



MAPPING OF SERVICES TO ADDRESS SEXUAL AND GENDER BASED VIOLENCE (SGBV) IN SRI LANKA

Mapping of Services to Address Sexual and Gender-Based Violence (SGBV) in Sri Lanka

A Note of Gratitude

VILUTHU expresses its sincere appreciation to the National Endowment for Democracy (NED) and Diakonia for the financial support extended to make the publication and the launch of this research report possible.

This research report stems from the 2024 study conducted by VILUTHU and the Centre for Equality and Justice (CEJ) titled “Mapping of Services to Address Sexual and Gender-Based Violence (SGBV) in Sri Lanka.” It is the first Sri Lankan civil society led collaborative study mapping SGBV service provision in the island conducted across eight districts with over 1000 women and service providers as direct respondents. Appreciating its contemporary relevance and efficacy to better SGBV service provision for all victim survivors, VILUTHU took steps to deliberate, design, print and present this publication to the readership including multi-level stakeholders and the public for much needed urgent action.

VILUTHU is a not for profit organisation operating in Sri Lanka since 2003 with the prime focus on working with communities for social change. Operating under the principles of creating an inclusive and socially cohesive society that practices participatory democracy and adheres to gender equality, economic, social justice and equitable development, VILUTHU seeks to enhance women and youth participation in policy discourse and provide a platform to the marginalised groups for such purposes.

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Mapping of Services to Address Sexual and Gender-Based Violence (SGBV) in Sri Lanka©

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EXECUTIVE SUMMARY

This study investigates the scope, effectiveness, and gaps in sexual and gender-based violence (SGBV) prevention and response services in Sri Lanka, by focusing on the experiences of 888 women victim-survivors and 109 service providers across eight districts. Conducted between May 2022 and December 2024, the research highlights the compounded vulnerabilities faced by women due to conflict, displacement, economic crises, and entrenched patriarchal norms. It reveals critical weaknesses in existing legal, institutional, and support mechanisms, including under-resourced services, fragmented coordination, and pervasive stigma. The study offers actionable recommendations to improve multi-sectoral collaboration, develop survivor-centered service delivery, and strengthen state accountability to ensure comprehensive and inclusive SGBV prevention and response nationwide.

SGBV remains a pervasive and deeply rooted issue in Sri Lanka, affecting women across all socio-economic backgrounds. Despite high female literacy and labor force participation, entrenched patriarchy, gender norms, and limited decision-making power contribute to widespread SGBV. This includes physical, sexual, psychological, economic, and cyber violence. While awareness of SGBV is relatively high, significant gaps remain in reporting due to stigma, shame, fear of retaliation, and institutional barriers. Most victim-survivors turn to informal channels like family and friends rather than formal mechanisms. Although some community-driven initiatives and awareness efforts show promise, systemic challenges hinder timely justice and comprehensive support for victim-survivors.

Sri Lanka's international obligations, as a State Party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), mandate the protection of women's rights and the elimination of violence against them. However, the domestic legal framework is fragmented. Despite constitutional guarantees of equality and several legislative measures, significant gaps remain in effective implementation and comprehensive protection for all victim-survivors of SGBV. Non-justiciable policy frameworks, including the National Action Plan for SGBV 2024-2027, emphasize the need for a coordinated, multi-sectoral approach to SGBV service provision. The Essential Services Package (ESP), launched in Sri Lanka in June 2018 as part of the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, aims to improve access to vital services. Despite UNFPA recognizing Sri Lanka as a pioneering country in implementing this initiative, challenges remain due to the absence of a unified legal framework. These findings underscore the urgent need for systemic legal and policy reforms to ensure that the rights and safety of victim-survivors are effectively upheld in Sri Lanka.

The study highlights the critical importance of ensuring the availability, accessibility, and quality of support services for victim-survivors of SGBV in Sri Lanka. Both state and non-state actors provide a spectrum of services. This includes medical care, psychosocial and psychiatric support, legal aid, and social services. However, disparities exist in service quality, regional access, and institutional responsiveness. Non-state actors often fill gaps, especially in offering emergency shelter, livelihood support, and legal assistance. While state health facilities offer free treatment, they face challenges such as shortages of trained staff (e.g., Judicial Medical Officers), lack of privacy, and insufficient medication. Public Health Midwives play a pivotal community-level role. However, barriers such as childcare duties, high transport costs, social stigma, and fear of reprisal significantly hinder victim-survivors' access to care. Psychosocial support services like Mithuru Piyasa/Natpu Nilayam centers exist but suffer from staff shortages and low public awareness. Police services are available but underutilized due to victim-survivors' mistrust, procedural delays, language barriers, and inadequate police training. Legal assistance and representation suffer from inadequate staffing, confidentiality issues, and in some instances, exploitative practices. Social support services like shelters, livelihood assistance, and awareness-raising efforts are extremely limited or poorly publicized, particularly in rural and conflict-affected areas. Additionally, victim-survivors often face repeated and traumatic retellings of their experiences due to

fragmented service delivery, while unpaid care work and economic dependence on abusers further hinder help-seeking. Overall, while services are present, their reach and effectiveness are uneven, revealing the urgent need for systemic reform and survivor-centered approaches. These findings highlight the urgent need for survivor-centered, coordinated, and culturally sensitive interventions that address structural, geographic, and socio-cultural barriers to justice and care.

Currently, there are no standardized policies, procedures, or guidelines applicable to all service providers involved in responding to SGBV regarding coordination and referral pathways for victim-survivors of SGBV. This has resulted in a lack of formal inter-agency coordination mechanisms. While some state and non-state actors have developed their own informal referral systems, these are inconsistent and often not tailored to the unique needs of first-time versus repeat service users. The Ministry of Health has issued guidelines for healthcare providers, establishing a pathway for referrals to various services, yet the absence of a cohesive national framework hampers effective service delivery to victim-survivors. Data collection and sharing practices are also fragmented, with no central database for SGBV cases, limiting the ability to track and monitor services. Non-state actors play a crucial role in providing support, often stepping in where state services are inadequate, but their informal networks risk sustainability due to reliance on individual initiative.

Further, the study compiles some critical gaps and challenges that hinder the effectiveness of support services for victim-survivors of SGBV. Key issues include the limited availability and accessibility of services, particularly in rural areas, where specialized support such as shelters and legal assistance is often scarce. Existing legal frameworks inadequately address forms of violence like marital rape and technology-facilitated abuse, which leaves many victim-survivors without appropriate legal recourse. Additionally, disparities in service quality arise from insufficient training for staff, lack of trauma-informed care, and inadequate facilities, which can further traumatize victims during legal proceedings. A pervasive lack of trust in state service providers, particularly law enforcement, is compounded by regressive attitudes among some service providers, which leads to victim-blaming and stigma. Fragmented service delivery and a lack of awareness about available resources exacerbate these challenges. Funding limitations severely impact both state and non-state service providers. Similarly, the absence of comprehensive service mapping and effective coordination mechanisms results in missed collaboration opportunities and inconsistent service standards. To address these challenges, the study emphasizes the urgent need for improved coordination, clearer referral pathways, and enhanced training to ensure comprehensive, survivor-centered care for all victim-survivors of SGBV in Sri Lanka.

To address the above challenges, the study provides key recommendations to specific stakeholders to strengthen SGBV service provision in Sri Lanka by emphasizing the need for coordinated implementation. Each recommendation is interconnected, calling for a holistic approach to create an effective system for addressing SGBV and supporting victim-survivors. A concise list of the key recommendations is as follows:

Ministry of Women and Child Affairs

- » Launch targeted awareness campaigns to inform victim-survivors about their rights and available services, focusing on marginalized groups.
- » Involve men and boys as allies in preventing SGBV through education and community engagement.
- » Increase funding and resources for specialized services in rural areas to ensure equitable access to support.
- » Provide ongoing training for service providers on trauma-informed care and cultural competency.
- » Standardize service quality across districts to ensure consistent and effective support for victim-survivors.
- » Introduce an enforceable coordinated referral mechanism with standardized protocols for data sharing among service providers.
- » Increase budgetary allocations for social support services essential to the recovery and empowerment of victim-survivors.
- » Establish accountability mechanisms for law enforcement to address victim-blaming and negligence.
- » Utilize the Women Empowerment Act to reform laws comprehensively addressing all forms of SGBV.
- » Develop comprehensive directories of available services and launch a centralized database to track referrals and services provided.

Police

- » Establish safe spaces for victim-survivors in police stations with trained officers.
- » Implement accountability mechanisms to address victim blaming and negligence.
- » Create a centralized database to track police referrals and services.
- » Provide training for officers on SGBV issues, including trauma-informed care.
- » Standardize service quality across districts to ensure consistent support.
- » Collaborate with local non-governmental organizations (NGOs) to facilitate referrals and service delivery.
- » Ensure mandatory interpreter services for effective communication.

Legal Aid Service Providers

- » Launch awareness campaigns about services available through the Legal Aid Commission (LAC).
- » Enforce protective measures to ensure victim-survivor safety during legal proceedings.
- » Train Legal Aid officers on SGBV issues and response protocols.
- » Standardize service quality across districts for consistent support.

Healthcare, Psychosocial, and Psychiatric Service Providers

- » Conduct awareness campaigns about available healthcare services for victim-survivors.
- » Increase funding for services in rural and underserved areas.
- » Establish safe spaces and integrated services for medical and mental health support.
- » Launch mobile units to provide health and psychosocial services in remote locations.
- » Develop peer support programs connecting survivors with trained individuals.
- » Standardize healthcare service quality and offer ongoing training for providers.
- » Implement accountability mechanisms to address victim-blaming in healthcare.

International NGOs and Development Agencies

- » Advocate for long-term funding models for non-state service providers.
- » Facilitate training on fundraising and financial management for service providers.
- » Promote collaboration among service providers to share resources and expertise.
- » Increase funding for social support services essential for victim-survivors.

Civil Society Organizations

- » Launch targeted awareness campaigns about rights and available services.
- » Involve men and boys as allies in preventing SGBV through education and outreach.
- » Lobby for long-term funding and diversify funding sources.
- » Develop comprehensive directories of available services for underserved communities.
- » Create a database to track referrals and services provided by civil society organizations (CSOs).
- » Provide ongoing training focusing on trauma-informed care and cultural competency.
- » Establish effective monitoring and evaluation approaches for continuous improvement.

SNAPSHOT OF THE RESEARCH

1 Prevalence of SGBV in Sri Lanka

1 in 4 women experience violence; nearly 2 in 5 experience broader SGBV.

Department of Census and Statistics, Sri Lanka, "Sri Lanka Women's Wellbeing Survey 2019 - Final Report, accessed June 17, 2024, http://www.statistics.gov.lk/Resource/reference/WWS_2019_Final_Report



24.9%

of women have experienced sexual and/or physical violence since age 15



39.8%

of women have experienced physical, sexual, emotional, economic violence and/or controlling behavior by a partner in their lifetime

2 Forms of SGBV

SGBV takes many forms — from physical harm to economic and cyber-facilitated abuse.



3 SGBV Reporting Practices in Sri Lanka



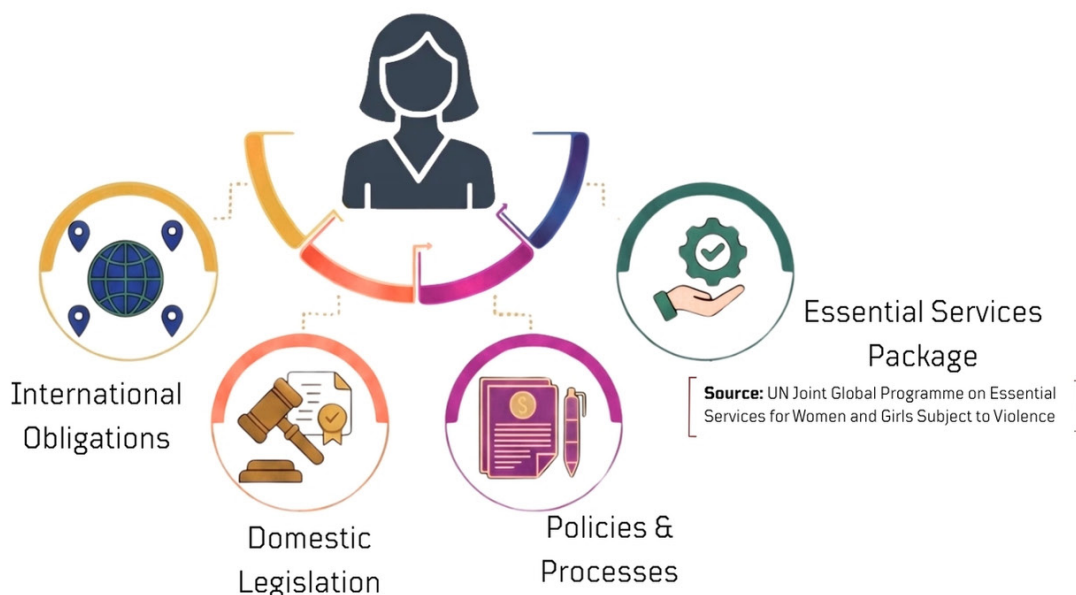
4 Most Commonly Used Reporting Channels:



5

SGBV Support Infrastructure

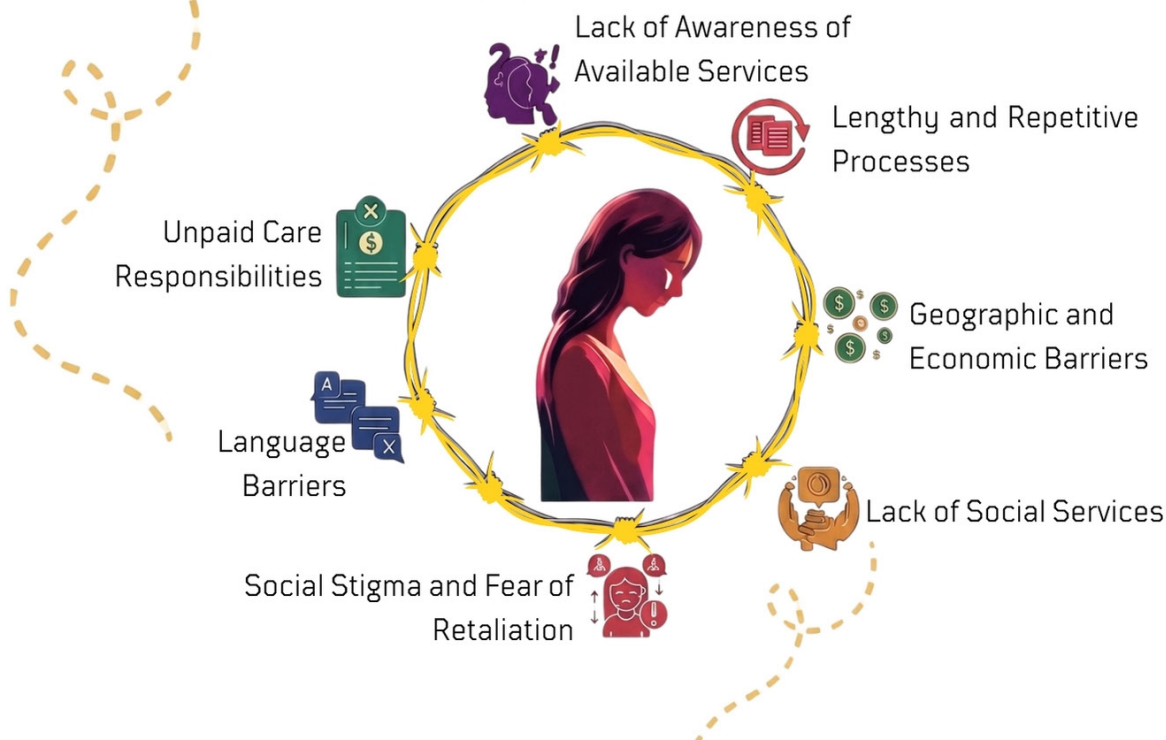
Survivor-centred support is built on interconnected international obligations, national laws, policies, and service frameworks.



6

Barriers to Accessing SGBV Support Services

Multiple structural, social, and practical barriers prevent survivors from reaching support services.



7 Major Gaps & Challenges in SGBV Support Services

Significant gaps in service availability, quality, legal frameworks, coordination, and trust hinder effective SGBV responses.

In availability, accessibility and quality of services

- Limitations in the Legal Framework
- Limited Availability of Services Across Districts
- Disparities in Quality of Services
- Lack of Trust in State Service Providers
- Regressive Attitudes of Some Service Providers
- Delays in Services
- Fragmented Service Delivery

Limited Knowledge of Available Services

Lack of Funding for Government Institution

Unsustainability of Funding Available to Non-State Service Providers

In coordination and referral pathways

Absence of SGBV Service Mapping at District or National Level

Absence of a Representative and Formal Coordination Mechanism for SGBV Service Provision at District Level

Lack of Awareness or non-Availability of Clear Referral Protocols

Insufficient Data Sharing

8 Targeted Actions for Key Stakeholders

A multi-sectoral, coordinated response strengthens prevention, support, and justice for survivors — tailored to each core actor's role.

Ministry of Women and Child Affairs

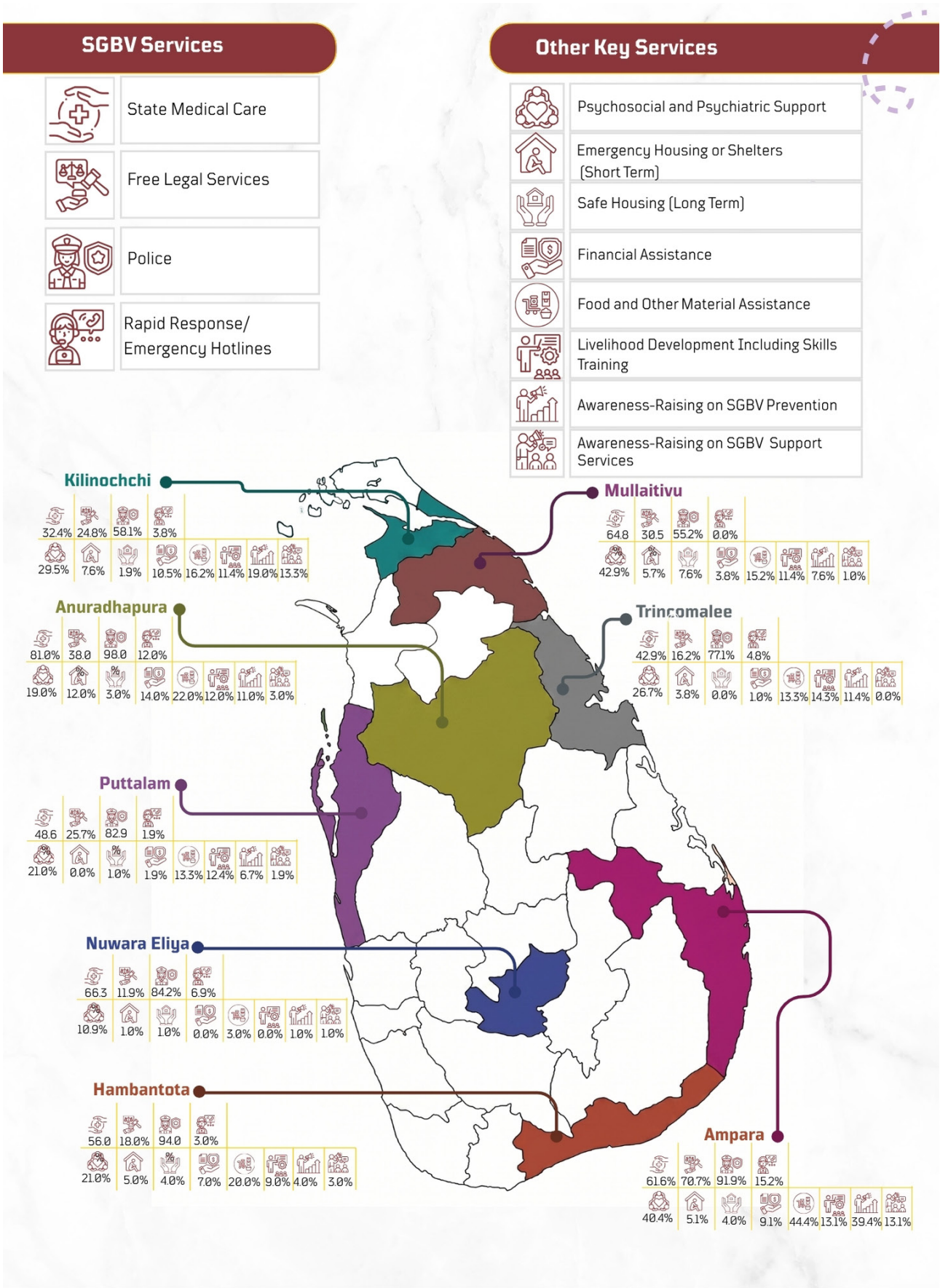
Police

Legal Aid Service Providers

Healthcare, Psychosocial and Psychiatric Service Providers

Civil Society Organizations

International Non-Government Organizations and International Development Agencies



PREFACE

VILUTHU

For more than two decades, VILUTHU has stood alongside women's groups across Sri Lanka, working in partnership to strengthen collective action, build legal literacy, and support women in recognising and asserting their rights with confidence. Through the war, post war, emerging conflicts and evolving forms of violence, we have journeyed together with women in this shared vision for participatory social change. However, in recent years, following the Covid pandemic and the start of the economic crisis in Sri Lanka, emerging trends were worrying. Post war and the transfer of violence from one hand to another, the generational transfer of violence, the normalization of it and the expectation that women in our societies should be ever resilient to handle all was a huge challenge. In trusted shared spaces, the conversations that lingered after legal awareness programmes and community engagements emerged a deeply troubling reality with unmistakable clarity. Women were telling us, with increasing urgency, that the violence shaping their lives was not diminishing. It was becoming more frequent, more severe, and more deeply entrenched.

