of the population entertained thoughts of suicide . All respondents were asked “have you ever actually tried to take your life (commit suicide)” - only 7% had done so. This is an area that needs research and intervention.

## Menstrual Health

### *Awareness on menarche and practices associated with it*



Menarche is the first menstruation (“becoming a ‘big girl’” as is commonly referred to within a Sri Lankan context) and varies among individuals depending on multiple factors.

The median age for Sri Lanka, according to an earlier study, was found to be 11.2 years with a range of 11 years to 13 years. The median age of experiencing menarche within the current study group was 13.6 years<sup>8</sup>. Awareness about the first menstruation prior to the event is important for a girl to cope with it emotionally and physically.

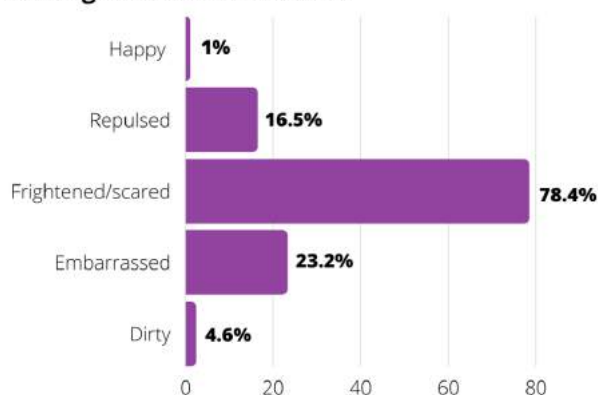
<sup>6</sup> Studies related to suicide typically need the use of tools such as GHQ-30 and Beck's Scale for Suicidal ideation.

<sup>7</sup> Samaraweera S1, Sumathipala A, Siribaddana S, Sivayogan S, Bhugra D (2010) “Prevalence of suicidal ideation in Sri Lanka Crisis”. Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/20197255>

<sup>8</sup> The finding warrants further study as the age of menarche is related to the nutritional status - particularly to underweight - and anemia.

Of the respondents, 53.7% said that they were unaware of it until it occurred. Of the 46.3 % women who were aware of it had either been educated through their mother, elder sister or a friend. Formal education on menstruation was obtained through lessons at school and through teachers.

#### Feelings towards menarche



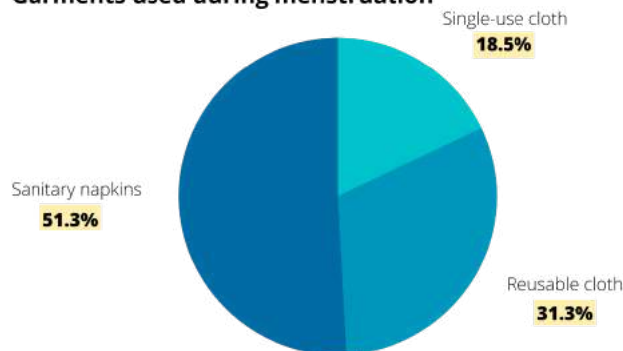
The emotional impact of not being aware of menarche was assessed among those who were unaware; no one was “proud” about it.

It was clear that a natural event that signals biological maturity was understood and accepted to be an unpleasant experience because they were not ready for it in their mind.

*This indicates the need for education in Sexual and Reproductive Health (SRH) to avoid a physiological event being depicted as a frightening experience.*

Half of the women in the study (51%) used disposable sanitary pads bought from a shop. One third (31.3%) was still using “reused” cloths, while 18% use single-use cloth. While using a cloth in lieu of a pad is not necessarily harmful, the uncleanliness of the cloth (once used) and the material of the cloth itself can cause harm - by fungal or bacterial growth - to the user.

#### Garments used during menstruation



**Traditional practices** in Sri Lanka which are associated with menstruation were looked into.

Nearly all women (92.1%) said they were not allowed to go to Kovil (or places of worship). One third (34.2%) said that they would not take a bath during their menstruation cycle, 6.8% of women were not allowed to go to work and the remaining 9.8% were not allowed to cook.