What began as legal awareness initiatives gradually became spaces of trust and disclosure. Women spoke candidly about experiences that ranged from the pervasive and often normalised realities of domestic and intimate partner violence to acts of brutality so severe, that they defied comprehension, including the mutilation of body parts. In conflict-affected communities, we also encountered a deeply disturbing pattern: the quiet normalisation of sexual exploitation and the coercive exchange of sexual favours for access to services, resources, or even basic security. Alongside these painful accounts, women also expressed, often with remarkable clarity, what they needed from systems intended to protect and support them. Yet, we recognised that there continued to exist gaps in structured mechanisms through which these voices could be meaningfully documented and translated into evidence capable of informing policy, practice, or service delivery.

Our engagement with women revealed another important reality. When seeking support, many did not turn first to formal institutions. Instead, they relied on informal networks, trusted community members, civil society community support or kinship structures. This was neither incidental nor merely a cultural preference; it reflected profound concerns about the accessibility, responsiveness, and trustworthiness of the formal systems established to address sexual and gender based violence. Walking alongside women as they navigated both survival and redress reinforced a simple but fundamental lesson. Meaningful reform must begin with an honest, evidence-based understanding of where women seek help, why they make those choices, and what those choices reveal about the systems meant to serve them.

These reflections gave rise, in 2022, to the idea of a locally led mapping of sexual and gender based violence (SGBV) services, one that would place women's lived experiences at its centre rather than position them as passive subjects of data collection. While circumstances prevented us from pursuing this vision immediately, it found renewed momentum in 2024 when VILUTHU and the Centre for Equality and Justice (CEJ) came together in partnership. That collaboration created the foundation necessary to transform an aspiration into a shared endeavour.

The journey from concept to completion was shaped by significant challenges. At a time when the global funding landscape for women's rights and civil society organisations has become increasingly constrained, timelines shifted and resources required careful stewardship. Even so, VILUTHU's commitment to ensuring that women's voices remained at the heart of this work never faltered. Working closely with researchers and digital experts, VILUTHU sought to ensure that the formats

in which the findings were presented here extend beyond technical documentation, making them accessible and relevant to diverse audiences, from grassroots organisations and frontline service providers to national policymakers responsible for shaping institutional responses.

This mapping is grounded in the experiences of more than 900 women across all the districts included in the study. Their testimonies are not supplementary to this research, instead, they constitute one of its defining foundations, shaping both its analysis and its recommendations. The study was also intentionally designed around participatory approaches, incorporating a dedicated consultative process that brought together the perspectives of women, service providers, and activists. In doing so, we hope this work contributes, however modestly, to the growing body of methodologies available to researchers and practitioners working to address gender based violence in Sri Lanka.

We are deeply grateful for the women who came forward to contribute to the research and its methodology, as well as the service providers and actors who engaged in this process. This research would not be also possible without the committed team of researchers who joined in our struggles through this time, understanding the immense importance this opportunity had to offer. The works of the research team including Amb. Prof. Fazeeha Azmi, Menaka Lekamwasam, Ambika Satkunanathan (Research Advisor), Rebecca Surenthiraraj, Shakti Devapura, Sumithra Sellathambi, Nipunika Pathirana, Divaincy Fernando, Thenuka Thangarasa, Tharushalini Sivathurai, Mohammedu Siddeek Shifna, Shashik Dhanushka, Kalyani Balathas, Akshayan Rajasingam, Arathiya Pushpalingam, Manisha Dissanayake, Mathusha Sabhanayakam and Peppercube Consultancies are appreciated for their efforts in realising this study.

This is the first SGBV service provision mapping in Sri Lanka to be led by local civil society organisations. That distinction carries significance not simply as an institutional milestone for Viluthu, but as a reaffirmation that research rooted in local knowledge and centred on women's lived realities has an essential role in shaping national policy and public discourse. We offer this mapping as a practical resource for those committed to strengthening SGBV services so that relevant stakeholders and communities are able to identify and address existing gaps, to improve accessibility and responsiveness, and ultimately to help create conditions in which women can seek support with safety, dignity, and confidence.

We do not present this study as a definitive conclusion. Rather, we offer it as one contribution to a continuing process of research, dialogue, and action. It is our hope that others will engage with its findings, challenge its assumptions where necessary, build upon its insights, and carry this work forward until the systems established to protect women fulfil that purpose in both principle and practice.

VILUTHU is committed to our journey on this reform process with the women and we hope to take this research to the grassroots, at the sites of service delivery and to discourses at the top levels on policy, so that this commitment is a shared vision for all of us in Sri Lanka.

Maithreyi Rajasingam

Executive Director, VILUTHU

PREFACE

THE CENTRE FOR EQUALITY AND JUSTICE

CEJ, in collaboration with the VILUTHU Centre for Human Development and funding support from Vital Voices Global Partnership, conducted a national mapping of services to address Sexual and Gender Based Violence (SGBV) in Sri Lanka between April 2024 and November 2024. At the time of conducting the study, Sri Lanka was going through a very challenging phase of economic recovery following the COVID-19 pandemic, and economic crisis, which caused dwindling foreign reserves with impending defaults on its international debt commitments, record-high inflation, and a man-made food crisis. SGBV is a significant problem faced by women and girls in Sri Lanka. Survivors struggle with many structural barriers in the criminal justice system, such as language barriers, legal delays, gender insensitivity among actors in the criminal justice system, lack of infrastructure, lack of trained medico-legal experts and lack of trained psychologists, ineffective implementation of the Prevention of Domestic Violence Act, and delayed responses to complaints of sexual violence from law enforcement authorities. There is a critical need to have better coordination among diverse stakeholders in the criminal justice system and the service providers that act as first responders in cases of SGBV. This research study analyzes the existing gaps and flaws in the system so that a national plan can be formulated to prevent and address SGBV in a more systematic manner.

This mixed methods study was conducted in eight districts, Anuradhapura, Ampara, Puttalam, Hambantota, Nuwara Eliya, Kilinochchi, Mullaitivu, and Trincomalee. Data was collected using Key Informant Interviews, surveys, Focus Group Discussions and case studies. The Partner organizations, Rajarata Praja Kendraya in Anuradhapura, Affected Women's Forum in Ampara, Women Development Federation (WDF) in Hambantota, and We Lead Lanka Organization in Nuwara Eliya district supported the data collection at district level. Lead researchers Prof.Fazeeha Azmi and Menaka Lecamwasam prepared this research report. We thank the lead researchers, research assistants, partner organizations, project coordinators, enumerators, interviewers, translators, reviewer, quantitative data analyst, and most importantly the women victim-survivors of SGBV and service providers for their time and input.

The findings of this report can be used by researchers, academia, CSOs, like-minded organizations, and government institutions for their work on SGBV in Sri Lanka, and to advocate for impactful services for the victim-survivors and to improve the quality of services. CEJ hopes that the findings will contribute to wider calls for addressing SGBV in Sri Lanka.

Shyamala Gomez
Executive Director

Centre for Equality and Justice

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ACRONYMS AND ABBREVIATIONS

AWF	Affected Women's Forum
CBO	Community-based organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEJ	Centre for Equality and Justice
CID	Criminal Investigation Department
CMW	Convention on the Protection of the Rights of All Migrant Workers and Their Families
COVID-19	Coronavirus disease 2019
CSGBV	Cyber sexual and gender-based violence
CSO	Civil society organization
DCS	Department of Census and Statistics
DEVAW	Declaration on the Elimination of Violence Against Women
DV	Domestic violence
ESP	Essential Services Package
FGD	Focus group discussion
FGM	Female genital mutilation
FHH	Female-headed household
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HRCSL	Human Rights Commission of Sri Lanka
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDP	Internally displaced person
ILO	International Labor Organization
INGO	International non-governmental organization
IPV	Intimate partner violence
IT	Information technology
JMO	Judicial Medical Officer
KII	Key informant interview
LAC	Legal Aid Commission
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer or Questioning

LTTE	Liberation Tigers of Tamil Eelam
M&E	Monitoring and evaluation
MHPSS	Mental health and psychosocial support services
MoWCASS	Ministry of Women and Child Affairs and Social Security
MWDT	Muslim Women's Development Trust
NAP WPS	National Action Plan for the Implementation of the UN Security Council's Resolutions on Women, Peace and Security
NCPA	National Child Protection Authority
NGO	Non-governmental organization
PDVA	Prevention of Domestic Violence Act
PHM	Public Health Midwife
SAARC	South Asian Association for Regional Cooperation
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SLCERT	Sri Lanka Computer Emergency Readiness Team
SOP	Standard operating procedure
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNTOC	United Nations Convention Against Transnational Organized Crime
VAW	Violence against women
VV	Vital Voices
WDO	Women Development Officer
WHO	World Health Organisation
WIN	Women in Need



CHAPTER 1: INTRODUCTION

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

1 INTRODUCTION

1.1 Background of the Study

Sexual and gender-based violence (SGBV) is a pervasive issue in Sri Lanka, cutting across geographical, socio-economic, and cultural boundaries.¹ According to the 2019 Sri Lanka Women's Wellbeing Survey, 24.9% of women reported experiencing physical and/or sexual violence since the age of 15 by a partner or a non-partner.² During the COVID-19 pandemic, the Government of Sri Lanka did not prioritize the provision of services to address SGBV within its official COVID-19 response. This led to the worsening of existing conditions, increasing the risks for women due to enforced isolation, limited access to support systems and services, and delays in service delivery. The economic crisis of 2022 further exacerbated these issues as decreasing incomes and public unrest compounded existing vulnerabilities.³ Many SGBV support systems, such as police and government services, diverted their attention to managing the civil unrest during this period. As a result, victim-survivors were left without access to critical resources like hotlines and shelters, shortages.

The legacy of Sri Lanka's 26-year civil war continues to affect the prevalence of SGBV, particularly in the Northern and Eastern Provinces. During the war, sexual violence was used as a weapon, leaving women and girls in conflict zones particularly vulnerable.⁴ Ampara also hosts a large population of internally displaced persons (IDPs). Without state-issued documentation for identification and the physical security of a permanent home, IDPs are more vulnerable to human trafficking and related forms of SGBV. In the post-conflict period, progress in addressing these issues has been limited, with access to justice and support services remaining inadequate⁵. Structural barriers such as delays in the criminal justice system, lack of trained personnel, and stigma surrounding SGBV prevent many victim-survivors from speaking out and seeking help.

Sri Lanka's patriarchal society continues to perpetuate SGBV. Although women are predominantly literate, with a literacy rate of 91.5%,⁶ they have limited decision-making power both at home and in political or economic spheres. Cultural norms often cast women in homemaker roles while positioning men as breadwinners, despite women often serving as primary income earners, particularly in traditionally feminized jobs such as domestic work, garment manufacturing, and tea plucking. This disparity is coupled with low awareness of sexual and reproductive health (SRH), which further disempowers women.

These vulnerabilities of women are compounded in certain contexts, such as during the 2004 tsunami, the COVID-19 pandemic, and the recent economic crisis. Many women lost their incomes and assumed increased unpaid caregiving responsibilities as social support structures were disrupted. The soaring cost of living burdened families with not being able to secure essential medical care and food. In response, some households have adopted negative coping strategies which, combined with job and food insecurity, which further exposes women to risks of violence, including sexual

¹ Georgetown Institute for Women, Peace and Security, The 2021 Women, Peace, and Security Index. Washington, D.C.: Georgetown University, 2021, accessed June 17, 2024, <https://giwps.georgetown.edu/the-2021-women-peace-and-security-index/>.

² Department of Census and Statistics, Sri Lanka, World War Sri Lanka 2019 Final Report, Colombo: Department of Census and Statistics, October 2020, accessed June 17, 2024, http://www.statistics.gov.lk/Resource/reference/WWS_2019_Final_Report

³ UNFPA Sri Lanka, "UNFPA Appeals for \$10.7 Million to Meet Urgent Needs of 2 Million Women and Girls Affected by Economic Crisis," published August 8, 2022, accessed June 17, 2024, <https://srilanka.unfpa.org/en/news/unfpa-appeals-107-million-meet-urgent-needs-2-million-women-and-girls-affected-economic-crisis>.

⁴ Shyamala Gomez, Post-War Sri Lanka: Specific Needs of Sexual Violence Victims/Survivors and Children Born of Rape (2017, UN Women) ; International Truth and Justice Project Sri Lanka, "Silenced"-Survivors of Sexual Violence and Torture in 2015 (January 2016); UN Human Rights Council, Report of the Office of the United Nations High Commissioner for Human Rights on Promoting Reconciliation, Accountability and Human Rights in Sri Lanka, 16 September 2015, A/HRC/30/61

⁵ CPA, Accountability and Reparations for Victims of Conflict Related Sexual Violence in Sri Lanka (July 2016)

⁶ World Bank, "Literacy rate, adult female (% of females ages 15 and above) - Sri Lanka," World Bank Open Data, accessed June 17, 2024.

exploitation and abuse, as well as harmful practices such as child marriage and human trafficking.⁷ Additionally, austerity measures implemented in the aftermath of the economic crisis further constrained the state's capacity to deliver essential social services, leading to underfunding and institutional neglect. This confluence of factors has deepened the structural challenges faced by women, highlighting the urgent need for comprehensive support and intervention.

The Policy Framework and National Action Plan to address SGBV (2016–2020) sought to combat violence through prevention, intervention, and advocacy. However, implementation was hindered due to weak coordination and insufficient resources. The newly proposed National Action Plan (2024–2028) aims to address these gaps by focusing on multi-sectoral collaboration. Despite these efforts, the lack of an independent commission for women, which has been under discussion for over 20 years, highlights the slow pace of institutional reform.

Existing services for SGBV victim-survivors in Sri Lanka include both state and non-state actors, such as civil society organizations (CSOs) and community-based organizations (CBOs). However, these services are fragmented and often inaccessible to the most vulnerable groups. Key challenges include:

- Lack of trained psychologists, medico-legal experts, and gender-sensitive law enforcement personnel.
- Structural impediments, including prolonged legal processes (cases of rape can take up to 15 years to resolve) and economic barriers that deter victims from seeking justice.
- Societal stigma and victim-blaming attitudes that discourage victim-survivors from reporting incidents.⁸
- Inadequate protection mechanisms for victim-survivors and witnesses within the criminal justice process.
- The lack of political will to prioritize SGBV, resulting in insufficient funding and resource allocation to relevant services as well as weak enforcement of existing laws and policies.

Against this backdrop, the current study aims to map existing services and identify gaps in SGBV prevention and response mechanisms in Sri Lanka. By examining both state and non-state interventions, the research provides actionable recommendations to improve service delivery, accessibility, and survivor support. The recommendations are intended to inform policy development, strengthen advocacy efforts, and foster collaboration among key stakeholders.

1.2 Objectives and Scope of the Study

This study was conducted between May 2022 and December 2024 to serve as an advocacy tool for enhancing SGBV prevention and service provision for women and girls across Sri Lanka. Data were collected from 888 adult women (above 18 years of age), who are victim-survivors of SGBV, as well as 109 state and non-state service providers across eight districts in Sri Lanka. The study focuses on the period from 2014 to 2024 to capture significant socio-political changes that have influenced both the prevalence of SGBV and SGBV service provision in the country.

⁷ UNDP, "Humanitarian Needs and Priorities: Gender-Based Violence," final program document, July 2022, accessed January 31, 2025, https://mptf.undp.org/sites/default/files/documents/2022-07/hnpp-gbv-final_programme_document_gw.pdf.

⁸ Women In Need, compiled June 2019, accessed June 17, 2024, <https://asiafoundation.org/wp-content/uploads/2021/09/Sri-Lanka-Inside-Justice-Summary-Report.pdf>.

Overall Objective

To strengthen SGBV service provision and prevention mechanisms in Sri Lanka, ensuring accessible, effective, and sustainable support systems for women and girls affected by SGBV.

Specific Objectives

1. Assessing Impact and Effectiveness:

The study aims to evaluate the performance of previously established task forces, policy frameworks, and service initiatives addressing SGBV. The study analyzes the extent to which these measures meet the needs of victim-survivors and identifies systemic gaps that hinder their effectiveness. The purpose is to propose actionable steps to enhance SGBV prevention and improve service delivery mechanisms across various regions.

2. Documenting Lessons Learned:

Through a comprehensive mapping exercise, the study identifies key lessons from existing interventions and highlights successful practices implemented by civil society actors, state agencies, and other stakeholders. These insights can contribute to the development of more sustainable and impactful approaches to SGBV prevention and response, ensuring a victim-survivor-centered and inclusive perspective.

3. Developing Practical Recommendations:

Building on the findings, the study offers practical recommendations tailored to meet the needs of policymakers, civil society actors, and service providers. These recommendations emphasize strengthening access to justice for victim-survivors, improving the quality and accessibility of SGBV prevention and response services, and raising awareness among stakeholders to foster coordinated action. The study also encourages stronger government engagement and accountability to ensure the effective implementation of these measures.

4. Fostering Collaboration and Networking:

To enhance the impact and sustainability of SGBV interventions, the study seeks to create opportunities for collaboration and dialogue between state and non-state actors. This includes exchanging perspectives, sharing lessons learned, and establishing robust networks to implement the report's recommendations effectively. Strengthening these partnerships will ensure a holistic and multi-sectoral approach to addressing SGBV.

1.3 Research Questions

The research seeks to understand the complex dynamics of SGBV in Sri Lanka, focusing on the official response to SGBV and the provision of SGBV support services. Within this context, the study also examines the prevalence and underlying causes of SGBV in order to assess the effectiveness of existing response mechanisms. The findings aim to inform strategies to strengthen legal frameworks, improve service accessibility, and address gaps in justice delivery.

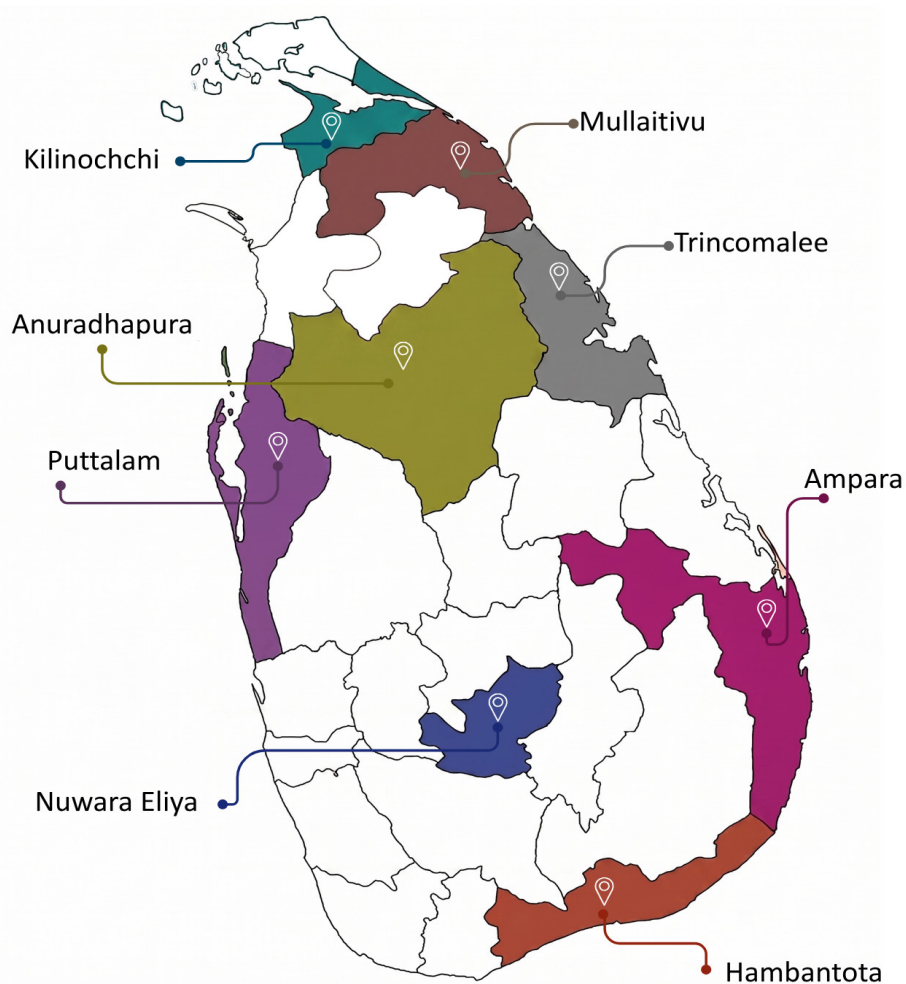
The following research questions guided the study:

1. What forms of SGBV against women are prevalent in Sri Lanka?
2. What factors influence the perpetration of SGBV against women in Sri Lanka?
3. How effective is the legal and policy framework governing the prevention of SGBV, and does it adequately respond to the needs of women victim-survivors of SGBV?
4. What is the scope of services available for women victim-survivors of SGBV, including the range of services, quality of delivery, accessibility, resource availability, and referral mechanisms?
5. Does the current service provision, including services required to access and navigate the criminal justice process, enable women victim-survivors to receive justice?
6. What lessons learned can inform a more effective and sustainable intervention for SGBV prevention and service provision for women victim-survivors?

1.4 Study Locations

The study focused on eight districts representing diverse socio-economic, cultural, and geographic contexts. These include conflict-affected areas, plantation-based economies, and urban-rural regions.

Figure 1: Study locations



Northern Province: Kilinochchi District

Battered by the war until its concluding stages, Kilinochchi remains one of the most impoverished districts in Sri Lanka. According to the estimated mid-year population data published by the Department of Census and Statistics (DCS), in 2024, the total population of the district is 137,000, in which 66,000 are males and 71,000 are females.⁹ The Department of Census and Statistics' poverty indices show that 23% of the households in Kilinochchi fell below the official district poverty line. This is significantly higher than the percentage of poor households in other districts based on respective district poverty lines.¹⁰ The presence of war-affected women, women heads of households, and communities experiencing caste-based marginalization has increased women's vulnerability. Poverty and economic deprivation have also made women vulnerable to SGBV, particularly in the form of sexual bribery. Women are amongst those who have been displaced by the war, and they currently undertake multiple jobs to make ends meet. Exposure to traumatic events, coupled with the pandemic situation, has exacerbated the challenges they were already facing. Patriarchal dominance observed in this district continues to have serious implications when it comes to dealing with matters of SGBV.

Northern Province: Mullaitivu District

Mullaitivu is one of the five districts in the Northern Province. According to the Department of Census and Statistics (2025), the total estimated mid-year population of the district in 2024 is at 123,000, of which 60,000 are males and 63,000 are females.¹¹ The district sustained the worst damages from 26 years of war and the 2004 Indian Ocean tsunami. Both these incidents, while of different but overlapping time spans, resulted in the loss of lives, livelihoods, and properties, as well as in large-scale displacement of people. Even though it has been a decade and a half since the end of the war, the district faces a myriad of problems. The legacy of war continues to impose difficulties associated with access to land, economic opportunities, and psychological trauma, thus increasing the residents' vulnerability and poverty. Women and children are at particular risk. The district has a high number of widows. According to research there are 7,200 female-headed households (FHHs) in Mullaitivu. Among them, 5,460 are widowed, 1,477 families experienced separation or divorce, 116 husbands went missing, 94 women remained unmarried, and 34 FHHs emerged due to other circumstances.¹² Many of these were a direct result of the war, particularly the spouse's death, enforced disappearance, imprisonment and disability.¹³ These women continue to experience the impacts of war and struggle to fulfil their new and unfamiliar responsibilities. Many women, including ex-combatants, encounter different types of SGBV, and there are several noting that figures are not reflective of reality as a result of under-reported reporting cases due to socio-cultural reasons, stigma, and impunity.

Eastern Province: Trincomalee District

Located in the Eastern Province, Trincomalee has a total population of 443,000 according to the Department of Census and Statistics, with the number of females (225,000) outnumbering that of males (218,000).¹⁴ In Trincomalee the Sinhalese account for 24.5%, Tamils 28.9%, Muslims 46.1%, and others account for 0.5%.¹⁵ According to the 2012 Census of Population and Housing, Trincomalee

⁹ Department of Census and Statistics, Sri Lanka, Vital Statistics, published October 2025, accessed May 1, 2026, <http://www.statistics.gov.lk/Population/StaticalInformation/VitalStatistics>.

¹⁰ Department of Census and Statistics, Sri Lanka, Pocket Book of Statistics 2025, accessed May 1, 2026, <https://www.statistics.gov.lk/Publication/PocketBook2025>.

¹¹ DCS 2025 (n9).

¹² Research and Publications Committee, *Policy for PhD and MPhil Program*, accessed June 17, 2024, https://sm.bdu.ac.in/uploads/research/submissionAttach/publishAttach/publish2_2_1506_20231214165227.p

¹³ Maatram, பல சவால்களுக்கு மத்தியில் சாதனை படக்கூடும் மூல்லை மாவட்ட படுண் தலமைத்தாவ கூடும்பங்கள், accessed January 27, 2025. <https://maatram.org/articles/11681>

¹⁴ DCS 2025 (n9).

¹⁵ Department of Census and Statistics, Sri Lanka, Population by ethnic group according to districts, 2024, accessed May 1, 2026, <https://www.statistics.gov.lk/Population/StaticalInformation/CPH2024>.

has the highest literacy rate in the Eastern Province which stands at 93.5% (95.5% among males and 91.7% for females). Trincomalee's economy, which was heavily affected by the 26 years of civil war, is mainly dependent on agriculture and fishing. It has a 50 Km coastline, where tourism-based economic activities provide livelihoods for many. The strategic location of the natural harbor in the district indicates potential for economic development. Despite post-war progress, Trincomalee continues to face socio-economic and political challenges. A study in post-conflict districts found that child marriage rates increased from 4.4% in 2012 to 8.9% in 2017, including in Trincomalee.¹⁶ Reports also document incidents of SGBV amongst IDPs living in camps in Trincomalee,¹⁷ similar to patterns observed in other districts in the Northern and Eastern provinces of Sri Lanka.

Eastern Province: Ampara District

Situated in the Eastern Province, Ampara has a population of 745,000, consisting of a higher number of females (391,000) than males (354,000).¹⁸ It is another district which was heavily affected by the civil war. Nearly one-third of households are FHHs (32.9%),¹⁹ and Ampara hosts a large IDP population whose women face increased vulnerability to SGBV. Furthermore, Ampara has experienced ethnically charged violence against its Muslim population, often caused by Sinhala-Buddhist extremists during the post-war period under the guise of thwarting attempts of alleged coerced sterilization of Sinhala-Buddhist women. Muslim women in this district face additional challenges, including the practice of female genital mutilation (FGM)²⁰ and the absence of reforms to the Muslim Marriage and Divorce Act. In the recent past, extreme forms of SGBV such as gang rape (inflicted upon local and foreign women) have been reported with subsequent impunity of the perpetrators and lack of legal redress for the victim-survivors.

North Western Province: Puttalam District

Located in the North Western Province, Puttalam has a total population of 818,000, with females (424,000) outnumbering males (394,000).²¹ Since the 1990s, Puttalam has witnessed a significant change in its demographic structures as a result of forced internal displacement due to the war. These waves of displacement considerably altered the social, economic, political, and cultural landscape of the district. Competition for resources, livelihoods, education and services intensified, creating challenges for both host and displaced communities. In the post-war period, issues related to return, relocation, and local integration, have continued to generate frustration and hardship, especially affecting the daily lives of women. There are many non-governmental organizations (NGOs), CSOs, CBOs, and international non-governmental organizations (INGOs) working in the district. District data also indicates the prevalence of domestic violence. The 2016 demographic and health survey found that 16.2% of women interviewed in the district have experienced domestic violence at least once, but only 28.1% of those victim-survivors have sought help.²² Puttalam's main city also functions as a transit hub, where the prevalence of sex work, and the accompanying exploitation, marginalization, and abuse by both the state and society remains high.

¹⁶ CEJ, Lost Childhoods In War: Child 'Marriage' Or Early Cohabitation In War Affected Districts Of Sri Lanka, published 2018, accessed January 29, 2025, https://cejsrilanka.org/wp-content/uploads/A4_Child-Marriage_infograph_V7.pdf

¹⁷ Megara Tegal, Today is International Day of the Girl Child Child marriage in Sri Lanka : A 2% too much, Sunday Observer, published October 11, 2015, accessed January 29, 2025, <https://archives.sundayobserver.lk/2015/10/11/spe-wom-01.asp>

¹⁸ DCS 2025 (n9).

¹⁹ Department of Census and Statistics, Sri Lanka, Census of Population and Housing – 2024: Final Report, accessed May 1, 2026, https://www.statistics.gov.lk//Resource/en/Population/CPH_2024/CPH2024_Final_Eng.pdf.

²⁰ Mannar Women's Development Federation (MWDF) and the World Organisation against Torture (OMCT) (2022). "Submission to the Universal Periodic Review of Sri Lanka". https://upr-info.org/sites/default/files/country-document/2023-03/JS5_UPR42_LKA_E_Main.p

²¹ DCS 2025 (n9).

²² Department of Census and Statistics (DCS), Sri Lanka Demographic and Health Survey 2016, accessed June 7, 2024, <https://www.aidsdatahub.org/sites/default/files/resource/srilanka-dhs-2016.pdf>.

Central Province: Nuwara Eliya District

Situated in the Central Province, Nuwara Eliya has a population of 726,000 and consists of a higher number of females (379,000) than males (347,000).²³ The district is home to an estate worker population of 380,274, which represents 52.5% of the district population.²⁴ These workers have been employed in tea, rubber, and other crop estates for generations. Nuwara Eliya has the highest multidimensional poverty rate in Sri Lanka (44.2%),²⁵ and the estate sector suffers from various socioeconomic issues due to low wage rates, poor infrastructure facilities, and limited access to quality education.²⁶ This minority population has been marginalized within the state's overall economic and legal policy-making processes. These issues, coupled with heavy alcohol consumption, has led to the high prevalence of domestic violence and other forms of SGBV in the district.²⁷ Victim-survivors face obstacles when obtaining medico-legal assistance and/or other types of SGBV services due to language limitations and poor physical accessibility. While trade unions hold substantial power and influence within this community, they tend to remain silent on issues of SGBV.

North Central Province: Anuradhapura District

Anuradhapura is the largest district in Sri Lanka, spanning over 7,000 square kilometres, with a population of 959,000.²⁸ The population comprises a higher number of females (493,000) than males (466,000) and over 90% of the population are Sinhala-Buddhist. It spans a written history running back to the 3rd Century BC as Sri Lanka's first ancient kingdom, at times led by female monarchs. Despite being progressive in the past, presently Anuradhapura lags in the protection it affords to women.²⁹ The district served as a key military coordination center during the Sri Lankan civil war. This has resulted in a high number of war widows and FHHs in the district. As of 2019, Anuradhapura had one of the highest proportions of FHHs (29.2%) among all 25 districts of Sri Lanka. Limited socio-economic opportunities and inadequate state assistance have driven many women into exploitative microfinance schemes and, in some cases, subsequent sexual bribery.

Furthermore, patriarchal ethno-religious values and societal norms have made women in Anuradhapura vulnerable to domestic violence and other forms of SGBV. Underage marriage is also a common practice in the district, often justified as a means of protecting the physical safety of girls. However, this curtails education and the employment prospects, thereby perpetuating a vicious cycle of dependence.

Southern Province: Hambantota District

Located in the Southern Province, Hambantota has a population of 671,000 and consists of a higher number of females (342,000) than males (329,000).³⁰ Over the past decade, Hambantota has been subject to rapid infrastructural development with the construction of the Southern Expressway,

²³ DCS 2025 (n9).

²⁴ DCS 2024 (n19).

²⁵ UNICEF Sri Lanka, "Multidimensional Poverty in Sri Lanka," accessed June 17, 2024, <https://www.unicef.org/srilanka/media/2371/file/Multidimensional%20Poverty%20in%20Sri%20Lanka.pdf>.

²⁶ Verité Research, "Hill Country Tamils: Analysis of Legal and Policy Issues Affecting Labour and Governance Structure," published February 2022, accessed June 17, 2024, https://www.veriteresearch.org/wp-content/uploads/2022/07/VR_EN_RR_Jul2022_Hill-Country-Tamils-Analysis-of-Legal-and-Policy-Issues-Affecting-Labour-and-Governance-Structure.pdf. and Verité Research, "Hill Country Tamils of Sri Lanka Report," published August 2019, accessed June 17, 2024, https://files.nstitutesi.org/Hill_Country_Tamils_Of_Sri_Lanka_Report.pdf.

²⁷ Institute of Social Development Kandy, "A Study on GBV and Discrimination at Home in the Plantation Sector: Final Report," published June 2022, accessed June 17, 2024, <https://www.isdkandy.org/wp-content/uploads/2022/06/A-Study-on-GBV-and-Discrimination-at-Home-in-the-Plantation-Sector.pdf>. and UNICEF Sri Lanka, "Socioeconomic Conditions Faced by Women and Children in Tea Estates in Sri Lanka," published 2023, accessed June 17, 2024, <https://www.unicef.org/srilanka/media/4271/file/SOCIOECONOMIC%20CONDITIONS%20FACED%20BY%20WOMEN%20AND%20CHILDREN%20IN%20TEA%20ESTATES%20IN%20SRI%20LANKA.pdf>.

²⁸ DCS 2025 (n9)

²⁹ DCS 2016 (n22).

³⁰ DCS 2025 (n9).

Hambantota International Port, and Mattala International Airport. However, socio-economic progress among those who live in rural Hambantota is yet to materialize. Women and girls in these patriarchal rural areas in Hambantota experience SGBV from an early age, often at the hands of close relatives. Following the 2004 tsunami, SGBV incidents in the district increased, as many displaced persons lived in insecure temporary shelters and unemployment and alcohol consumption increased among men from the coastal areas. In recent years, similar to Ampara, incidents of extreme SGBV such as gang rape (including of children) have been reported from Hambantota with limited law enforcement intervention.³¹

1.5 Methodology

1.5.1 Approach

Desk Review

A desk review of previous mappings, studies on SGBV service provision and other relevant literature was undertaken to ascertain the issues studied in the past and identify gaps to inform the present mapping. Past studies provided deeper insights into the forms of violence faced by women, the relevant legal and policy framework, SGBV prevention mechanisms, and services available to victim-survivors of SGBV. The desk review also supported the identification of key stakeholders to include in the mapping. The outcome of the desk review forms part of the findings of this report. The desk review was also instrumental in informing the development of the tools for the initial mapping exercise and consultations, which were finalized in consultation with the technical team at Vital Voices.

Initial Mapping Exercise (33 interviews)

An initial mapping exercise preceded the research with the aim of obtaining a clearer image of the current context of SGBV service provision in the target districts. The exercise consisted of two parts:

1. Online research to collect secondary data, from various open sources such as the Department of Census and Statistics, District/Divisional Secretariats, Police, and other state and non-state service providers.
2. Remote interviews 33 with stakeholders, including representatives of local-level CSOs, medical professionals, lawyers working on SGBV, police officers from children and women's desks, counselling officers from divisional secretariats, and local-level activists, depending on their availability.

Initial Consultations with Service Providers (40 interviews)

An interview guide in Sinhala, Tamil, and English was developed and administered to gain a preliminary understanding of stakeholders' approaches to addressing SGBV, the range and accessibility of services, challenges in service provision, and best practices. A list of 20 stakeholders was compiled by the research team for each district. This included representatives of CBOs, CSOs, government officials, police, journalists, academics/researchers, lawyers, faith-based institutions, women activists, etc. In each of the eight districts, five stakeholders from the list were interviewed based on their availability and willingness to participate. In total 40 key informant interviews (KIIs) were conducted. These interviews informed the methodology and data collection tools for Phases II and III of the study.

³¹ Ada Derana, "Gang-raped teen girl attempts suicide after writing a letter" January 12, 2018, accessed June 17, 2024, <http://www.adaderana.lk/news.php?nid=45355>.

Development of Data Collection Tools

Insights from the desk review, mapping exercise, and initial consultations with stakeholders informed the development of substantive data collection tools. Separate tools were developed for different respondent categories in Sinhala, Tamil, and English. All tools underwent pilot testing to identify and address potential gaps before being administered to respondents.

1.5.2 Data Collection

In addition to the secondary data collected from the desk review conducted as part of this study (mentioned under section 1.5.1 above), primary data was collected as described below:

Quantitative Surveys with Women (820 interviews)

The quantitative survey was conducted with women in the target districts using a structured questionnaire. A total of 820 women, representing diverse demographic and social backgrounds, were surveyed across the eight selected districts. Respondents were selected purposively by partner organizations and district staff of Viluthu and the Centre for Equality and Justice (CEJ) based on their experiences of and/or surrounding SGBV service provision. Prior to data collection, enumerators were trained on ethical data collection techniques, confidentiality protocols, and how to handle potential sensitive issues that arose during interactions.

The data collected provided insights into the prevalence and forms of SGBV, women's experiences with and perceptions of service providers, and barriers to accessing justice and support services.

Demographic characteristics of the respondents

Table 1 below shows the basic demographic and socio-economic characteristics of the respondents.

Table 1: Demographic and socio-economic characteristics of respondents

Variable	Percentage	Number
Rural or Urban		
Rural	89.3	732
Urban	10.7	88
Ethnicity		
Sinhala	27.4	225
Sri Lankan Tamil	44.9	368
Malaiyaga Tamil (Up-country Tamil)	12.0	98
Muslim	15.7	129
Religion		
Buddhism	27.1	222
Hinduism	47.6	390
Islam	15.7	129
Roman Catholicism	6.0	49
Christianity (Non-Roman Catholic)	3.4	28
No Response	0.2	2
Civil Status		
Never married	5.9	48

Currently married	41.0	336
Cohabiting with a man, not married	0.4	3
Cohabiting with a woman, not married	0.1	1
Spouse has been disappeared	0.7	6
Abandoned	8.7	71
Separated	24.6	202
Divorced	6.8	56
Widowed	9.5	78
No Response	2.3	19

Accordingly, 89.3% of the respondents were from rural areas while 10.7% were from urban areas. In terms of civil status, a majority of respondents were married (41%), while 24.6% were separated, 9.5% were widowed, 8.7% were abandoned by their partners, 6.8% were divorced, and 5.9% of the respondents were never married.

In terms of ethnicity, a majority of the respondents were Sri Lankan Tamils (44.9%), followed by Sinhalese (27.4%), Muslims (15.7%) and Malaiyaga Tamils (12%). In terms of religion, 47.6% identified as Hindus 27.1% as Buddhists, 15.7% as Muslims, 6% as Roman Catholics, and 3.4% as Christians.

Qualitative Interviews with Service Providers (41 KIIs)

A total of 36 KIIs were conducted with state and non-state service providers at the district-level (four to five KIIs per district). In addition, 5 KIIs were conducted with national-level stakeholders. These interviews were conducted with police officers, healthcare providers, legal aid officials, social workers, and representatives from women's and children's desks. The interviews explored the effectiveness, accessibility, and quality of services offered by state institutions, as well as the challenges faced in providing these services.

Focus Group Discussions with Non-State Service Providers (8 FGDs)

Focus group discussions (FGDs) were held with non-state service providers, one in each of the eight target districts. Participants included representatives from CSOs, CBOs, and NGOs involved in SGBV prevention and victim-survivor support. The FGDs captured diverse perspectives on service provision, best practices, gaps in current systems, and recommendations for improvements.

Focus Group Discussions with Women Victim-Survivors (8 FGDs)

FGDs were conducted with women victim-survivors, one in each of the eight target districts, to gather qualitative data on their lived experiences. Each FGD included women from different socio-economic backgrounds who had experienced SGBV.

Case Studies with Women Victim-Survivors (24 Case Studies)

In addition to the FGDs, a total of 24 case studies (3 per district) with women victim-survivors were documented to provide in-depth insights into the challenges faced by individual victim-survivors, their interactions with service providers, and the outcomes of their cases.

The secondary and primary data gathered through the methods described above were analyzed to develop the findings of this study and to formulate recommendations for strategies to enhance SGBV service delivery to victim-survivors in Sri Lanka.

1.5.3 Ethical and Safety Considerations

Ethical considerations were central to the data collection process. All tools were developed using a survivor-centered and trauma-informed approach and avoided intrusive or unnecessary lines of questioning.

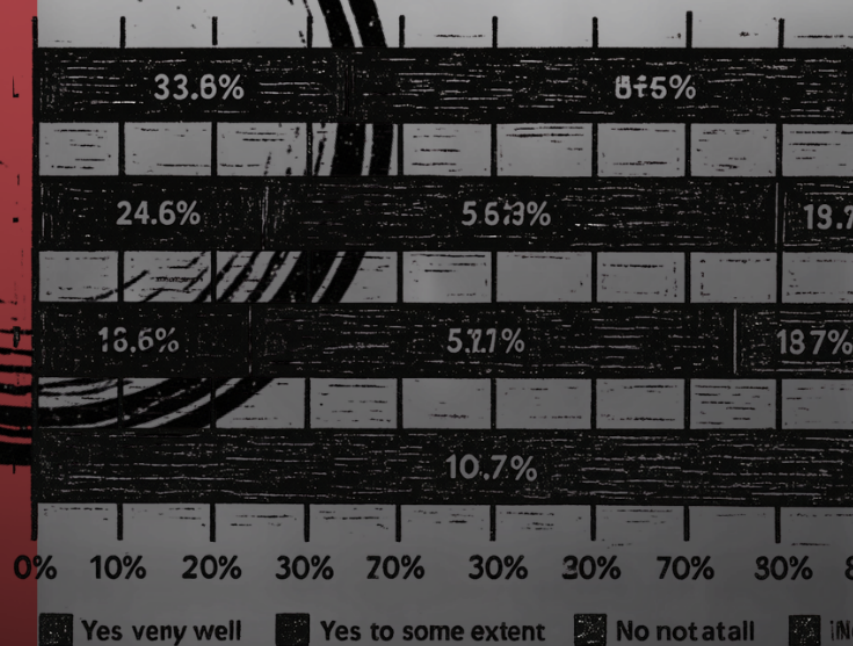
Prior to commencing any data collection activities, informed consent was obtained from all respondents. Each participant was briefed on the objectives of the study, the voluntary nature of their participation, and their right to withdraw at any stage without providing justification. Confidentiality and anonymity were maintained throughout the data collection process, and special care was taken to ensure the participants' safety and emotional well-being during interviews and discussions. Enumerators and researchers received training on handling sensitive topics and recognizing signs of distress among respondents. Counselors were present during the FGDs to support victim-survivors, and referrals for counselling were provided to victim-survivors where needed.