These findings indicate a clear need to revamp SRH education in schools as the accuracy and benefit of information from informal sources is marginal.

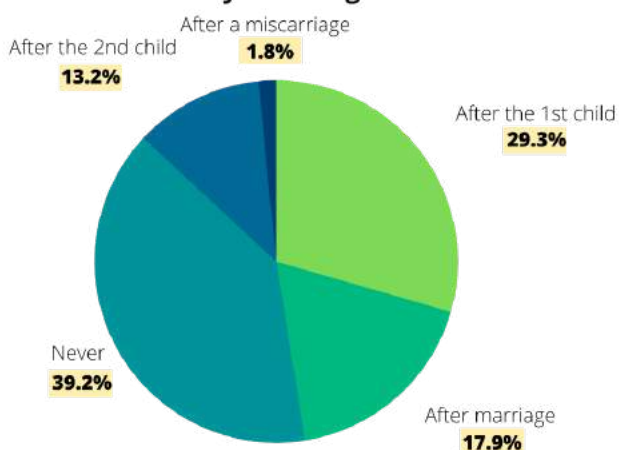
# Sexual and Reproductive Health (SRH)

## *Family Planning*

Family planning is a key component of Sexual and Reproductive Health (SRH) rights and the services are provided free to the doorsteps of homes by the state's public health system, through Public Health Midwife (PHM) and clinics.

Husbands of 39.2% of women (married or in a relationship) have never discussed family planning. This indicates a significant lapse in acquiring information and the opportunity to get information, as they should have been counseled at the National Programme for newly married couples or at domiciliary visits by PHM. It is possible that the gender norms and taboos on sexuality prevents them having open discussions on such matters.

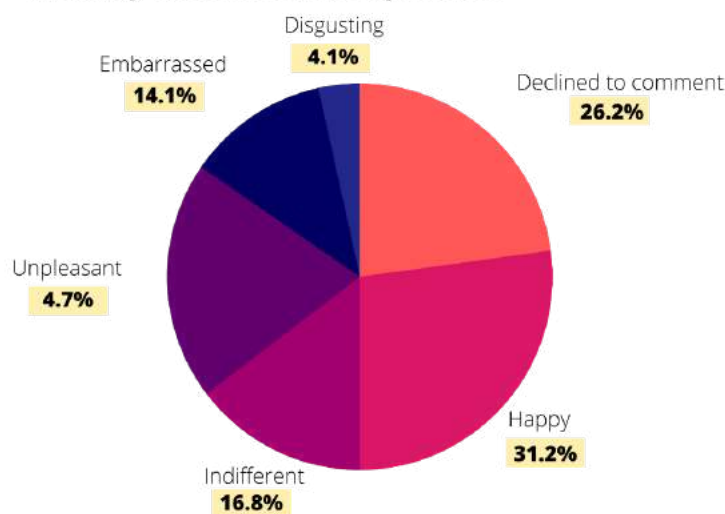
### Discussed Family Planning



Of the responding women, 51.8% did not use any contraceptives and the prevalence of contraceptive usage among the respondents (married or with a partner) was 48.2%<sup>9</sup>. Attitude of the partners towards

family planning was questioned by all respondents. Injectables appear to be the most popular method; Oral Contraceptive Pill (OCP) being the next popular.

### Memory of first sexual experience



The data indicate that there is a relatively higher proportion seeking female sterilization and injectables. When questioned, 69.6% of the respondents said their husbands were aware of their use of contraceptives. On the other hand nearly one third (30%) said that they are not aware. This may indicate that women may resort to using contraceptives while husbands may not agree or do not care.

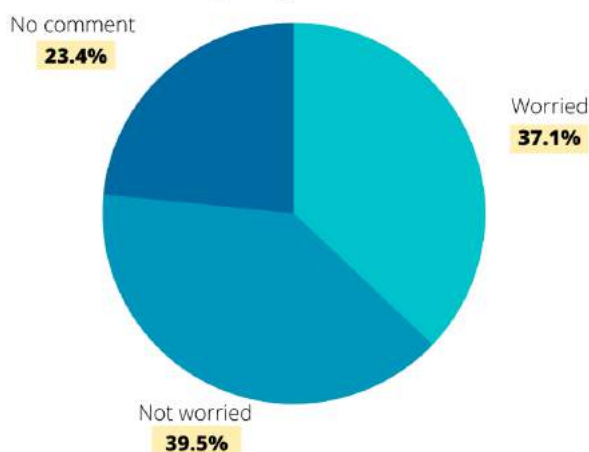
<sup>9</sup>This is marginally low relative to the contraceptive prevalence rate of 65% (DHS 2016) among married women aged 15-49 years.

The first experience of sexual intercourse or a sexual experience is a key event in the life of an individual and can have a long-lasting impact on an individual.

**Percentage of women who refused to answer was 18.8%, indicating that a fair percentage of women are still uncomfortable disclosing information about their first sexual experience.**

When asked about an impression/ memory of their first sexual intercourse, almost one third did not answer. It is arguable that if sexuality is better addressed in awareness programmes for adolescents and newly married couples, they would have a happier experience overall.

### Evidence of Virginity



Marriage-related traditional aspects such as virginity-testing was explored with the respondents who were married or had a partner. The emotional effects of anticipating such a “trial” was explored through the question “*Were you worried about evidence of virginity/bleeding on the wedding night when you got married?*”

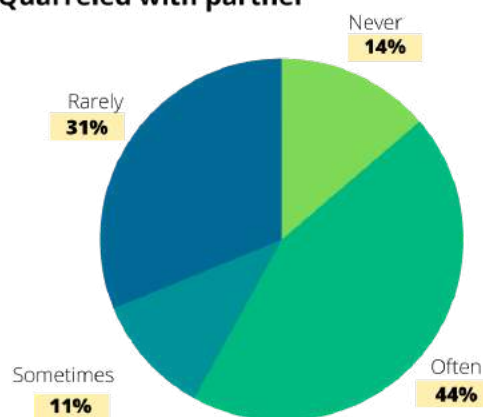
Communication between partners is key towards enabling healthy relationships. The question was asked whether the couple would discuss what happened to the husband during the day at the end of the day.

Only one third (35%) of the couples would engage in such a conversation. When the same question was asked about the wife, a similar situation was seen with 34.7% replying in the affirmative.

Direct questions on sharing one's worries and concerns with the partner, 34.6% of women said that they shared with their husband/partner and 35.1% of women said that their partners do the same.

The question “*in your relationship with your (current or most recent) husband/partner, how often would you say that two of you quarreled?*” in order to move on to the sensitive topic of Intimate Partner Violence (IPV).

### Quarreled with partner



# Gender-based Violence (GBV) and Abuse

Gender-based Violence (GBV) takes place in five forms namely, sexual violence, physical violence, emotional violence, economic abuse and social abuse (controlling behaviour). The prevalence of Intimate Partner Violence (IPV), which consists of any of the 5 kinds of abuse mentioned above, during the last 12 months was recorded as 19.7%. In this study, the experience of IPV was measured under 2 indicators: “within the last 12 months prior to the inquiry” and “sometime during their life.” The prevalence of GBV is key indicator that measures Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages.

Although marital rape is not described as a punishable offence, forced sex is unacceptable within the definition of a healthy sexual relationship marital or otherwise. The data from the study indicated that **10% of women suffered sexual violence within the last 12 months** from the inquiry while **30% had experienced it sometime during their lifetime**.

The proportion of women who experienced both Sexual *and* Physical Violence during the last 12 months was 3.7% (n=11) while 20.1% had experienced at some point during their lifetime (n=79). The proportion of women who experienced both Sexual *or* Physical Violence during the last 12 months was 13.0% (n=39) while 37.7% had experienced it at some point during their lifetime.