1.5.4 Participatory Approach

The study adopted a participatory approach throughout the research process. First, initial consultations were conducted with key stakeholders to help map the status quo of SGBV services at the time of commencing the research. These findings also informed the development of data collection tools. Second, representation was included as a key focus of the research methodology, with respondents drawn from various stakeholder groups and across diverse social groups. Data from qualitative interviews also ensured that the experiences of different groups were considered in the analysis. Third, a validation session was conducted with key stakeholders following data collection and analysis, to confirm the study's findings. The recommendations in this report also include some insights shared by participants at the validation session.

1.6 Limitations

- The absence of a centralized governance structure for reporting, monitoring, documenting, and coordinating services related to SGBV limits a comprehensive understanding of all existing services. This report is based on information provided by various service providers and victim-survivors surveyed and interviewed for the study, as well as on the knowledge and expertise of the research team. Therefore, the report may not reflect all available information or services.
- While it is acknowledged that SGBV is also perpetrated against men and boys in Sri Lanka as highlighted in several studies, the current study specifically focuses on women's experiences, the challenges they face, and the gaps in SGBV prevention and response, particularly since women are often overlooked when developing national plans and strategies. However, the study team acknowledges that this poses a limitation, and that by not engaging with male victim-survivors, the study does not provide a comprehensive understanding of the prevalence, nature, and impact of SGBV on all genders.
- Two key elections were held in Sri Lanka during the period assigned for data collection. This affected some timelines for and methods of data collection. Specific concerns that affected data collection include additional duties assigned to state sector employees that impacted their availability for participation, avoiding perceived bias in data collection, and ensuring the safety of researchers. Accordingly, some data collection activities were postponed until after the elections, and some qualitative interviews with service providers were conducted online.



CHAPTER 2: SITUATIONAL ANALYSIS OF THE INCIDENCE OF **SGBV** IN SRI LANKA

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

2. SITUATIONAL ANALYSIS OF THE INCIDENCE OF SGBV IN SRI LANKA

SGBV is widely prevalent in Sri Lanka. Within the present study alone, qualitative data records a range of harms, including harassment of women on public transport; domestic violence including physical, sexual, psychological, and verbal abuse; rape; and human trafficking. The Sri Lanka Women's Wellbeing Survey conducted in 2019 reports that one in four women (24.9%) have experienced sexual and/or physical violence since the age of 15 and two in five women (39.8%) have experienced physical, sexual, emotional, and/or economic violence and/or controlling behaviors by a partner in their lifetime.³²

While SGBV pervades all strata of Sri Lankan society, the forms of violence experienced by women may change based on where they live and their socio-economic status. SGBV against women (by male perpetrators) is most common in Sri Lanka, although some cases of SGBV against men (including by female perpetrators) are also reported. The high prevalence of SGBV, particularly against women may largely be attributed to entrenched patriarchal norms and male dominance within Sri Lankan society. The rate of literacy among women in Sri Lanka is high. In 2019, the literacy rate of amongst women aged 15 and above in Sri Lanka was 91.5%.³³ Sri Lankan women also contribute to the workforce through both formal and informal employment. Female labor force participation in Sri Lanka is 34%, which is higher than the South Asian regional average of 22%.³⁴ Despite this, women are only minimally involved in decision-making in both public and private spheres. Stereotypical gender roles, alongside lack of education and awareness about sexual and reproductive health, create an environment conducive to SGBV.

In this broader context, two central concerns emerge when mapping services and service provision addressing SGBV in Sri Lanka: levels of awareness about SGBV and its diverse forms both among community members and service providers, and SGBV reporting (or under-reporting) practices among victim-survivors.

2.1 Forms of Sexual and Gender-Based Violence

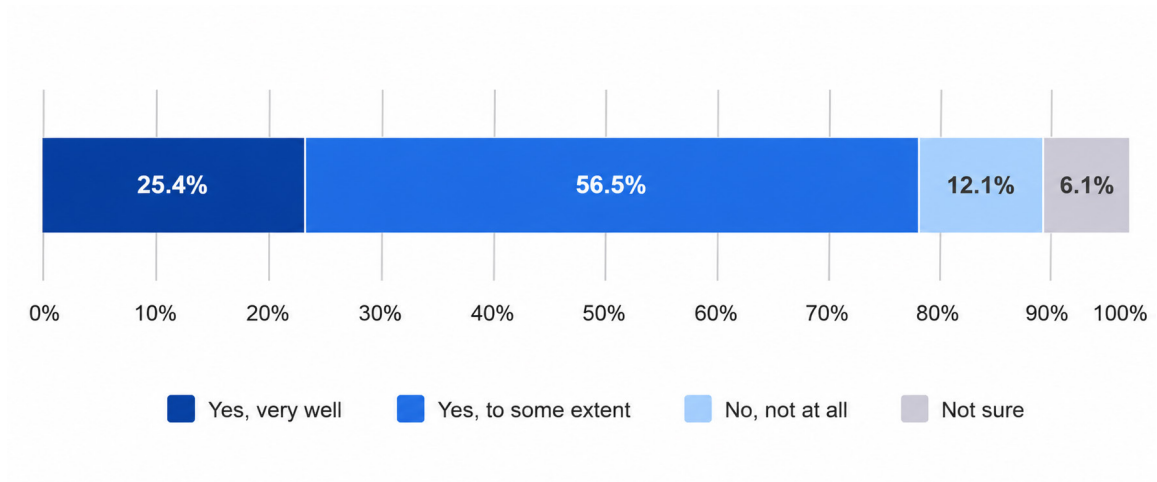
The first concern is the need to understand the extent of knowledge on SGBV and its diverse forms among both women and service providers. While there may be discrepancies between perceived and actual knowledge, an evaluation of women's self-reported knowledge provides valuable insights into their awareness of SGBV.

³² Department of Census and Statistics, Sri Lanka, "Sri Lanka Women's Wellbeing Survey 2019 - Final Report, accessed June 17, 2024, http://www.statistics.gov.lk/Resource/refference/WWS_2019_Final_Report.

³³ World Bank, "Literacy rate, adult female (% of females ages 15 and above) - Sri Lanka," World Bank Open Data, accessed June 17, 2024.

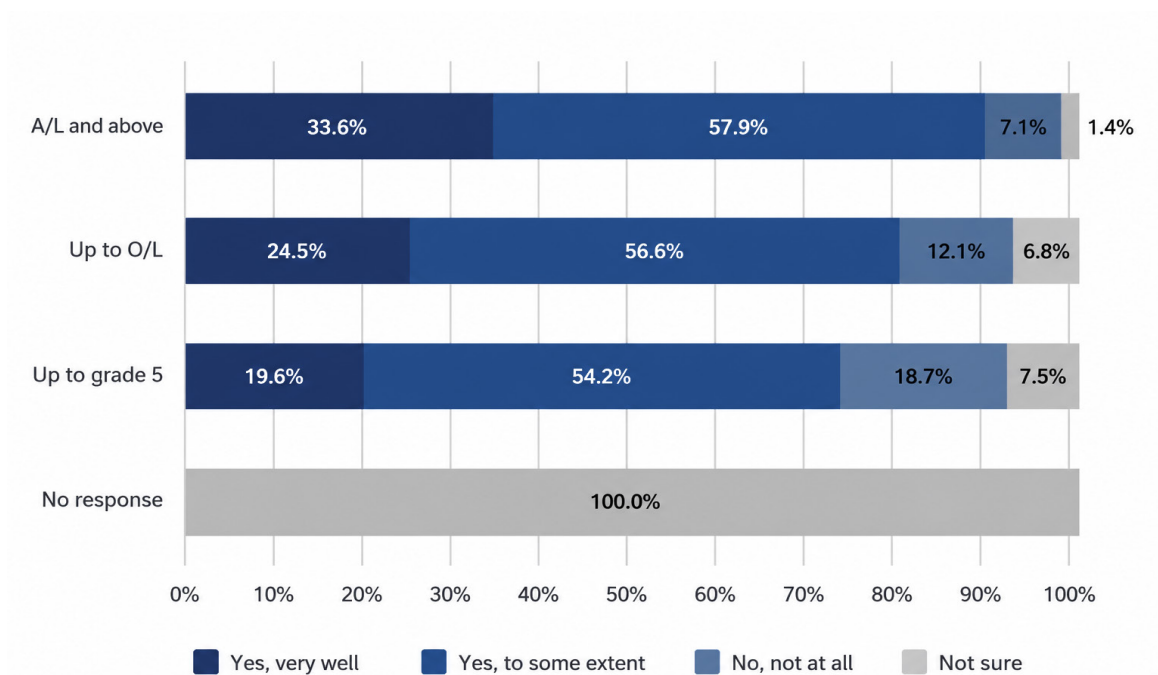
³⁴ World Bank, "Labour force participation rate, female (% of female population ages 15+) (modelled ILO estimate) - South Asia," World Bank Open Data, accessed June 17, 2024, <https://data.worldbank.org/indicator/SL.TLF.TOTL.FE.ZS?locations=8S>

*Figure 2: Knowledge of sexual and gender-based violence
(Source: interviewed women)*



As per Figure 2 above, a significant majority of respondents reported having knowledge of SGBV. At least one in four respondents (25.4%) self-assessed their knowledge of SGBV as very good, while over half the sample (56.5%) indicated some level of understanding of SGBV.

*Figure 3: Knowledge of sexual and gender-based violence disaggregated by level of education
(Source: interviewed women)*



As demonstrated in Figure 3, a positive correlation was observed between self-reported awareness of SGBV and educational attainment. Findings suggest that knowledge about SGBV tends to increase as education levels advance. Among respondents with advanced level or higher education, 33.6% reported stronger knowledge of SGBV, compared to 24.5% of those educated up to ordinary level and 19.6% of those educated up to grade 5.

The literature review and primary qualitative data yielded diverse forms of SGBV perpetrated in Sri Lanka. Identified forms of SGBV include:

Physical violence: The 2019 Women's Wellbeing Survey reports that 7.2% of women in Sri Lanka have been subjected to physical violence by non-partners, while 18.9% of the women have been subject to physical violence by partners.³⁵ A study in 2020 with 488 women receiving care at two hospitals in Colombo found that 64.5% of respondents had been subjected to physical violence.³⁶ In 94% of the cases, the perpetrator had been either the husband or an intimate partner.

Victim-survivors interviewed for the current study also reported experiencing various forms of physical violence. One respondent described in detail the physical violence her partner inflicted on her, including slapping and hitting her, and breaking her arm. Another recounted being beaten, strangled and suffocated by her partner. Some women also reported being assaulted on the street by unknown assailants and sustaining severe physical injuries as a result.

"Physical violence cannot be differentiated from sexual violence. These two are interconnected. For example, a complaint is made that the husband is beating his wife, and it is revealed only during the investigation that there is sexual violence along with physical."

Non-state service provider, Mullaitivu

Sexual violence: Sexual violence is also a pervasive issue, manifesting in various forms. A 2015 study by United Nations Population Fund (UNFPA) found that a staggering 90.1% of women aged 15-35 years have experienced sexual harassment on public transport at least once in their lifetime.³⁷ This highlights the constant threat women face in public spaces. Furthermore, the 2019 Women's Wellbeing Survey reveals that 6.8% of women in Sri Lanka have been subjected to sexual violence by partners, while 4.1% have experienced sexual violence by a non-partner.³⁸

"Sexual violence against young girls is increasing. When women remarry, their daughters are sexually exploited by their stepfathers."

Victim-survivor, Kilinochchi

"He forces me to have sex every day... I was stressed every day."

Victim-survivor, Ampara

Psychological/emotional violence: These forms of violence frequently co-occur with other forms of abuse, such as physical and sexual violence. The study conducted at the two Colombo hospitals found that almost all respondents (94.3%) had suffered emotional violence. This form of violence

³⁵ Department of Census and Statistics (2019) (n30)

³⁶ Dasuni Yahanika Pathiraja , Ramya Priyanwada Pathiraja , Lakshmen Senanayake , Rukshani Mayawanthi Edirisinghe , and Nethanjalie Mapitigama, 'Gender-based violence: Experiences from two tertiary care settings in Sri Lanka' (2020). <http://dr.lib.sjp.ac.lk/bitstream/handle/123456789/12391/Gender-based%20violence%20Experiences%20from%20two%20tertiary%20care.pdf?sequence=1&isAllowed=y>

³⁷ UNFPA. (2018). Does She Travel Safe? Report on Sexual Harassment in Public Transportation in Sri Lanka. https://srilanka.unfpa.org/sites/default/files/pub-pdf/Online_DoesSheTravelSafe_Report%201032019-compressed_1.pdf

³⁸ Department of Census and Statistics (2019) (n30)

often manifests as verbal abuse, including the use of derogatory language, unfounded accusations and victim-survivor blaming.³⁹ A major concern with this form of violence is that it has become so normalized that it is under-recognized as a form of SGBV, not only by victim-survivors, but also by service providers.

“His constant accusations about my character broke me emotionally.”

“Every argument felt like a battle I was losing. He would dismiss my feelings and make me question my worth.”

Victim-survivor, Nuwara Eliya

“He accused me of not providing food or tea and blamed me for not being intimate after my cesarean section.”

Victim-survivor, Nuwara Eliya

Economic violence: This form of SGBV exploits women’s financial dependence or limited access to employment and income and can have a two-fold impact. On one hand, there is a feminization of poverty caused by factors such as discriminatory inheritance rights, and discrimination in the labor market through low wage and negligence.⁴⁰ Many women are compelled to work in poorly regulated, precarious conditions such as sex work (which is illegal to solicit and hence remains unregulated), manpower labor, and migrant labor.⁴¹ On the other hand, household poverty is often tied to other forms of SGBV such as domestic violence (DV) and intimate partner violence (IPV). In 2016, a survey by the DCS found a significantly higher prevalence of violence among women from households in the lowest wealth quintile.⁴² Women facing economic hardship are also preyed upon by micro credit schemes that exploit their vulnerability.⁴³

“There are so many microfinance companies now, and it’s common for women to take multiple loans. When they struggle to repay, some staff members may exploit or mistreat them.”

Service provider, Nuwara Eliya

Cyber/technology-facilitated violence: This is not a new form of violence itself, but rather a concerning new way in which perpetrators can inflict harm. The UN defines it as “any act that is committed, assisted, aggravated, or amplified by the use of information communication technologies or other digital tools, that results in or is likely to result in physical, sexual, psychological, social,

³⁹ Dasuni Yahanika Pathiraja , Ramya Priyanwada Pathiraja , Lakshmen Senanayake , Rukshani Mayawanthi Edirisinghe , and Nethanjalie Mapitigama, ‘Gender-based violence: Experiences from two tertiary care settings in Sri Lanka’ (2020)

⁴⁰ Chulani Kodikara and Thiagi Piyadasa, Domestic violence intervention services in Sri Lanka : an exploratory mapping, 2009-2011 (2012. ICES)

⁴¹ Women’s Action Network. (2016). Women’s Access to Justice in The North and East of Sri Lanka. https://www.ecoi.net/en/file/local/1402157/1930_1497432878_int-cedaw-ngo-lka-25964-e.pdf

⁴² DCS 2016 (n22)

⁴³ Gamage, A study on Gender Based Violence and Discrimination at Home in the Plantation sector (2022) <https://www.isdkandy.org/wp-content/uploads/2022/06/A-Study-on-GBV-and-Discrimination-at-Home-in-thePlantationctor.pdf>

political, or economic harm, or other infringements of rights and freedoms.” Rapid technological advancement, especially internet access and increasing use of smartphones has opened doors to these new forms of SGBV. Women and children are now vulnerable to harassment, extortion, blackmail, and other forms of abuse through online channels. This abuse can transcend regional and even national boundaries, making it difficult for victims to seek help. Service providers note this is a growing problem, exacerbated during times of crisis such as the COVID-19 lockdowns. They also highlight the heightened vulnerability of children and young girls to this form of abuse.

“School students and married men of all ages sexually abuse women by threatening them, saying their nude pictures will be shared online. This trend is increasing.”

State service provider, Puttalam

Female genital mutilation (FGM)/Female genital cutting (FGC): FGM or FGC, encompasses all procedures that involve partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons. FGM is recognized internationally as a violation of girls’ and women’s human rights.⁴⁴ While no incidents of FGM were reported in the current study, recent literature suggests that the practice persists, particularly within certain Muslim communities in Sri Lanka.⁴⁵

Other forms of SGBV and risk factors: Other forms of SGBV highlighted by respondents include verbal abuse, harassment in public spaces, human trafficking, and femicide. While most concede that girls and young women are most at risk, they recognize that women of all ages are susceptible in different ways to SGBV. It is also important to note that, while SGBV is classified according to these distinctions, many women experience multiple and repeated forms of SGBV, simultaneously and separately, throughout their lives.

The prevalence of **domestic violence (DV)** and/or **intimate partner violence (IPV)** in Sri Lanka warrants particular mention within this discussion of forms of SGBV. DV and IPV are often perpetrated by persons within the victim-survivors domestic circle, including partners, ex-partners, other immediate family members, or relatives. DV/IPV takes many forms, including but not limited to the above-mentioned forms of SGBV such as physical, sexual, psychological, emotional, and economic violence, and may be inflicted both within the domestic sphere as well as in public spaces. The 2019 Women’s Wellbeing Survey reports that one in five (20.4%) of ever-partnered women have been physically/sexually abused by an intimate partner in their lifetime.⁴⁶

An earlier study reveals that 17% of ever-married women aged 15-49 experienced DV at the hands of an intimate partner, with the Northern and Eastern Provinces showing the highest reports of DV.⁴⁷ A 2015 scoping review of published and grey literature of over 35 years, estimated the reported

⁴⁴ World Health Organization, ‘Fact Sheet: Female genital mutilation’, (2024), <https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation>

⁴⁵ Zainab Ibrahim and Ermiza Tegal (2019). Towards understanding female genital cutting in Sri Lanka. Colombo: FPA. https://www.fgmc.org/media/uploads/Academic%20Papers/ibrahim_srilanka_2019.pdf; Center for Policy Alternatives (2020). Legal Reform to Combat Sexual and Gender-Based Violence: PART III Female Genital Mutilation. <https://www.cpalanka.org/wp-content/uploads/2020/11/Law-Reform-to-combat-SGBV-PART-3-FGM-Centre-for-Policy-Alternatives.pdf>; Mannar Women’s Development Federation (MWDF) and the World Organisation against Torture (OMCT) (2022). “Submission to the Universal Periodic Review of Sri Lanka”. https://upr-info.org/sites/default/files/country-document/2023-03/JS5_UPR42_LKA_E_Main.pdf

⁴⁶ Department of Census and Statistics (2019) (n30)

⁴⁷ Department of Census and Statistics, Ministry of National Policies and Economic Affairs, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka Demographic and Health Survey 2016 (2017), <http://www.statistics.gov.lk/health/StaticInformation/DemographicAndHealthSurveyReport-2016-Chapter13>

prevalence of intimate partner violence to range between 25-35%.⁴⁸ Service providers note that early marriages and substance abuse often exacerbate the incidence of DV and/or IPV and that the onset of crises further intensifies these risks. For instance, lockdowns during COVID-19 resulted in a sharp rise in DV. The 1938 national hotline recorded 1215 cases of DV in 2020 and 3489 out of 4976 calls (70% of the total calls) in 2021 were related to DV.⁴⁹ Many respondents also note that child abuse is a significant aspect of DV.

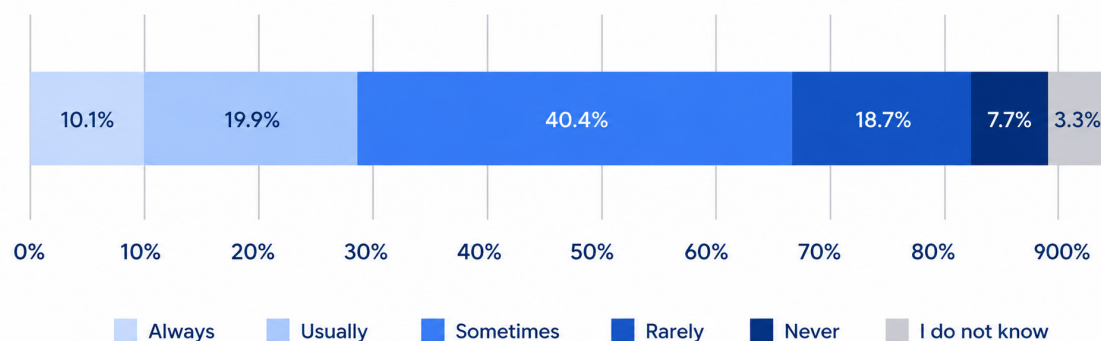
“My parents arranged my marriage at the age of 15, when I had no knowledge of sex.”

Victim-survivor, Ampara

2.2 SGBV Reporting Practices

The second central concern in mapping services and service provision addressing SGBV in Sri Lanka is measuring the extent to which SGBV is reported.

Figure 4: Likelihood of women subjected to violence reporting it to the authorities or support services (Source: interviewed women)



As per Figure 4 above, despite the high prevalence of SGBV in Sri Lanka, survey findings show that only 30.0% of respondents believe women subjected to violence in their community are always or usually likely to report it to the authorities or support services. Interestingly, this perception differs across urban and rural areas. Respondents from rural areas (31.4%) expressed a slightly higher likelihood of reporting compared to those from urban areas (18.2%).