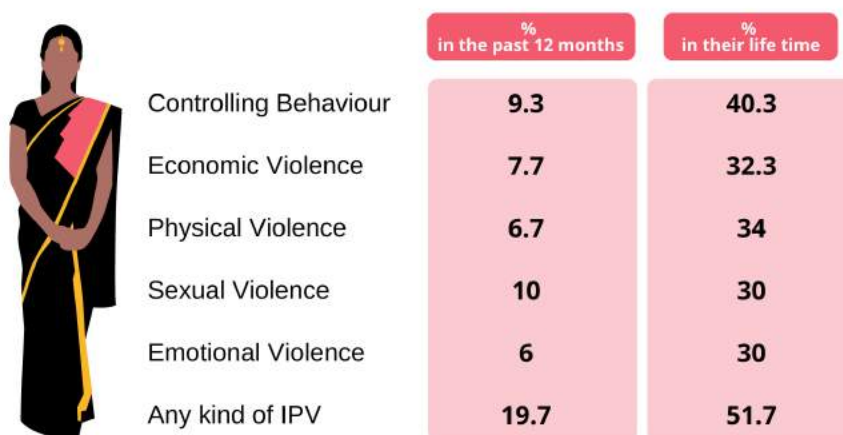


It is seen that the prevalence of all three types together (experienced by the same individual) is 20.7% compared to a single type of violence. This means that **a woman often experiences all three types of violence within her life**.

Of the 300 women who opted to answer positively to all the four questions on economic abuse 7.7% had suffered within the last 12 months while 32.3% had suffered sometime during their life.

Experiencing physical violence after the age of 15 years by any person other than the intimate partner was looked into. Physical abuse including corporal punishment is a very demeaning and degrading experience, especially among adolescents and can affect their personality.

The respondents were asked whether they were “*beaten or physically mistreated in any way?*”



All 394 respondents opted to answer. 22.6% of women had experienced physical violence by a person other than the husband or the partner.<sup>10</sup>

When the site of the violence by non-partners was considered one fourth of instances were “on the way to work”, another fourth at “home”

Non-partner physical violence-	22.6%
Non-partner sexual violence-	11.4%
Non-partner sexual abuse-	45.4%
Non-partner violence-	54%

Public transport scores low among these women as their work is mainly within the estate and within walking distance. When non-partner sexual abuse after 15 years of age was looked in to, 11.4% of the respondents said that they had suffered sexual violence sometime after 15 years of age.

Forty one (41) women who had experienced sexual violence were asked about the perpetrator. They mentioned 45 types of perpetrators indicating that women had experienced violence from more than one person.

Surprisingly, the most common person mentioned (26.8%) as the abuser - by women of childhood sexual abuse - was the “parent” with another 14.6% mentioning “parent in law”. The hierarchical power structure with the father being the head is possibly strongly-entrenched and the poorly ventilated and crowded housing within the community could possibly contribute to this unexpected finding.

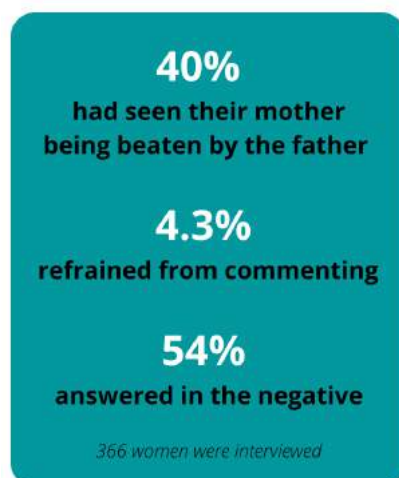
## Coping mechanisms

Of the 38 women who mentioned that they had been violated and opted to answer the question “*to whom you divulged the violence*”, 14 women (36.8%) had ‘not told anybody’ while 34.2% of them had spoken to one of the parents, 13.2% to parent in law, 10.5% to the teacher, 7.9% to the midwife.