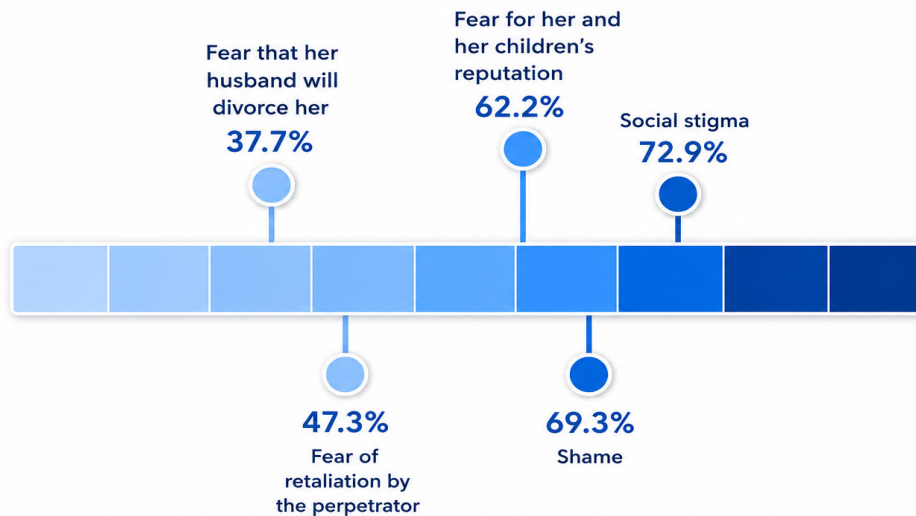
“Before we thought that there are no cases like this in our DS. Now there are complaints.”

Service provider, Mullaitivu

⁴⁸ Guruge, S., Jayasuriya-Illesinghe, V., Gunawardena, N. and Perera, J, “Intimate partner violence in Sri Lanka: a scoping review’ (2015) Ceylon Medical Journal, 60(4), p. 133-138. Available at: <https://doi.org/10.4038/cmj.v60i4.8100>.

⁴⁹ Centre for Equality and Justice, Shadow Pandemic Lobby Document on Addressing Domestic Violence During The Pandemic. (2022). <https://cejsrilanka.org/wp-content/uploads/Shadow-Pandemic-English-1.pdf> document/Report%20of%20the%20Leader.pdf.

Figure 5: Most common reasons for victim-survivors not reporting SGBV
(Source: interviewed women saying women in their community are less likely to report SGBV)



The question on barriers to reporting about SGBV focused on cultural and social factors, economic and financial issues, knowledge and awareness, structural and institutional challenges, as well as accessibility barriers. As illustrated in Figure 5 above, out of 547 respondents who said women in their community are less likely to report SGBV, 72.9% identified social stigma as a reason for not reporting, while 69.3% identified shame and 62.2% identified fear for their own and their children's reputation as reasons for the same. Fear of retaliation by the perpetrator (47.3%) and fear of divorce (37.7%) were also identified as important reasons for not reporting SGBV. The cross tabulation at district level also revealed similar trends. Within this sample, 75.3% of respondents from the rural areas and 57.1% of respondents from urban areas reported social stigma as the main barrier for not reporting SGBV.

"Due to honor our extended family members- parents, siblings- stop us from going to courts."

Victim-survivor, Kilinochchi

Service providers believe these fears are often compounded by a number of other factors such as economic dependence, the fear of being misunderstood or further exploited, the police's preference to mediate rather than take legal action, and delays in legal processes. In 2019, although 1,779 rapes were reported in Sri Lanka, only 235 complaints and/or indictments had been filed in relation to those offences,⁵⁰ and existing mechanisms often allow complainants to be revictimized. A study published in 2014 found that not only do cases of rape usually take up to 15 years to conclude, but the perpetrator also experiences no legal consequences in an overwhelming 96.5% of rape cases.⁵¹ Service providers and victim-survivors note that such trends discourage women from approaching formal channels to report SGBV. These findings indicate that barriers to reporting SGBV are still heavily influenced by patriarchy.

⁵⁰ Centre for Policy Alternatives, "Law Reform to Combat Sexual and Gender-Based Violence (SGBV) in Sri Lanka, Part 1: General," November 2020, accessed June 17, 2024, <https://www.cpalanka.org/wp-content/uploads/2020/11/Law-Reform-to-combat-SGBV-PART-1-General-Centre-for-Policy-Alternatives.pdf>.

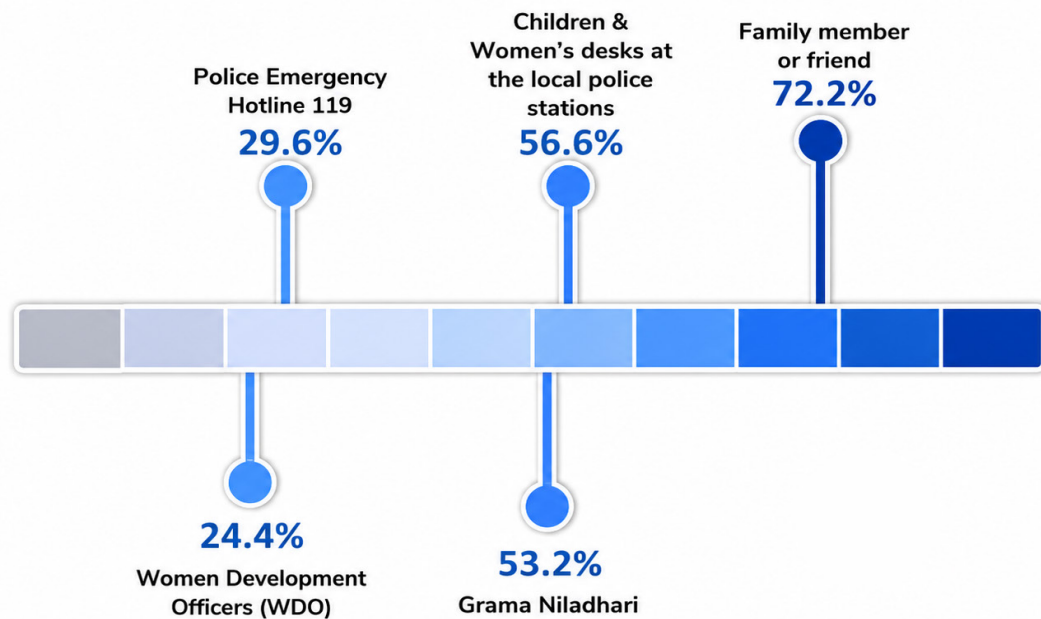
⁵¹ "Report of the Leader," published December 2014, accessed June 17, 2024, <http://gbvforum.lk/r-library/>

Deeply entrenched gender norms, power dynamics, and women's economic dependency create a culture that discourages victim-survivors from coming forward. Additional obstacles, such as access costs and institutional barriers, further aggravate the situation.

“No one invites me or my daughter to any events in the village. My daughter is bullied at school, and we are treated like outcasts.”

Victim-survivor, Anuradhapura

*Figure 6: Most commonly used channels when reporting SGBV in the community
(Source: interviewed women)*



As shown in Figure 6, a significant proportion of the sample (72.2%) identified family members and friends as the most common channels for reporting SGBV incidents. Over half the sample also identify Women and Children's desks at local police stations (56.6%) and the Grama Niladhari (53.2%) as common reporting channels. This suggests that these may be the most widely known reporting mechanisms among respondents.

However, variations in responses were observed at the district-level regarding the channels used to report SGBV. In Nuwara Eliya, a majority of respondents (64.4%) cited midwives; in Mullaitivu, 58.1% preferred the police emergency hotline (119); and in Ampara, 55.6% preferred community NGOs.

On a positive note, service providers report an increased likelihood of SGBV being reported now in comparison to the past. They attributed this trend to awareness programs and intensified grassroots efforts in recent years. At the same time, community vigilance supplements individual reporting. For instance, in some villages in Kilinochchi, volunteer vigilante teams are formed to help identify and report SGBV, particularly during disasters. Despite not being practiced in all districts, the formation of vigilante teams reflects a collective grassroots response to SGBV, where community members take an active role in monitoring, identifying, and reporting cases.



CHAPTER 3: EXISTING LEGAL AND POLICY FRAMEWORK FOR SUPPORTING **SGBV** VICTIM-SURVIVORS IN SRI LANKA

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

3. EXISTING LEGAL AND POLICY FRAMEWORK FOR SUPPORTING SGBV VICTIM-SURVIVORS IN SRI LANKA

3.1 International Obligations

International law consistently recognizes the equality of all persons regardless of sex, gender, and sexual orientation. It further recognizes the obligation of all states to ensure that women are free from all forms of discrimination. Article 1 of the Universal Declaration of Human Rights (UDHR), Article 2 of the International Covenant on Civil and Political Rights (ICCPR), and Article 3 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) oblige states to protect the rights of all persons without discrimination of any kind⁵².

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) places a more specific obligation on states to protect the rights of women. Sri Lanka has ratified CEDAW and its Optional Protocol which ensures the protection of women and girls from all forms of violence directed against them. CEDAW remains the most prominent international treaty body. State Parties are required to implement national-level legal instruments in furtherance of the principles enshrined in CEDAW. Article 15 of CEDAW stipulates that women and men must have equality before the law and benefit from equal protection of the law whilst Article 2 stipulates that State parties must take all appropriate measures to guarantee the substantive equality of men and women in all areas of life, including through the establishment of competent national tribunals and other public institutions, to ensure the effective protection of women against any act of discrimination. Article 3 of the Convention affirms the principle of equality when it requires State parties to take all appropriate measures for the full development and advancement of women in order to guarantee them equal rights with men. Similarly, Article 2 of the Convention on the Rights of the Child (UNCRC), with near universal ratification, also recognizes gender equality.

CEDAW Committee has interpreted Articles 2, 5, 11 (employment), 12 (health), and 16 (equality in family relations) of the Convention as creating the obligation for states to protect women from violence. It recognized that violence against women (VAW) is an infringement of women's rights to equality and freedom from discrimination. In General Recommendation 19, the Committee recognized that violence against women constituted a violation of their human rights, which was recognized as a principle of customary international law in Recommendation 35.

The 1993 Declaration on the Elimination of Violence against Women (DEVAW) provided a framework for national and international action to combat violence against women. Article 4 of the declaration places a direct obligation on states to pursue a policy of eliminating violence against women including: the development of penal and civil sanctions in domestic legislation to persons committing acts of violence against women, development of national action plans to protect women against violence, preventing the revictimization of women, recognizing that victim-survivors are entitled to specialized assistance, and ensuring gender-sensitivity among law enforcement.⁵³

The 1995 Beijing Platform for Action reinforced the state obligations set out in DEVAW requiring states

⁵² United Nations General Assembly, International Covenant on Civil and Political Rights, Article 26, adopted December 16, 1966, entered into force March 23, 1976, <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights>

⁵³ United Nations General Assembly, Intensifying global efforts for the elimination of female genital mutilation, A/RES/75/161, 16 December 2020

to introduce measures to prevent and eliminate violence against women,⁵⁴ to study the causes of violence against women,⁵⁵ and eliminate trafficking in women and assist victim-survivors of violence due to trafficking and prostitution.⁵⁶ In 2020, at the 64th session of the Commission on the Status of Women, leaders undertook to strengthen efforts to fully implement the Beijing Declaration and Platform for Action, including ending all forms of violence and harmful practices against women and girls⁵⁷. In a similar vein, Goal 5 of the 2030 Agenda for Sustainable Development Goals calls for the achievement of gender equality and empower all women and girls while Target 5.2 specifically calls for the elimination of all forms of violence against women.

Recognizing the rise in cyber sexual and gender-based violence (CSGBV), certain obligations are cast on states to take cognizance of and address CSGBV. General Recommendation 35 of the CEDAW Committee also recognizes that SGBV includes violence that occurs in technology mediated environments while Recommendation 36 requires states to enact legislation that penalizes CSGBV.

General Recommendation 30 on Women in Conflict Prevention, Conflict, and Post-Conflict Situations by the CEDAW Committee recognizes that states must take measures to protect the rights and interests of women before, during, and after armed conflicts. The recommendation highlights the state's obligation to ensure women's participation in peacebuilding processes and the prevention of conflict related SGBV in post-conflict situations such as that seen in Sri Lanka.⁵⁸

Sri Lanka is a party to the United Nations Convention against Transnational Organized Crime (UNTOC), and its Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (commonly known as the Palermo Protocol). The protocol places emphasis on measures to prevent the trafficking of women and children and to ensure protection against re-victimization. Additionally, Sri Lanka ratified the Convention on the Protection of the Rights of All Migrant Workers and Their Families (CMW) in 1995, as well as all core conventions of the International Labor Organization (ILO) which focuses on discrimination in employment and promotes equality and has endorsed the ILO Multilateral Framework on Labor Migration. However, Sri Lanka is yet to ratify ILO Convention No.190 on Violence and Harassment in the World of Work which recognizes SGBV as a barrier to achieving equality and decent work. Currently, significant advocacy efforts are in motion in Sri Lanka lobbying the government to ratify Convention No.190.

Further, the Sustainable Development Goals (SDG) recognize the urgent need to eliminate SGBV as a critical component of achieving global equality and sustainable development. Specifically, SDG 5 explicitly calls for the elimination of all forms of violence against women and girls in both public and private spheres.

The elimination of SGBV is a prerequisite for achieving other SDGs as well, with over 80 indicators intricately linked to Target 5.2.⁵⁹

⁵⁴ United Nations, Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women, Beijing, 4–15 September 1995, Strategic Objective D.1, https://www.un.org/en/events/pastevents/pdfs/Beijing_Declaration_and_Platform_for_Action.pdf.

⁵⁵ Ibid., Strategic Objective D.2.

⁵⁶ Ibid., Strategic Objective D.3.

⁵⁷ UN Women, "Member States Agree to Fully Implement the Beijing Declaration on Gender Equality, Addressing Gaps That Hold Women Back," March 9, 2020, <https://www.unwomen.org/en/news/stories/2020/3/press-release-csw64-adopts-political-declaration>.

⁵⁸ UN CEDAW, General recommendation No. 30 on women in conflict prevention, conflict and post-conflict situations, 1 November 2013, <https://www.refworld.org/legal/general/cedaw/2013/en/53711>

⁵⁹ UNDP, "Ending Gender Based Violence to Achieve Sustainable Development Goals (SDGs)," 2019, <https://www.undp.org/bhutan/stories/ending-gender-based-violence-achieve-sustainable-development-goals-sdgs>

SGBV Support Infrastructure



In addition to the above, international law also recognizes the right of access to justice. This places an obligation on states to ensure that women including victim-survivors of SGBV have access to justice and legal recourse. Goal 16 of the SDGs requires states to provide access to justice for all and build effective, accountable and inclusive institutions at all levels. This obligation has also been recognized in Recommendation 33 which stipulates that states have an obligation to ensure that all women have access to education and information about their rights, the remedies that are available and how to gain access to them. The recommendation creates a state obligation to ensure access to competent, gender-sensitive dispute resolution systems, as well as equal access to effective and timely remedies.⁶⁰

3.2 Domestic Legislation

The legal framework addressing SGBV against women in Sri Lanka is fragmented, and could be found across several laws, policies, and guidelines. However, the objective of this report is not to exhaustively analyze all relevant legal provisions, but rather to highlight those laws most frequently utilized by victim-survivors, law enforcement, and prosecutors in the context of SGBV cases. The selected legal provisions are significant because they represent the primary frameworks through which stakeholders engage with SGBV issues, making them crucial to understanding the current legal landscape. This focused approach allows for a more practical examination of the laws that directly impact the handling of SGBV cases in practice.

Equality of women is constitutionally recognized. Article 12 of the Constitution ensures equality before the law for all persons regardless of sex and Article 12(4) provides for affirmative action in relation to women. In effect, Article 12 ensures that women shall not be discriminated against based on their gender. Article 11 of the Constitution also protects women from SGBV, given that SGBV may reasonably and rationally be argued to constitute torture or cruel, inhuman or degrading treatment.⁶¹ However, the Constitution has no specific independent provision protecting women against SGBV.⁶²

Several legislations have been enacted to penalize the perpetrators of SGBV and protect victim-survivors. In addition, the labor law regime also provides protection to women in their workplace. The penal legislative framework includes:

- The Penal Code 1883
- The Criminal Procedure Code No. 15 of 1979
- The Prevention of Domestic Violence Act No. 34 of 2005
- The Women Empowerment Act No. 37 of 2024
- The Prohibition of Ragging and Other Forms of Violence in Educational Institutions Act No. 20 of 1998
- The Assistance to and Protection of Victim-Survivors of Crime and Witnesses Act No. 10 of

⁶⁰ United Nations Committee on the Elimination of Discrimination against Women, General Recommendation No. 33 on Women's Access to Justice, CEDAW/C/GC/33, 2015, <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no-33-womens-access-justice>

⁶¹ United Nations Human Rights Council, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, A/HRC/31/57, 5 January 2016, <https://documents.un.org/doc/undoc/gen/g16/000/97/pdf/g1600097.pdf>

⁶² Kodikara, The National Machinery for the Protection and Promotion of Women's Rights in Sri Lanka (Colombo: International Centre for Ethnic Studies, 2008), 119.

2023

- Obscene Publications (Amendment) Act No. 22 of 1983
- Computer Crimes Act, No. 24 of 2007

The Penal Code 1883

The Penal Code of Sri Lanka, enacted in 1883, was amended in 1995 and 1998 to incorporate new sexual offences and to penalize perpetrators of SGBV including for rape and grave sexual abuse. These amendments included revisions to the definition of rape,⁶³ and statutory rape⁶⁴, and procuration⁶⁵. The Amendments also introduced new offences such as anti-trafficking laws, criminalization of sexual violence, incest, and the prohibition of the publication of details which reveal the identity of victim-survivors of sexual crimes.⁶⁶ The broad definition of grave sexual abuse contained in Section 365B allows for the criminalization of a wide range of violent acts of a sexual nature, including those causing “psychological and mental trauma”. These offences carry mandatory minimum sentences of rigorous imprisonment and are not offences in respect of which suspended sentences may be imposed.

Furthermore, Section 345 recognizes the offence of sexual harassment. However, the Grave Crimes Abstract of the Sri Lanka Police for 2023 does not contain statistics on complaints recorded or disposed of in relation to the crime of ‘sexual harassment’. This could be because sexual harassment is not categorized as a grave crime or because no complaints were filed regarding the offense. In either case, the outcome undermines a strong protection regime for women.

Section 363 which criminalizes Rape was also amended by way of the 1995 Penal Code Amendment, to stipulate that evidence of resistance was not required to prove sexual intercourse took place without consent. However, despite the introduction of this progressive definition, the courts have continued to require corroboration of evidence.⁶⁷ Several other issues in relation to the provisions in the Penal Code also give rise to questions of legislative intent and the need for legal reforms to effectively address SGBV, the foremost of which is the restrictive definition of rape which is limited to penile-vaginal penetration (and thus excludes male victim-survivors,⁶⁸ non-consensual oral or anal penetration, and penetration using objects.⁶⁹

The restrictive definition also excludes violence in the context of same sex partners.⁷⁰ Further, marital rape of a wife by a husband is excluded from the purview of the Penal Code, unless they are judicially separated.⁷¹ Section 365 of the Penal Code criminalizes “intercourse against the order of nature,” a provision that has historically been used to criminalize consensual same-sex sexual activity.

⁶³ 363 (a) -(d)

⁶⁴ Section 363E

⁶⁵ Section 360A

⁶⁶ Section 360A, 360C, 365A, 365B, 365C, 364A

⁶⁷ Sunil and Another v. Attorney General [1986] 1 Sri LR 230; Upali Senarathne v. Attorney General, CA 25/09, CAM 6 March 2014.