## Childhood sexual abuse

Childhood sexual abuse is a devastating event recognized under Adverse Childhood Experiences (ACEs) that can have a long term impact and is an important determinant of the individual’s health.

<sup>10</sup> Parent, parent in law and teacher seems to be the commonly mentioned dispenser.



Inquiry about childhood sexual abuse (before the age of 15) was done through the question “Do you remember if a stranger or anyone in your family made you do something sexual that you didn’t want to?” Of the respondent women, 13.5% (n=53) said they had experienced some form of sexual abuse before the age of 15 years .

Another ACE explored, was exposure to violence in “seeing the mother being hit by the father.” Exposure to domestic violence is a ground reality in these communities with its impact on the child’s health and behavior and subsequently in intergenerational transmission of intimate partner violence (IPV).

Considering the perpetrators of abuse mentioned by the women, nearly three fourth of women (72.5%) were family members (Parent: 17.5%, Parent in law: 22.5%, sibling: 2.5%, other members of the family 30%). This is a significant finding and needs further study.

Official avenues of redress such as the Grama Niladhari (2.6%), Police (2.6%) or the supervisor of the estate (0.0%) was not utilized much by women. te that Only 2.6 % of women divulged the experience suffered, to husband (data was not disaggregated according to the relationship status)

***This possibly indicates the lack of trust or constraints in access to formal services is a challenge for women and provides a space for urgent action.***

Parents and parents in law appear as key “helpers” on one hand and also as a prominent group of ”violators” on the other hand. Therefore, the “elders’ ’ particularly the male parents/parents in law: the power holders should be the target group for awareness raising intervention to address GBV in this community.



# Key Findings and Recommendations

- **Service provision mechanisms are less effective in the estate sector when compared with the rest of the country where they are typically robust.**
  - The **Grama Niladhari** unit usually covers 200 to 300 families while the same in the estate sector covers around 1,500 families. Since the GNs are overburdened with other issues they would give lesser importance to SGBV.
  - Similarly, the **PHMs** covering the estates cover more households in spite of the difficult terrain. Less trained and less skilled creche attendants or health volunteers often step in to fill in the gap in care provision including in GBV issues.
  - There is a disjoint between the state health mechanisms and the estate health delivery mechanism with hardly any common ground to interact.
  - Lack of integration of the preventive health services/ hospital services with the **Estate Medical Practitioners** and creche attendants who are key health persons trusted by the estate community.
  
- **Many limitations exist in the access to existing services.**
  - Reluctance of women in accessing service points including **Mithuru Piyasa/Natpu Nilayam** in hospitals (beyond the Estate Medical Center) for reasons of privacy
  - Women work more during the day time (typically 2 hours more than that of men) so they cannot access the services provided to them for lack of time<sup>11</sup>.
  - Other barriers such as transport, sensitivities and unfriendliness of some service-providers make the government hospital where Mithuru Piyasa/Natpu Nilayam is available a secondary choice<sup>12</sup>.

***Higher incidence of attempts at suicide among women with intimate partner violence is an indication of how badly the professional psycho social counselling is needed in this DS Division. This being a highly skilled profession at least a referral service should be available to women.***

- **The plantation community is experiencing a transitional stage, led by the younger population and influenced by technological developments** - More youth are leaving the estate sector in search of better opportunities but they maintain close linkages with the family. Nearly every one owns a mobile device while these help to maintain communications opens out the population to the potential space for cyber violence. It is unlikely that this community is able to protect themselves.

<sup>11</sup> Women working in the estates have no arrangements to get sick leave with pay. It is a major limitation to getting GBV services.

<sup>12</sup> The Estate Dispensary is usually the first choice however, it isn't developed adequately to support survivors of GBV.