⁶⁸ A. A. Edirisinghe and N. K. K. Mudalige, “Male Victimization in Rape: Case of Sri Lanka,” in Proceedings of the APIIT Business, Law & Technology Conference, Asia Pacific Institute of Information Technology, 2017, <https://www.conference.apiit.lk/pdf2/Law/LBAT201714.pdf>

⁶⁹ Centre for Equality and Justice, Rape and Sexual Violence in Conflict: Definitions under Domestic and International Law, 2018. <https://cejsrilanka.org/wp-content/uploads/Rape-and-Sexual-Violence.pdf>

⁷⁰ Centre for Equality and Justice and Equality Now, Submission to the UN Universal Periodic Review: Forty-Second Session of the UPR Working Group of the Human Rights Council, 2022, <https://equalitynow.storage.googleapis.com/wp-content/uploads/2022/07/13104622/Sri-Lanka-UPR-by-Equality-Now-and-Centre-for-Equality-and-Justice.docx.pdf>

⁷¹ Penal Code of Sri Lanka, § 363(a)

This legal provision presents a significant challenge to the protection of Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer or Questioning (LGBTIQ+) rights.⁷² Equally concerning is section 155(4) of the Evidence Ordinance No. 14 of 1895 which allows the introduction of evidence in rape cases which shows that “the prosecutrix was of generally immoral character.” This provision institutionalizes victim-blaming and results in the re-victimization of victim-survivors.⁷³ Section 364 sets a minimum mandatory sentence for the offence of rape, including statutory rape. However, a Supreme Court judgment from 2008⁷⁴ is used as a precedent by the courts of original jurisdiction to impose lesser sentences on perpetrators of rape: the judgment held that while a woman’s consent is immaterial for rape to be perpetrated if she is under the age of 16 years, the existence of consent is a factor courts may consider in deciding the appropriate sentence for statutory rape. This raises questions of judicial sensitivity to the impact of SGBV on women, and a woman’s freedom from violence.⁷⁵

The Penal Code (Amendment) Act No.16 of 2006 criminalizes human trafficking through a comprehensive definition of the offence in section 360(C). The definition includes trafficking of children and criminalizes all aspects of human trafficking in line with the Palermo protocol. This provision is supplemented by Section 17 of the *Code of Criminal Procedure Act No. 15 of 1979* which allows the court to order the offender to pay compensation to the victim-survivor up to one hundred thousand Rupees; and the *Convention on Preventing and Combating Trafficking in Women and Children for Prostitution Act No. 30 of 2005* which was enacted to implement the South Asian Association for Regional Cooperation (SAARC) Convention on Trafficking in Women and Children for Prostitution (not yet in operation). This Act includes provisions enabling the payment of compensation for victim-survivors. However, this legislation has not yet come into force. The definition of human trafficking contained in the Penal Code poses challenges to prosecutors due to its complexity, making it difficult to secure convictions, especially in cases of sexual exploitation. Therefore, in practice, prosecutors tend to rely on lesser offences such as procuration to ensure successful prosecutions against perpetrators of trafficking in persons for sexual exploitation.⁷⁶

The Prevention of Domestic Violence Act, No. 34 of 2005

The Prevention of Domestic Violence Act (PDVA) No. 34 of 2005 provides protection for victim-survivors of domestic violence which includes physical and emotional abuse. However, it excludes financial or economic abuse in its definition of domestic violence.⁷⁷ The Act also does not include marital rape as a form of violence against which protection is needed, which may be due to the fact that marital rape is not criminalized in Sri Lanka. The Act enables victim-survivors to obtain protection orders against their perpetrators to ensure physical and emotional safety.⁷⁸ It uses gender-neutral language, thereby extending the scope of the Act to all genders. The Act defines domestic violence as violence that is carried out between persons sharing a relationship which is personal in nature.

⁷² U.S. Department of State, 2021 Country Reports on Human Rights Practices: Sri Lanka, 2022, https://www.state.gov/wp-content/uploads/2022/03/313615_SRI-LANKA-2021-HUMAN-RIGHTS-REPORT.pdf

⁷³ Women and Media Collective, Legal Framework on Sexual Violence in Sri Lanka: The Need for Reforms, 2021, https://womenandmedia.org/wp-content/uploads/2021/11/FINAL-LAYOUT-POLICY-BRIEF_Legal-Framework-on-Sexual-Violence-in-Sri-Lanka-English.pdf

⁷⁴ S.C. Reference No. 03/08 [2008] B.L.R. 160.

⁷⁵ Centre for Policy Alternatives, Legal Reform to Combat Sexual and Gender-Based Violence: Part I – Reforming Existing Laws and Policies, 2020, <https://www.cpalanka.org/wp-content/uploads/2020/11/Law-Reform-to-combat-SGBV-PART-1-General-Centre-for-Policy-Alternatives.pdf>.

⁷⁶ U.S. Department of State, 2022 Trafficking in Persons Report: Sri Lanka, 2023, <https://www.state.gov/reports/2022-trafficking-in-persons-report/sri-lanka/>

⁷⁷ The Prevention of Domestic Violence Act, No. 34 of 2005, § 23 (Sri Lanka).

⁷⁸ The Prevention of Domestic Violence Act, No. 34 of 2005, § 7 (Sri Lanka).

Accordingly, men, women and children alike are allowed to enjoy the protection under the Act.⁷⁹ However, the PDVA only allows the aggrieved person or a police officer to institute action.⁸⁰ This may deter victim-survivors who cannot attend court from instituting legal action through counsel.⁸¹ It also does not provide for compensation or relief for victim-survivors of domestic violence.

The PDVA suffers from weak implementation by law enforcement officers including first responders such as the police. The common tendency is to refer cases of domestic violence for mediation rather than seek protection orders under the PDVA.⁸² This may be attributed to the misconception some legal officers hold that the protection orders issued under the PDVA unjustly deprived the perpetrator of his right to the marital home and the children of their father.⁸³ Similarly, the counselling sessions mandated under Section 5(2) and Section 12(1), may compel victim-survivors to be in close proximity to their abusers often compromising their security and subjecting them to secondary victimization. The judiciary also often fails to give full effect to the law. Section 7 empowers the court to continue with the inquiry and issue a protection order in the absence of the respondent provided that notice has been served to the respondent. In practice there have been instances of judicial officers insisting on summoning the respondent prior to granting interim relief orders. This is not a legal requirement as per the Act and may place the victim-survivor at greater risk, thus defeating the very purpose of the Act.⁸⁴

The Women Empowerment Act No. 37 of 2024

The Act was enacted with the objective of aligning Sri Lanka's national policy with its international treaty obligations under CEDAW, aiming to empower women and eliminate gender discrimination.⁸⁵ The Act establishes a National Commission on Women which is vested with the power to protect and promote women's rights by intervening in court, setting national policy, conducting inquiries, and initiating legal action, raise awareness, recommend reforms, assess legislation, and award compensation.⁸⁶ The commission may also investigate infringements of women's rights on its own motion.⁸⁷ A salutary feature of the Act, section 30, gives the commission the authority to enforce its recommendations through contempt of court proceedings. Given its new enactment, its efficacy remains to be seen.

The Assistance to and Protection of victim-survivors of Crime and Witnesses Act No. 10 of 2023

This Act provides for fair treatment, access to information, and protection measures for victims of crime and witnesses. It also establishes a National Authority and a dedicated fund for these purposes. It specifically extends SGBV victim-survivors protection against any reprisal or exacerbated violence from the perpetrator. The Act enforces the duties of the State and its public officers to

⁷⁹ Baker McKenzie, Fighting Domestic Violence - Sri Lanka, 2021, <https://resourcehub.bakermckenzie.com/en/resources/fighting-domestic-violence/asia/sri-lanka/topics/1legal-provisions>

⁸⁰ The Prevention of Domestic Violence Act, No. 34 of 2005, § 2(2) (Sri Lanka).

⁸¹ Centre for Policy Alternatives, Legal Reform to Combat Sexual and Gender-Based Violence PART I: Reforming Existing Laws and Policies, 2020, <https://www.cpalanka.org/wp-content/uploads/2020/11/Law-Reform-to-combat-SGBV-PART-1-General-Centre-for-Policy-Alternatives.pdf>

⁸² UNFPA, Mapping of Social Services Sector for the Prevention and Response to Sexual and Gender-Based Violence Affecting Women and Girls, 2021, https://srilanka.unfpa.org/sites/default/files/pub-pdf/unfpa_report_2021.01.05.pdf

⁸³ UNFPA, Mapping of Social Services Sector for the Prevention and Response to Sexual and Gender-Based Violence Affecting Women and Girls, 2021.

⁸⁴ Women in Need, Why Accessing Justice is Challenging for Victims of Sexual and Gender-Based Violence? 2019, https://asiafoundation.org/wp-content/uploads/2021/09/Sri-Lanka_-Inside-Justice-Summary-Report.pdf

⁸⁵ The Women Empowerment Act, No. 37 of 2024, § 2 (Sri Lanka).

⁸⁶ The Women Empowerment Act, No. 37 of 2024, § 6 (Sri Lanka).

⁸⁷ The Women Empowerment Act, No. 37 of 2024, § 18 (Sri Lanka).

ensure this protection is executed,⁸⁸ and includes specific provisions to enable both victim-survivors and witnesses to testify through audio-visual means. Its special measures include treatment for vulnerable victim-survivors or witnesses of crime experiencing psychological trauma,⁸⁹ as well as a compensation scheme for victim-survivors.

While the Act provides a strong legal framework for the protection of victim-survivors, its effective implementation is challenged by systemic issues related to institutional capacity, including inadequate numbers of trained staff.⁹⁰ Reports have also indicated an under-utilization of resources by the Authority, which may hinder the efficacy of its service provision. For instance, as at the end of December 2023, a safe house had not been utilized for a period of two years.⁹¹ Moreover, during its first ten years of operation, the Authority placed only a few victims and witnesses under protection, possibly due to challenges encountered in conducting investigations.⁹² At the same time, it must be noted that the requirement for a victim-survivor to seek redress through multiple separate laws—such as prosecution under the Penal Code and protection and compensation under the Victim-survivors and Witness Protection Act—can lead to situations of secondary victimization through the inevitable re-telling of personal experiences, which should be avoided.

The Prohibition of Ragging and Other Forms of Violence in Educational Institutions Act No. 20, 1998

The Prohibition of Ragging and Other Forms of Violence in Educational Institutions Act No. 20 of 1998 seeks to address SGBV that occurs as a part of the ragging tradition in state-universities. This statute forbids any form of SGBV carried out as harassment, bullying, or abuse of new students by senior students, and imposes rigorous punishment including a sentence of not exceeding ten years and pecuniary compensation.⁹³

Obscene Publications (Amendment) Act No. 22 of 1983 and Computer Crimes Act, No. 24 of 2007

Section 2 of the Obscene Publications (Amendment) Act No. 22 of 1983 prohibits the trade, distribution, public display, or possession of “obscene” photographs, films, and videos. As a result, any woman threatened with the non-consensual exposure of intimate images can invoke this legislation to challenge such threats or actions. One significant shortcoming of this law is its failure to clearly define the term ‘*obscene*’. As a result, individuals in possession of content that may not qualify as *obscene* may escape punishment. For instance, the possession of non-consensual photographs of schoolgirls in uniform may not fall within the scope of the law, despite the evident violation of privacy and potential harm involved.⁹⁴

⁸⁸ The Asia Foundation, Inside Justice: Enabling Justice for Victim Survivors of Sexual and Gender-Based Violence – Sharing of The Asia Foundation’s Experiences, 2021, https://asiafoundation.org/wp-content/uploads/2021/09/Sri-Lanka_Inside-Justice-Learnings-Report_English.pdf.

⁸⁹ The Women Empowerment Act, No. 37 of 2024, §§ 2, 34, 82 (Sri Lanka).

⁹⁰ Michelle Handy, “A legal empowerment approach to improving access to justice for victim-survivors of Sexual and Gender-based Violence”, University of Colombo Review (Series III), Vol.5, No.1, 2024, <https://doi.org/10.4038/ucr.v5i1.97>

⁹¹ Audit of the financial statements of the National Authority for the Protection of Victims of Crime and Witnesses – 2023, <http://www.auditorgeneral.gov.lk/web/images/audit-reports/upload/2023/State-Corporations/2-xviii/National-Authority-for-the-Protection-of-Victims--E.pdf>

⁹² Daily FT, “Protection for victims and witnesses is a must for due process of law”, 6 April 2023, [https://www.ft.lk/ft_view_editorial/Protection-for-victims-and-witnesses-is-a-must-for-due-process-of-law/58-747124#:~:text=The%20National%20Authority%20for%20the%20Protection%20of,years%20of%20the%20Authority%20being%20in%20operation.](https://www.ft.lk/ft_view_editorial/Protection-for-victims-and-witnesses-is-a-must-for-due-process-of-law/58-747124#:~:text=The%20National%20Authority%20for%20the%20Protection%20of,years%20of%20the%20Authority%20being%20in%20operation.;); National Authority for the Protection of Victims of Crime and Witnesses, Annual Report 2022, <https://www.parliament.lk/uploads/documents/paperspresented/1708412100017626.pdf>

⁹³ The Women Empowerment Act, No. 37 of 2024, § 2(2) (Sri Lanka).

⁹⁴ https://www.sfcg.org/wp-content/uploads/2023/11/CitW_Gap_Analysis_2023_SFCG.pdf

The Computer Crimes Act was later introduced in 2007 to implement the Budapest Convention on Cyber Crime. This legislation prohibits computer hacking and the use of information obtained without the consent of the user or owner. While these provisions may not explicitly prohibit cyberbullying, some have argued that the provisions of the Act could be interpreted expansively to cover cyberbullying.⁹⁵ However, such cases have not come up for interpretation as they are often dismissed at the investigation stage.⁹⁶ In the absence of an expansive interpretation, the provisions of the Computer Crimes Act are inadequate for tackling cyberbullying, as the Act only addresses hacking and interception of communications, leaving cyber violence unaddressed. This leads to first responders for Technology-facilitated SGBV such as the Criminal Investigation Department's (CID) Computer Crimes Division and Sri Lanka Computer Emergency Readiness Team (SLCERT) dismissing complaints at the very outset, as the law does not explicitly provide for an offence under which they may act.⁹⁷ Similarly, certain sections of the Computer Crimes Act, designed to address offences such as hacking and unauthorized access, can be applied to prosecute cases of revenge porn.⁹⁸ However, these offences would be limited to penalising unauthorised access and not distribution or threat of distribution.⁹⁹ Therefore, though the Act provides victim-survivors of Technology-Facilitated SGBV with some degree of protection, it is dependent on the Act being interpreted expansively, thus limiting the scope and efficacy of protection.

3.3 Policies and Processes

Sri Lanka has introduced several non-justiciable mechanisms to support the implementation of CEDAW including the Sri Lanka Women's Charter adopted on March 3, 1993, which affirms the country's commitment to CEDAW and DEVAW. The Charter promotes gender equality and protection against gender discrimination. The Preamble of the said Charter explicitly recognizes "gender-based violence is a violation of human rights and fundamental freedoms in that it impairs or negates women's enjoyment of these recognized rights and freedoms." Article 16,¹⁰⁰ reconfirms the intention of the State to take measures to prevent the many manifestations of violence against women in the family. The state has also adopted several policies in relation to SGBV. The National Action Plan Addressing Sexual and Gender Based Violence 2016-2020 viewed education, community awareness, and life skills training as key to combating violence against women and gender discrimination.¹⁰¹ Similarly, the National Policy on Gender Equality and Women's Empowerment aims to ensure equal rights and opportunities for women and girls in all spheres and structures of government, public and private workplaces, community, family, and civic space. The policy requires the state to ensure the availability, accessibility, and affordability of survivor friendly medical, legal, psychosocial, shelter, and emergency SGBV support services.

⁹⁵ Aparrajitha Ariyadasa, "Harassment Beyond Borders: Sexting, Cyber Bullying and Cyber Stalking in Social Media. Can Sri Lanka Protect Victims?", SSRN, 2019, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3382683

⁹⁶ Ibid.

⁹⁷ Ibid.

⁹⁸ Section 3 and 4

⁹⁹ Kushanthi Harasgama and Paramie Munasinghe, "Combatting Non-Consensual Pornography Through Legislation: A Multi-Jurisdictional Analysis", SSRN Electronic Journal, 2021, 10.2139/ssrn.3893483

¹⁰⁰ The State shall take all measures to prevent the phenomenon of violence against women, children and young persons in society, in the workplace, in the family as well as in custody, in particular such manifestation of it as rape, incest, sexual harassment and physical and mental abuse, torture and cruel, inhuman or degrading treatment.

¹⁰¹ Ministry of Women and Child Affairs, Policy Framework and National Plan of Action to Address Sexual and Gender-Based Violence in Sri Lanka 2016–2020 (Colombo: Ministry of Women and Child Affairs, 2016), 80.

The National Human Resource and Employment Policy (2017) recommends measures such as flexible or online working arrangements, attitudinal change, and the establishment of a social security system.¹⁰² The National Action Plan for the Implementation of the UN Security Council Resolution on Women, Peace and Security (NAP WPS) (UNSCR 1325) was introduced with the objective of protecting women's safety and wellbeing during and after conflict, disasters and pandemics and to facilitate relief for women affected by conflict. It must also be noted that most state universities have adopted SGBV policies aimed at preventing SGBV occurring as a form of ragging.

The Policy Framework and Multi-Sectoral National Action Plan to address Sexual and Gender-Based Violence (SGBV) in Sri Lanka 2024-2028 aims to create a violence-free life for all individuals, regardless of gender identity or sexual orientation, and is grounded in the principle of zero tolerance for SGBV. It focusses on 3 main sectors and 5 sub-sectors, including Gender Empowerment, Child Affairs, Social Protection & Welfare, Education, Health & Indigenous Medicine, Economic Empowerment, Labor etc.¹⁰³ and is therefore, closely aligned with the SDGs. Despite Sri Lanka's commitment to the SDGs, the most recent review of the progress in achieving the SDGs does not refer to SGBV.¹⁰⁴

3.4 Essential Services Package (ESP) for Women and Girls Subject to Violence

For SGBV service provision to be effective, a coordinated effort among various institutions to meet the diverse needs of women experiencing SGBV is essential. This multi-sectoral holistic approach necessitates collaboration between state and non-state service providers. The United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (a partnership by UNDP, UNFPA, UNODC, UN Women, and WHO) has developed the "Essential Services Package," which aims to provide victim-survivors with greater access to essential services.¹⁰⁵ The package identifies health, social services, and police and justice as key sectors providing essential services to victim-survivors of SGBV, and provides guidelines for coordination of essential services.

It sets out six principles which underpin the delivery of effective services:¹⁰⁶

1. Employing a rights-based approach
2. Advancing gender equality and women's empowerment
3. Ensuring cultural sensitivity and age - appropriateness
4. Utilizing a survivor centered approach
5. Prioritizing safety which is paramount

¹⁰² Government of Sri Lanka, National Human Resources and Employment Policy for Sri Lanka (Colombo: Ministry of Labour and Trade Union Relations, 2012), §§ 292–300.

¹⁰³ Ministry of Women, Child Affairs and Social Empowerment. The Policy Framework and Multi-Sectoral National Action Plan to Address Sexual and Gender-Based Violence (SGBV) in Sri Lanka 2024-2028, 2025, <https://srilanka.unfpa.org/sites/default/files/ub-pdf/2025-01/National%20Action%20Plan%20to%20Address%20on%20SGBV%20ENGLISH%2020241218%20%281%29.pdf>

¹⁰⁴ UNDP, Sri Lanka's Progress in Achieving the Sustainable Development Goals (SDGs) – 2024, 2025, https://www.sdc.gov.lk/sites/default/files/2025-02/SDG%20Progress%20Report%202024_25%20Feb.pdf

¹⁰⁵ UN Women, Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines, 2015, <https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence>

¹⁰⁶ UN Women, Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines, Module 5: Coordination and Governance of Coordination, 2015 <https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2015/Essential-Services-Package-Module-5-en.pdf>

6. Working towards perpetrator accountability

To support the effective functioning and delivery of services, each service must have nine essential characteristics:¹⁰⁷

1. Availability
2. Accessibility
3. Adaptability
4. Appropriateness
5. Safety prioritization
6. Informed consent and confidentiality
7. Data collection and information management
8. Effective communication
9. Liaising with other sectors and agencies through referral and coordination

Together, the Essential Services Package sets an important framework from within which availability, accessibility, quality, and efficacy of SGBV service provision could be assessed.

The ESP was launched in Sri Lanka June 2018, and UNFPA acknowledges Sri Lanka as a pioneering country in its implementation.¹⁰⁸ At present Sri Lanka does not have national level policies or guidelines for the police and justice sector, nor does it have specific guidelines in place for the coordination of essential services as advocated for through the Essential Services Package. The Ministry of Women and Child Affairs and Social Security (MoWCASS) with the technical support of the UNFPA, has issued Guidelines for District and Divisional level referral systems for SGBV cases for the Hambantota and Mannar districts. Developed through a consultative process, the guidelines acknowledge that though limited in scope to two districts, it could be used to scale up and replicate referral systems for SGBV in other districts and divisions, which is yet to be rolled out throughout the country.¹⁰⁹ This lack of a specific legal or policy framework for the coordination of SGBV service provision based on a common understanding of what essential services are and the causes and consequences of SGBV, have left service provision agencies unfamiliar with specific coordination responsibilities of individual agencies or entities. However, in relation to health services, two key guidelines have been adopted.

In 2014, the National Guidelines on Examination of Sexually Abused Victim-Survivors for Medico-Legal Purposes were developed. These guidelines describe best practices in the medico-legal management of individuals who have been sexually assaulted. It includes detailed guidance on medico-legal examination, reporting and case management of individuals who have been sexually assaulted, performing a thorough physical examination for medico-legal purposes, recording findings as well as providing medical, psychological, legal, and social support to individuals who have been sexually abused.

¹⁰⁷ Ibid.

¹⁰⁸ Ministry of Children and Women Affairs, Guidelines for District and Divisional Level Referral System: Sexual and Gender-Based Violence, https://childwomenmin.gov.lk/frontend/files/Downloads/Laws,%20Polices,%20Guidelines/Guidelines/Referral%20uidelines%20English/Final%20SGBV%20Referral%20Guidelines_%20English-EDT%2024.05.2021_hg_compressed.pdf

¹⁰⁹ Ibid.

In 2019, the National Guideline for First Contact Point Healthcare Providers on the Health Sector Response to Gender Based Violence (GBV) was issued. This guideline aims to: Provide healthcare providers with an updated technical understanding of GBV/DV, including its prevalence in Sri Lanka. Comprehensively describe the necessary essential services for responding to SGBV cases. Supplement this information with standard operating procedures (SOPs) tailored to different healthcare provider roles at first contact level. These SOPs provide detailed instructions on how to deliver care effectively.

The guideline adheres to international standards and recommendations from organizations like the World Health Organization (WHO), focusing on survivor-centered care and the Essential Services Package for SGBV. It emphasizes: Guiding principles and approaches for providing care to survivors.

Comprehensive care for survivors of GBV, including medical and psychological support. A multi-sectoral approach to ensure delivery of comprehensive care through referrals for appropriate services, such as legal aid and social support.