- **There exists, a prolonged lack of exposure to mainstream society and traditional narratives have enabled harmful practises** - Over the years of isolation from mainstream society, plantation communities have become afflicted with poverty, illiteracy and lack of opportunities and remain as an enclave with inherent social, cultural and traditional practices. These issues correlate in enabling GBV within communities (e.g. alcoholism, strong traditional practices and male dominated power relations).
- **Harmful, gendered stereotypes have been internalized within the community** - Women seem to be under the traditional “power grip” of their parents and parents in law, as “protectors” who impose authority and use physical violence even if women or girls are above 15 years of age. Internalization of gender attitudes and norms and the stigma attached to non-compliance generate a strong reluctance among women to divulge violence and access services, particularly the formal service points. Possibly lack of trust in these institutions and the grievance redress mechanisms may have contributed to this negative behaviour.
- **There is a lack of accurate knowledge on SRH** - This appears to generate a milieu which normalizes traditional practices such as virginity testing and other restrictions related to menarche/ menstruation. This often leads to negative impacts on women’s health. This eventually is linked to cases of SGBV and issues in menstrual hygiene. Access to disposable protection material is still an issue that needs to be addressed.
- **Women experience limited financial independence in comparison to their male counterparts** - Although most women are employed and draw a substantial income, the power and opportunity to utilize the money is limited among women. The “power holders” (husband/partner) tend to use violence to get money earned by the women, which makes the potential source of power defunct.
- **Basic living requirements do not receive adequate attention** - Basic needs for the estate community such as living arrangements with adequate privacy is considered as “welfare” rather than a “human right”. This leads to non-prioritization of these issues unlike attention towards water or sanitation. This directly affects family dynamics and sexual health in turn promoting SGBV at home and in the community.
- **There exists a need for gender-positive administrative leadership** - Focus of the estate management and supportive services appear to divert attention to behavior changes of an already strained community. Instead, the administration should empower women and girls and their position in society.
- **Lack of inclusivity for children’s participation within existing programmes** - Children of families where intimate partner violence occurs are at risk of many negative health impacts and even intergenerational transmission of SGBV. Children of all families should be targets of programmes to help them with coping skills to manage trauma and gain awareness.

- **Lack of uniform mandates across activities** - Although different committees are active in some areas, there is no uniformity in their mandates or the manner in which activities are carried out due to the absence of guidelines or protocol.
- **Underutilization of local Trade Union support** - Trade Unions are a powerful institution with strong influence on this community. At present the contribution to address GBV by Trade Unions is meagre. It is essential to “buy in” the leadership on the significance of SGBV as a major determinant of health, through effective advocacy using the findings of the study and work with them.
- **Lack of adequate sensitivity training among staff** - Although most of the administrative staff and care providers are aware of the issues of SGBV, their service delivery is affected by apathy, disbelief, denial and lack of prioritization of addressing SGBV. The findings of the study provide strong evidence to “jump start” the system to be more active, receptive and effective to assist the survivors.

*Further study is needed to explore some findings of the study such as high rates of Suicides and suicidal ideation, Higher age of menarche, contraceptive use etc. in comparison to national patterns.*

## Recommendations

The recommendations below are based on the results of the study.

### **Improved service delivery**

- There is an urgent need to integrate state and estate service delivery relating to SGBV in a more effective manner.
  - Study the availability of state officials (Grama Niladhari, Public health Midwives and Women Development Officers) and initiate a discussion to establish an equitable integrated service provision to support survivors of SGBV.
  - Include Estate Medical Practitioners and creche attendants in the training programmes in GBV, with relevant state health staff so that the knowledge and the linkages are developed for concerted response.
  - Conduct training for first contact health persons so they would be receptive to survivors. National guidelines developed by Family Health Bureau (FHB) may be used.
- **Access to resources**
    - Raise awareness among the women in the Ambagamuwa DS Division.
    - Promote women in accessing service points including Mithuru Piyasa/Natpu Nilayam in hospitals (beyond the estate medical center).

- Conduct awareness programmes on services and share experiences of Mithuru Piyasa/Natpu Nilayam with estate management, EMAs, creche attendants and state officials.
  - Develop IEC materials, Mobile App and raise awareness of the services of Mithuru Piyasa and disseminate among the public in Ambagamuwa Division.
  - Explore the possibility with Mithuru Piyasa/Natpu Nilayam to have prior appointments for survivors referred by the estate to minimize the time.
- Recognize the evolving socio demographic changes in the estate sector and the opening out of the cyber space to the community.
    - Conduct a study on the socio demographic trends in the estate sector and the use of cyberspace with emphasis on cyber violence
    - Based on recommendations, conduct a public awareness campaign on “Safe use of cyberspace”.
- **Awareness and outreach programmes**
    - Address the inherent social, cultural and traditional practices and outcomes of male dominated power relationships through programmes on Reproductive Health including Gender and GBV. Conduct awareness raising among women’s groups and providers such as creche attendants.
    - Conduct awareness raising programmes with older members in addressing this issue and how to be more sensitive to the needs of the adolescents and youth.
    - Support SRH education in schools through health officials.
    - Facilitate the mechanisms where cheaper disposable napkins could be made available at local level.
    - Conduct awareness programmes through women’s societies, creche attendants where older women “mothers of young girls” can be sensitized.
    - Develop educational material to make women and girls aware of the services and service points available to women.
    - Promote positive behaviour of husbands through awareness raising through selected peers/champions from the community to address economic violence.
- **Economic and social empowerment of women**
    - Strengthen the power and opportunity to utilize the money earned by women.
    - Negotiate with estate management to bank the women’s salaries to retain their power over the money.
- Advocate for having a minimum of two rooms in housing units and make it a policy of the estate administration.
- Active NGOs in the area could facilitate a discussion between Dick Oya Hospital/ Mithuru Piyasa/Natpu Nilayam and estate management to see how services for GBV survivors could be made easily accessible.

- Services of the Counseling assistant at the Gender and Women's Unit must be fully utilized to support survivors of GBV. Her availability needs to be informed to all EMAs, Medical Officers MOHs etc.
- Possibility of having a professional **counselor** either through authority of DS or through an NGO or as part of the **ACCEND** Project be explored. Counselors could be based at Mithuru Piyasa/Natpu Nilayam and the referrals could be made.
- **Institutional interventions**
  - Streamline GBV committees, mention good practices and formalize a uniformed implementation methodology through protocol or guideline in the form of vigilant committees. They should be affiliated to and/or supervised through the Divisional Secretariat for sustainability.
  - Advocate for a collaborative response to the findings on health and GBV through the Divisional Secretariat.
  - Conduct awareness raising with the DS office staff and present the findings
  - Advocate trade union leadership to include addressing GBV in the trade union agenda.
  - Appoint a Steering Committee to monitor and guide the implementation of the action plan so that they could direct the appropriate collaborative response.

*Conduct further research in some of the findings of the study such as high rates of suicides and suicidal ideation, higher age of menarche, contraceptive use in comparison to national patterns of usage.*

# Appendix

## *Research Questions*

1. What is the level of prevalence of experiencing SGBV including IPV among women in the Ambagamuwa DS Division?
2. What are the key negative health issues in reproductive health? What are the suggestions to overcome them?
3. What are the key cultural and social practices that affect reproductive health which in turn promote SGBV in these areas that are prevalent in the community (including traditional harmful practices)?
4. What are the consequences of GBV experienced by survivors including health, social and economic plans at individual level and on their children?
5. What are the associated factors and how the hierarchical structure and the power dynamics promote SGBV, in particular non partner violence within the specific environment?
6. What are the responses of the survivors, coping mechanisms including informal networks, and care seeking behaviors adopted by the survivors?
7. What are the service and structural gaps to prevent and address Sexual and Gender-based Violence?
8. What are the recommendations for sustainable interventions including enhancing GBV care services for district level programming in addressing and preventing Sexual and Gender-based Violence?

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