In relation to social services, recently in 2024, Sri Lanka adopted a guideline on shelter management, entitled “The National Guidelines for the Management of Shelters for Victim-Survivors of Sexual and Gender Based Violence.” These were introduced with the objective of enhancing victim-survivor support services including the *“provision of comprehensive shelter services aimed at the protection, rehabilitation, self-reliance and empowerment of victim-survivors.”* The guidelines seek to provide the women victim-survivors and their children and those at risk of SGBV: *A. Immediate relief and shelter support b. Protection and safe environment c. Remedial, rehabilitative and therapeutic services d. Referral services e. Vocational training for Reintegration f. Feedback Monitoring.”*

Within this legal and policy framework, the next chapter will discuss the availability, accessibility, quality, and efficacy of SGBV service provision in the surveyed districts.



CHAPTER 4: AVAILABILITY, ACCESSIBILITY, AND QUALITY OF **SGBV** SUPPORT SERVICES IN SRI LANKA

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

4. AVAILABILITY, ACCESSIBILITY, AND QUALITY OF SGBV SUPPORT SERVICES

Multiple state and non-state sector service providers offer a range of support services to victim-survivors of SGBV in Sri Lanka, such as state medical care, psychosocial and psychiatric support, legal aid, and livelihood support. The delivery structures of state-sector services are largely uniform while adhering to formal bureaucracy. However, the quality of state-sector services provided varies across districts and are usually individual-driven. Despite significant resource constraints, the state-sector provides important relief to victim-survivors.

Even though non-state service provision lacks uniformity, they are able to provide a wider range of services to victim-survivors of SGBV. This is particularly evident in the area of social services, where non-state service providers are better positioned to provide emergency shelter, legal aid, subsistence assistance, livelihood training for economic empowerment, and reintegration services among others.

4.1 Health Services

The state health sector includes primary-care hospitals, district hospitals, base hospitals, general hospitals, and teaching hospitals. Treatment is provided free of charge. Hospitals provide clinical as well as mental health treatment and play a crucial role in delivering emergency care and services to victim-survivors of SGBV, albeit with certain deficiencies. STI/AIDS clinics at base, general, and teaching hospitals offer free testing and clinical care for victim-survivors of SGBV.

In addition to state hospitals, most districts are served by one or more private hospitals and numerous private medical practitioners. Private hospitals typically offer more comfortable settings and shorter wait times compared to public facilities. This can be particularly important for victim-survivors seeking timely care. However, access to private medical care is often hindered by the associated monetary costs of receiving treatment. Therefore, most victim-survivors of SGBV who have suffered physical or mental trauma opt to receive treatment at state health facilities.

At the community level, the Public Health Midwives (PHM) deployed by the Ministry of Health serve as key first responders in SGBV cases. The PHMs are frontline health workers, delivering home-based care to women and children in the community. Each PHM is assigned a specific geographic area that encompasses a population of 3,000 to 5,000 people. They maintain a register of all women of reproductive age and families with children under the age of 5, and conduct regular community visits. Due to this close link with the community, PHMs act as a vital connection between community members and institutional healthcare services.¹¹⁰

Availability and accessibility of clinical treatment: Victim-survivors usually receive care at all available hospitals. These facilities are equipped to handle emergency situations, providing essential medical treatment for injuries and health complications resulting from violence. Depending on the severity of injuries, clinical care in SGBV cases may involve a multidisciplinary team, including Medical Officers, psychiatrists, pediatricians, and gynecologists, who collaborate to address the diverse needs of victim-survivors.

However, the health system continues to face challenges due to shortages of qualified healthcare professionals. For instance, according to KIs and FGD participants, Judicial Medical Officers (JMOs) are not available in sufficient numbers in all districts, which impedes efficient clinical management

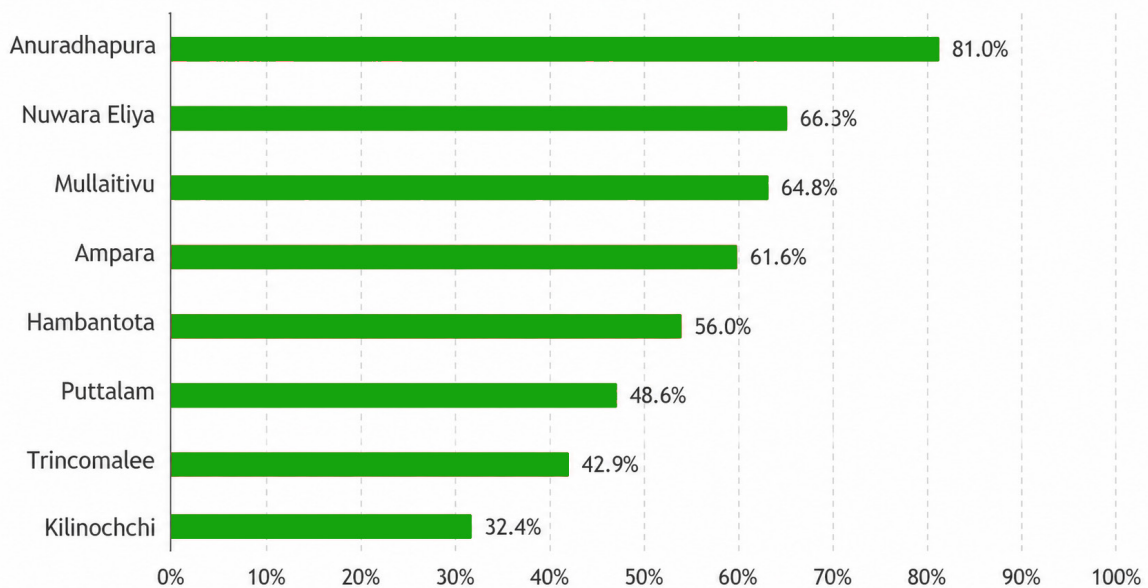
¹¹⁰ Yale School of Public Health, "Public Health Midwives in Sri Lanka," published June 4, 2018, accessed June 17, 2024, <https://ysph.yale.edu/news-article/public-health-midwives-in-sri-lanka/>

of rape cases. In many districts, only one or two JMOs are appointed, which means not every hospital has a JMO on staff.

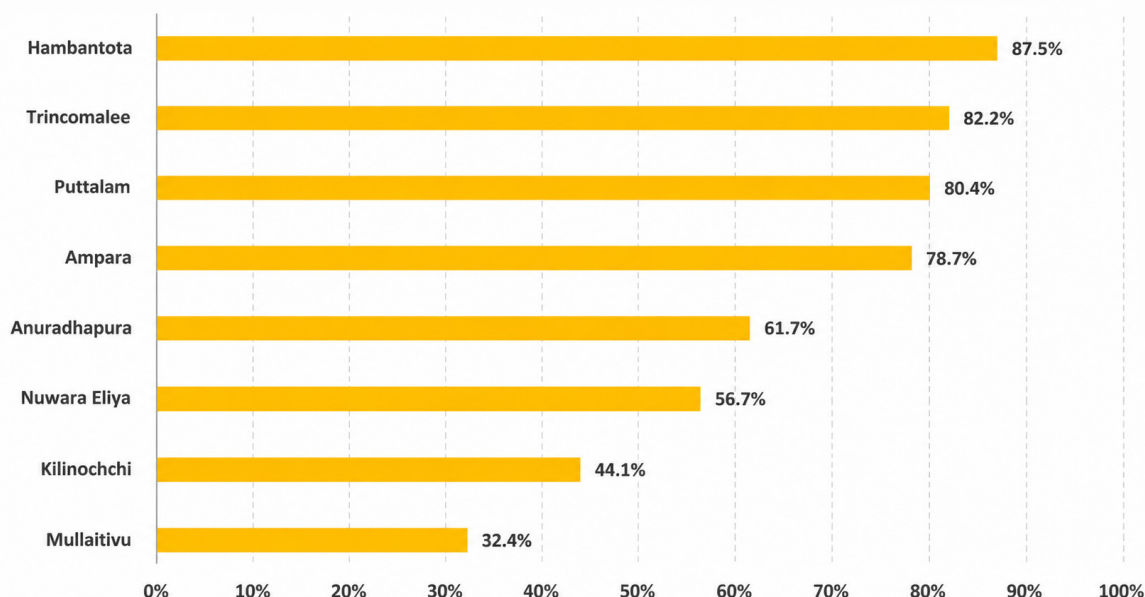
Victim-survivors of rape and sexual abuse either access hospitals directly or are referred to by the police or CSOs. Upon admission to a hospital, in the absence of a JMO, a medical officer with training in medico-legal examinations conducts a basic examination and will assess for evidence of sexual abuse or trauma. Whenever possible, the victim-survivor will be transferred to a hospital with a JMO on staff after the initial assessment for the collection of samples for analysis. JMOs also conduct risk assessments in order to make appropriate referrals to the STI center, psychiatrists, and other services as deemed necessary. All base and district hospitals are staffed with visiting obstetricians, gynecologists and pediatricians, who will examine victim-survivors when required.

However, state hospitals do not always have necessary medication available. This results in patients having to purchase medication from private pharmacies at their own expense. Additionally, space and human resource constraints contribute to long wait times, a lack of privacy, and reduced comfort for victim-survivors seeking treatment from state hospitals.

*Figure 7: Perceived availability of state medical care within the community or beyond
(Source: Interviewed women)*

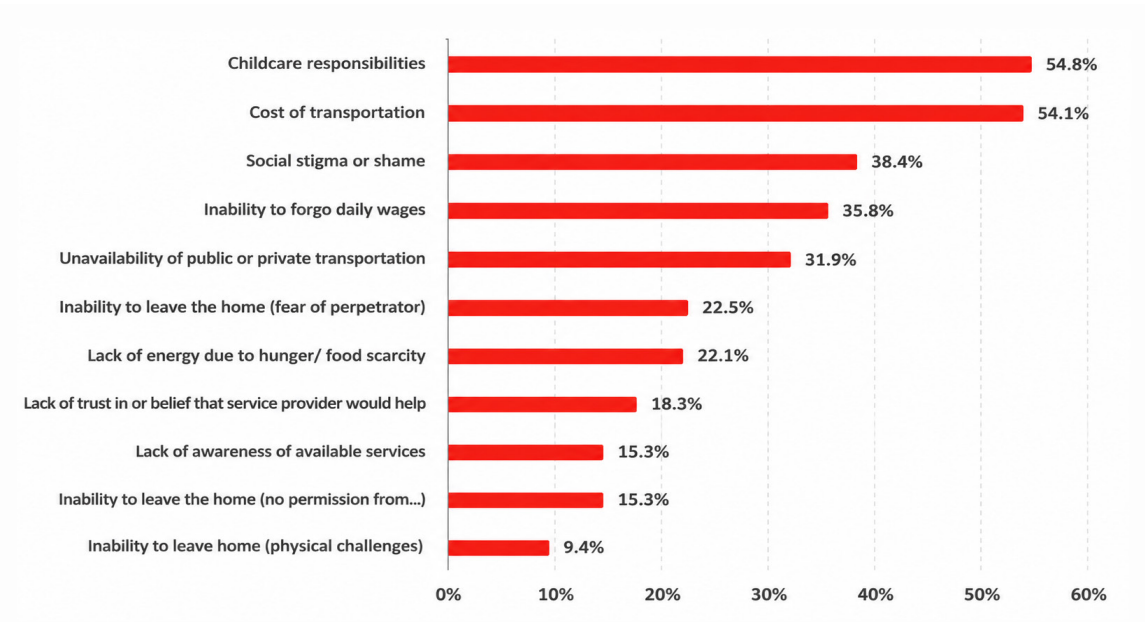


Availability of state medical care, both immediate and long-term, is critical for SGBV victim-survivors. As shown in Figure 7 above, among the respondents, 81% from Anuradhapura mentioned that they have state medical services in their district, while such services are reported lowest in Mullaitivu (32.4%). These findings suggest that the Mullaitivu district, which was heavily affected by the war between the LTTE and the Sri Lankan government for 26 years, continues to suffer from inadequate basic infrastructure.

*Figure 8: Proportion of respondents accessing state medical care**(Source: interviewed women reporting that state medical care is available in their community or beyond)*

According to Figure 8 above, amongst respondents who reported that state medical services are available, a significant number in the districts of Hambantota (87.5%), Trincomalee (82.2%), and Puttalam (80.4%) confirmed that they had personally accessed state medical care or accompanied a victim-survivor who had.

In contrast, this proportion was considerably lower in the districts of Mullaitivu (32.4%) and Kilinochchi (44.1%), where less than half of the respondents in each district who confirmed the availability of state medical care reported accessing it.

*Figure 9: Barriers to accessing state medical care**(Source: Interviewed women reporting that state medical care is available in their community or beyond)*

Although services may be available, certain barriers impede access. According to Figure 9 above, among respondents who say state medical care is available, more than half cited childcare responsibilities (54.8%) and high transportation costs (54.1%) as main access barriers. Many respondents also identified social stigma and shame (38.4%) as well as the inability to forgo daily wages (35.8%) as factors impeding their access to state medical care.

“There’s no proper medical facility in our village. We had to travel far, which was costly and time-consuming.”

Victim-survivor, Ampara

The findings show that despite the availability of state medical services, victim-survivors could not access them due to the gendered nature of childcare responsibilities. Furthermore, the cost of transport has been identified as a major issue. Most of the specialist services are available mainly in the hospitals in the urban areas. Hence, the victim-survivors have to bear the cost of transport, which they may not always be able to afford. Given the sensitive nature of the issue, social stigma also prevents some victim-survivors from accessing state service providers and reporting violence.

“No matter how much I was beaten, I never wanted to go to the hospital to report it. It was embarrassing; I couldn’t bring myself to tell anyone.”

Victim-survivor, Hambantota

If the perpetrator is a close relative, victim-survivors or their immediate family members do not want to report the case. If the perpetrators are powerful, the victim-survivors might also become re-victimized. Therefore, some cases go unreported due to fear of the perpetrator. Qualitative discussions and interviews with victim-survivors further confirm that shame, stigma, fear of reprisals and rejections by their own family members and community discourage victim-survivors from reporting incidents. Addressing these barriers is essential to ensure equitable access to SGBV support services.

“There’s a common belief that such matters shouldn’t be made public. Many women feel ashamed or scared of what others might say about them.”

Victim-survivor, Nuwara Eliya

Table 2: Perceptions of state medical care - ensuring a safe and private place to talk
 (Source: Interviewed women who have accessed or have accompanied someone who accessed this service)

	Puttalam	Ampara	Trincomalee	Anuradhapura	Kilinochchi	Mullaitivu	Hambantota	Nuwara Eliya
Yes	80.5%	70.8%	70.3%	70.0%	60.0%	59.1%	55.1%	52.6%
No	14.6%	16.7%	24.3%	28.0%	33.3%	4.5%	26.5%	42.1%
Do not know	4.9%	12.5%	5.4%	2.0%	6.7%	36.4%	18.4%	5.3%
Base	41	48	37	50	15	22	49	38

It is critical for victim-survivors to be offered adequate levels of safety and privacy to encourage them to comfortably discuss their experiences. As shown in Table 2 above, across all districts, at least half and up to 80% of the respondents confirmed that such spaces are available at state medical service delivery points.

The highest percentage of “do not know” responses were recorded in Mullaitivu (36.4%), while Nuwara Eliya recorded the highest percentage of respondents (42.1%) who did not feel they were provided with a safe and private space to talk. When safe and private spaces for discussions are limited or not available, there is a substantial risk that SGBV cases may go unreported. An FGD conducted with women in the Nuwara Eliya district confirmed that they do not have safe spaces for reporting and some of the existing spaces even expose victim-survivors.

Availability and accessibility of psychosocial and psychiatric support: In Sri Lanka, *Mithuru Piyasa/Natpu Nilayam* centers are established and managed within tertiary care institutions in selected districts.¹¹¹ *Mithuru Piyasa* (meaning “friendly abode”) is a drop-in assistance center designed as a one-stop crisis facility. These centers, managed by the Family Health Bureau of the Ministry of Health, are open from 8AM to 4PM. *Mithuru Piyasa/Natpu Nilayam* centers are staffed by trained medical and nursing officers.

In addition to providing counselling services such as ‘befriending’, these centers also refer victim-survivors to other state and non-state service providers for support. All hospitals classified as Type B or higher, have a consultant psychiatrist on staff, ensuring that *Mithuru Piyasa/Natpu Nilayam* centers located in these facilities have access to psychiatric expertise as needed. The other centres only provide psychiatric services on a needs basis, relying on support from District Mental Health or Medical Health Officers when required.

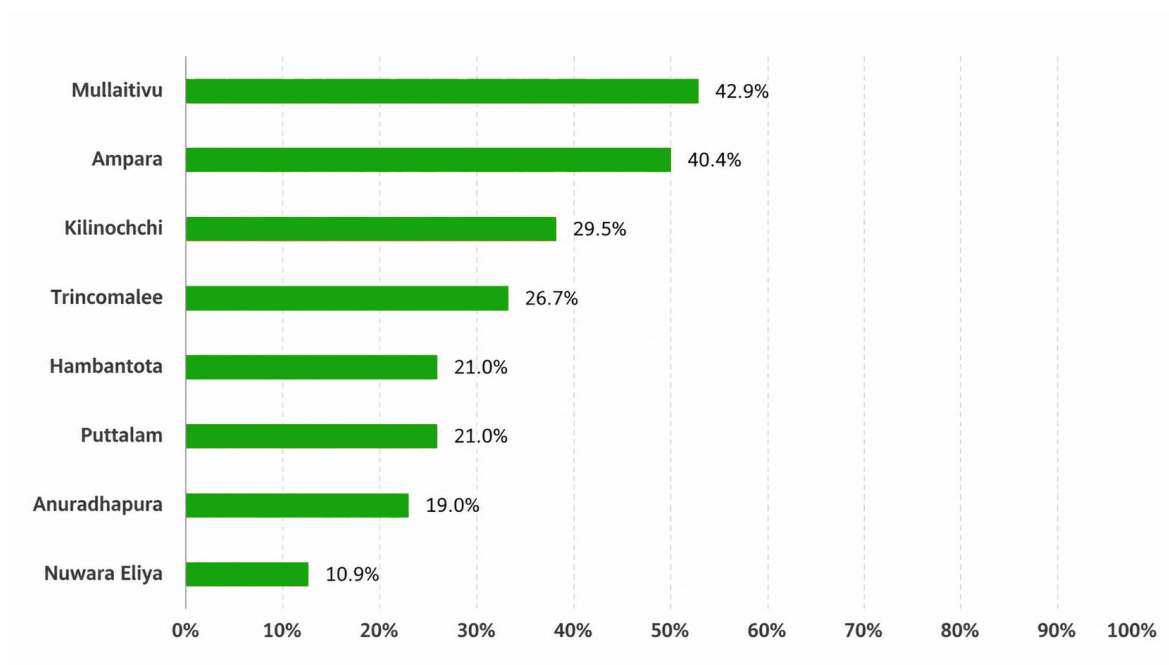
¹¹¹ Directorate of Mental Health, Ministry of Health, Nutrition and Indigenous Medicine, accessed June 17, 2024, https://mentalhealth.health.gov.lk/index.php?option=com_content&view=article&id=9&Itemid=220&lang=en

However, qualitative findings revealed that these centers are sometimes not staffed with dedicated personnel. Staff members are often required to assume other duties, thus limiting their availability and presence at centers. Several KIs believed that some of the staff may benefit from further training on responding to SGBV cases. This included training in areas such as trauma-informed care, sensitivity in responding to victim-survivors, documenting cases, and maintaining confidentiality.

“The clinic treated my physical conditions, but no one asked about the trauma I was going through.”

Victim-survivor, Nuwara Eliya

*Figure 10: Perceived availability of psychosocial and psychiatric support within the community or beyond
(Source: Interviewed women)*



Despite the availability of psychosocial and psychiatric support at hospitals, awareness of these services remains low across most districts. Only 26.5% of the total sample reported awareness about the availability of these services.

According to Figure 10 above, the highest level of awareness regarding the availability of these services was reported in Mullaitivu (42.9%), while the lowest was reported in Nuwara Eliya (10.9%). Although psychosocial and psychiatric support services are available in both Mullaitivu and Nuwara Eliya districts, awareness on the availability of these services appears to be higher in Mullaitivu, likely due to the district's prolonged exposure to the war, which created a sustained need for trauma-related support.

Figure 11: Barriers to accessing psychosocial and psychiatric support
(Source: Interviewed women reporting that psychosocial and psychiatric support is available in their community or beyond)



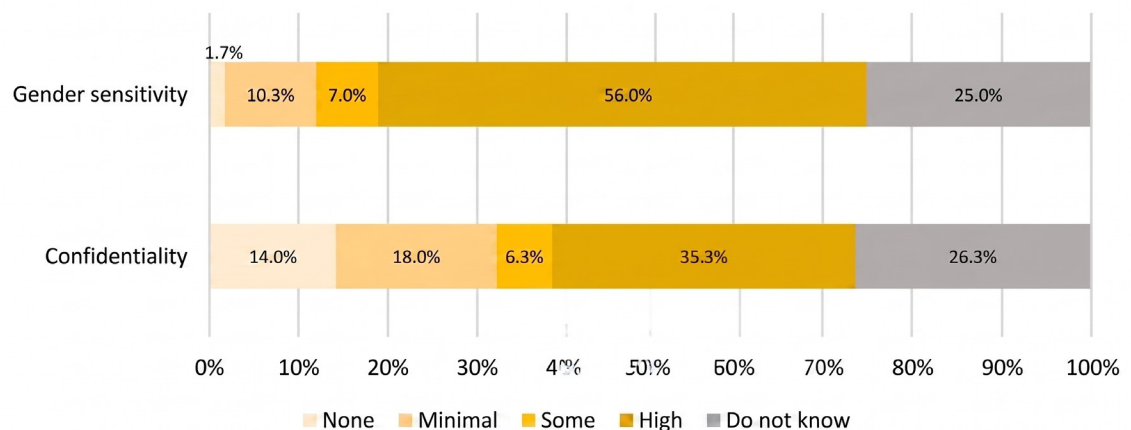
As shown in Figure 11 above, among respondents aware of mental health and psychosocial support services (MHPSS), the primary barriers to access these services were childcare responsibilities (59.4%) and high transportation costs (55.9%).

Interestingly, social stigma and shame (47.6%) were cited as barriers to accessing MHPSS by more respondents than those who reported the same reason as a barrier for accessing general state health services (38.4%) (see Figure 9). Other barriers reported by respondents included the inability to forgo daily wages (39.9%) and the inability to leave home due to fear of the perpetrator (36.4%).

Quality of medical care and psychosocial and psychiatric support

The following figure summarizes how respondents who had accessed, or accompanied someone accessing, state hospital services (clinical care or MHPSS), evaluated the levels of gender sensitivity and confidentiality within those services.

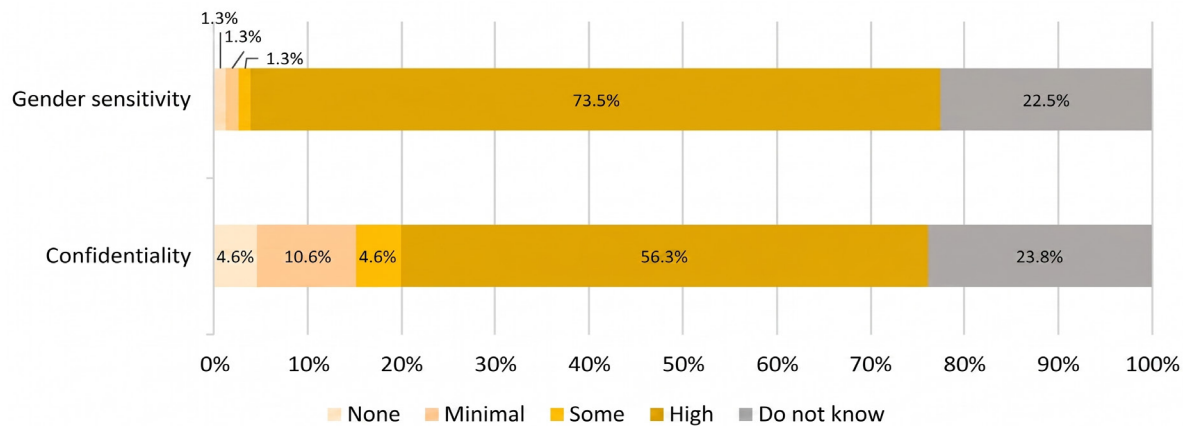
Figure 12: Perceptions of gender-sensitivity and confidentiality of state medical care
(Source: Interviewed women who have accessed or have accompanied someone who accessed this service)



According to Figure 12 above, the findings indicate that, with regard to state medical care, just over half of respondents (56.0%) confirmed gender sensitivity, while 19.0% reported either some, minimal or no gender sensitivity, and 25.0% reported “do not know”.

Ratings of confidentiality were considerably lower: only 35.3% believed confidentiality was maintained, whereas 38.3% felt there was some, minimal or no confidentiality. One in four respondents (26.3%) reported “do not know”.

Figure 13: Perceptions of gender-sensitivity and confidentiality of psychosocial and psychiatric support (Source: Interviewed women who have accessed or have accompanied someone who accessed this service)



According to Figure 13 above, a majority of respondents (73.5%) perceived psychosocial and psychiatric services as gender-sensitive, with only 1.3% each reporting some, minimal, or no gender sensitivity and 22.5% of respondents reporting “do not know”.

However, as with state medical care, perceptions of confidentiality were notably lower. More than half of the respondents (56.3%) believed that services were confidential, while 4.6% reported some confidentiality, 10.6% reported minimal confidentiality, and a further 4.6% reported no confidentiality. The remaining 23.8% reported “do not know”.

Table 3: Perceptions of state medical care - promptness/ responsiveness
(Source: Interviewed women who have accessed or have accompanied someone who accessed this service)

	Ampara	Puttalam	Mullaitivu	Anuradhapura	Kilinochchi	Trincomalee	Hambantota	Nuwara Eliya
Satisfactory	77.1%	73.2%	72.7%	70.0%	60.0%	56.8%	55.1%	36.8%
Somewhat satisfactory	18.8%	14.6%	4.5%	22.0%	33.3%	35.1%	34.7%	47.4%
Unsatisfactory	0.0%	7.3%	0.0%	4.0%	0.0%	0.0%	10.2%	5.3%
Do not know	4.2%	4.9%	22.7%	4.0%	6.7%	8.1%	0.0%	10.5%
Base	48	41	22	50	15	37	49	38

While the majority of respondents across most districts who had directly or indirectly accessed state-run medical care expressed satisfaction with the timeliness and responsiveness of services, Table 3 above shows that Nuwara Eliya recorded notably lower satisfaction rates (36.8%). This may be due to disparities in regional healthcare delivery and language barriers.

Although healthcare professionals are required to pass a language examination other than their native language for promotion, not all services in Nuwara Eliya are offered in Tamil, despite the district's substantial Tamil-speaking population. Similarly, the low satisfaction rates in districts like Hambantota (55.1%) point to broader inequalities in healthcare service delivery in peripheral regions.

"I heard there is no Tamil-speaking counsellor in the hospital ... They said there is only a Sinhalese lady. They say she speaks Tamil but [we] don't know how [effective] it is."

Non-state service provider, Mullaitivu

*Table 4: Perceptions of state medical care – safety**(Source: Interviewed women who have accessed or have accompanied someone who accessed this service)*

	Puttalam	Ampara	Kilinochchi	Mullaitivu	Anuradhapura	Hambantota	Trincomalee	Nuwara Eliya
Satisfactory	82.9%	81.3%	73.3%	68.2%	64.0%	57.1%	56.8%	50.0%
Somewhat satisfactory	9.8%	14.6%	20.0%	9.1%	30.0%	20.4%	35.1%	31.6%
Unsatisfactory	2.4%	0.0%	0.0%	0.0%	2.0%	18.4%	0.0%	5.3%
Do not know	4.9%	4.2%	6.7%	22.7%	4.0%	4.1%	8.1%	13.2%
Base	41	48	15	22	50	49	37	38

Across the surveyed districts, a majority of respondents (66.3%) reported feeling safe when accessing and receiving state medical services (see Table 4 above). Puttalam recorded the highest perceptions of safety, with 82.9% of respondents reporting “satisfactory”.

However, some disparities were observed across districts. Hambantota reported the highest level of dissatisfaction (18.4%), followed by Nuwara Eliya (5.3%). In Nuwara Eliya, only 50% of respondents reported “satisfactory”. This is the lowest perceived level of satisfaction for feeling safe recorded across all surveyed districts.

4.2 Legal Remedies and Services

Police:

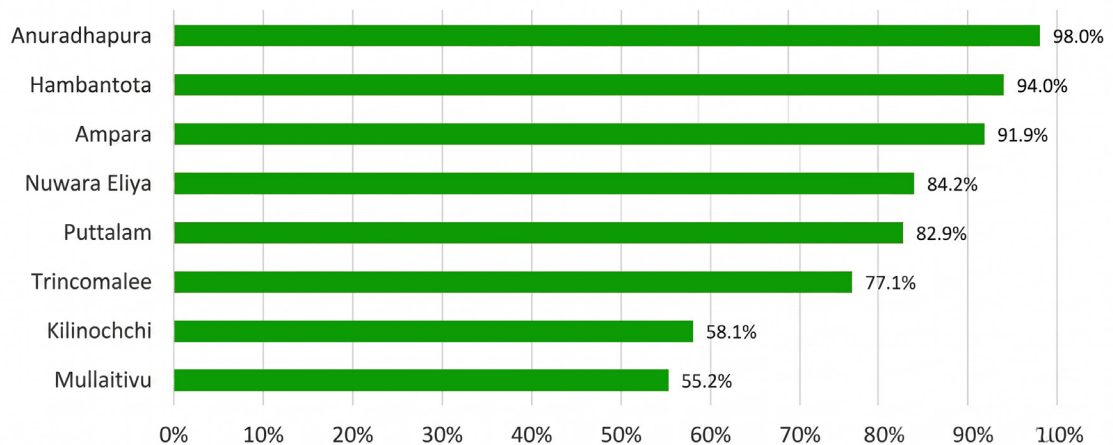
While each police station in the area has a Women and Children’s Desk staffed by female officers to serve as first responders for victim-survivors, several factors hinder their effectiveness. These desks accept direct reports and referrals from the Police Emergency Hotline (119), state officials such as the Grama Niladari, Women’s Development Officers (WDOs), and PHMs, as well as from hospitals (which are obligated to report any SGBV incidents to the hospital police post), and from *Mithuru Piyasa/Natpu Nilayam* centers. Despite these mechanisms, victim-survivors are often reluctant to engage with the police and courts. This hesitancy stems from lengthy processes and legal delays, as confirmed by KIs and participants in both non-state and victim-survivor FGDs. Consequently, many victim-survivors prefer seeking assistance from WDOs and women’s NGOs.

“With regard to the police, there is a big language problem. Training for women police is insufficient. They don’t know the laws or procedures governing domestic violence. They don’t have resources either.”

Non-state service provider, Puttalam

KIs also revealed that some police officers lack adequate training on SGBV, including its definition, causes, and appropriate handling of cases through a victim-survivor-centered approach. This skill gap further contributes to victim-survivors seeking alternative avenues of redress outside the formal judicial system.

*Figure 14: Perceived availability of police service within their community or beyond
(Source: Interviewed women)*



As shown in Figure 14 above, a majority of survey respondents reported that police services are available within their community or beyond.

*Figure 15: Barriers to accessing police services
(Source: Interviewed women reporting police services are available in their community or beyond)*



Although police services are generally widely available, survey respondents who confirmed their availability identified several obstacles to accessing them (see Figure 15 above). In particular, 47.9% of respondents cited childcare responsibilities, 46.4% identified societal stigma or shame, and 44.8% mentioned high transportation costs as barriers to access. Notably, childcare responsibilities and social stigma continue to emerge as the most significant barriers to accessing most SGBV-related services, followed by societal stigma or shame. Additionally, deeply entrenched socio-cultural norms continue to influence women's access to services addressing SGBV, including police assistance.

“Recently a mother went to the police to file a SGBV complaint. She said that because of her husband’s influence, the police refused to take her complaint and laughed at her”.

State service provider, Trincomalee

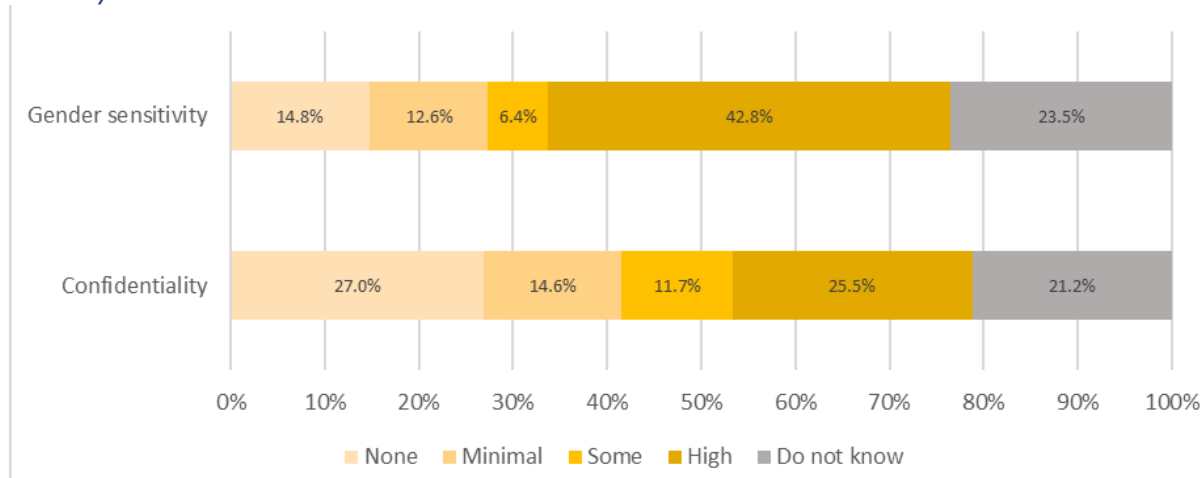
Qualitative findings also reveal that negative experiences, such as dismissive attitudes of police officers or instances where officers are perceived as biased toward or supportive of the perpetrators, further discourage victim-survivors from reporting SGBV incidents. These results highlight the need for targeted interventions to improve accessibility and create more victim-survivor-friendly support services.

Quality of police services:

The following figure summarizes how respondents who had accessed, or accompanied someone to the police, evaluated the levels of gender sensitivity and confidentiality within those services.

Figure 16: Perceptions of gender-sensitivity and confidentiality of police services

(Source: Interviewed women who have accessed or have accompanied someone who accessed this service)



While almost half of the respondents who had accessed police services or accompanied someone who had reported a high level of gender-sensitivity within the police (42.8%), a considerable proportion (33.8%) report some, minimal or no gender sensitivity, and 23.5% reported “do not know” (see Figure 16 above).

Perceptions of confidentiality were notably lower. More than one-fourth of respondents who have themselves accessed or have accompanied someone who accessed police services reported no confidentiality was maintained (27.0%). However, an equal proportion (25.5%) perceived high levels of confidentiality, highlighting significant disparities in service provision across surveyed districts.

A young girl was taken into a forest and abused. She was later taken to the police ... A woman in the village who works at the police station had informed the villagers about the incident. When the girl returned home, everyone in the village knew about it, and they were all asking what had happened.

State service provider, Hambantota

Although a relatively large percentage of respondents perceived a high level of gender sensitivity in police services, several pointed out the limited availability of female police officers at stations. Importantly, out of 491 police stations, 481 have a Women and Children's Unit,¹¹² which is remarkable. However, many of these units face challenges related to physical and human resources. Most female police officers are not available during nights. This poses a challenge to maintaining gender sensitivity and confidentiality for victim-survivors.

"We are unable to see women police officers at the station. If they are available, we could feel more comfortable to express ourselves"

Victim-survivor, Kilinochchi

Qualitative findings also disclosed incidents where male police officers attempted to solicit sexual favours from victim-survivors reporting violence. Such exploitation of victims' vulnerabilities creates an environment that is unsafe for women victim-survivors seeking assistance. This further discourages them from accessing necessary support and reporting crimes. This in turn undermines trust in law enforcement and perpetuates a culture of fear among victim-survivors.

"We feel that involving the police won't help, and sometimes it only makes things worse. It's difficult to trust that the law will protect us."

Victim-survivor, Nuwara Eliya

Availability and accessibility of legal assistance and representation:

Legal Aid: The Legal Aid Commission (LAC) and various NGOs/CSOs offer free or low-cost legal aid, in the form of consultations and representation, to victim-survivors of SGBV. Eligibility for LAC assistance generally requires a monthly income of less than LKR 25,000. However, this restriction does not apply to maintenance and domestic violence cases, thereby improving accessibility for women seeking justice in these matters.

Despite this provision, KIs noted that the LAC faces substantial staffing issues and infrastructural constraints. Most LAC offices are in small, shared spaces within court complexes that lack privacy for consultations. While in some areas there are effective communication channels between non-state service providers and LAC legal officers, others report the contrary.

¹¹² National Police Commission, United Nations Development Programme, and Centre for Women's Research, Divisional Bureaus for the Prevention of Abuse of Children and Women: An Assessment, 2019, <https://www.undp.org/sites/g/files/zskgke326/files/migration/lk/NPC-Gender-Study-A---Final-Report.pdf>

“As we don’t have money to pay government lawyers or others, we need to go to LAC. LAC not responding on time even if they don’t take time to inquire about us. First, it is very difficult to meet the lawyer”

Victim-survivor, Kilinochchi

Some victim-survivor respondents in FGDs expressed a preference for fee-levying private lawyers over LAC officers due to a perceived lack of confidence in the latter’s experience. Similarly, many non-state legal aid organizations struggle with funding and capacity, limiting their ability to assist all those in need. This is observed more in rural areas where awareness of the availability of their services is low, as confirmed by KIIs and FGDs with non-state service providers.

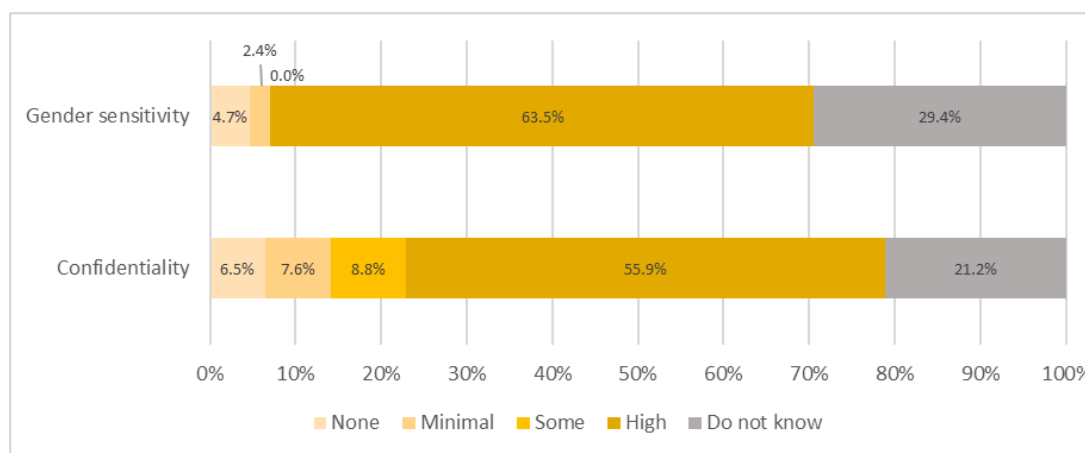
Fee-levying private lawyers: Law firms and individual practitioners provide private legal advice and representation. While these services may be sought in the absence of legal aid services, the associated fees can be prohibitive for many victim-survivors, especially for those who are economically disadvantaged. In some cases, the vulnerability of victim-survivors may expose them to exploitation, such as sexual bribery by unethical legal practitioners who charge excessive fees or make false promises regarding case outcomes. Despite these potential risks, some victim-survivors prefer the services of fee-levying private lawyers over LAC officers.

Quality of legal assistance and representation:

The following figure summarizes how respondents who had accessed, or accompanied someone to free legal services, evaluated the levels of gender sensitivity and confidentiality within those services.

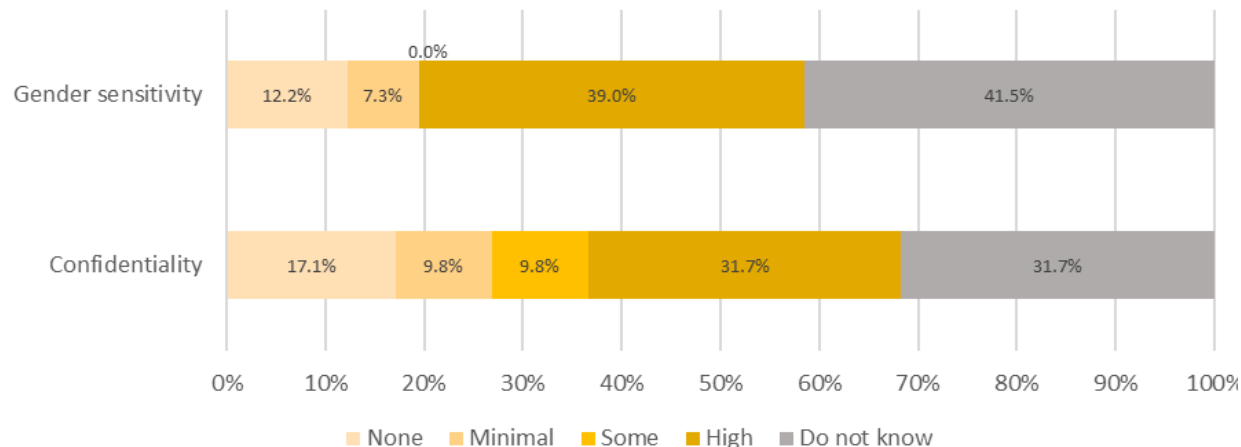
Figure 17: Perceptions of gender-sensitivity and confidentiality of free legal services

(Source: Interviewed women who have accessed or have accompanied someone who accessed this service)



As shown in Figure 17 above, a majority of those who have accessed free legal services or have accompanied someone who accessed them, report high levels of gender sensitivity (63.5%) and confidentiality (55.9%).

Figure 18: Perceptions of gender-sensitivity and confidentiality of private (fee-levying) legal services (Source: Interviewed women who have accessed or have accompanied someone who accessed this service)



In comparison, Figure 18 above reveals that positive perceptions regarding gender sensitivity and confidentiality are lower among those who have personally accessed or have accompanied someone who accessed private legal services. Only 39.0% of respondents report high gender sensitivity in private legal services, while 19.5% reported some, minimal or none, and 41.5% reported “do not know”. More than one-third (36.7%) of respondents reported some, minimal or no perception of confidentiality in private legal services, whilst only 31.7% report a high level of confidentiality.

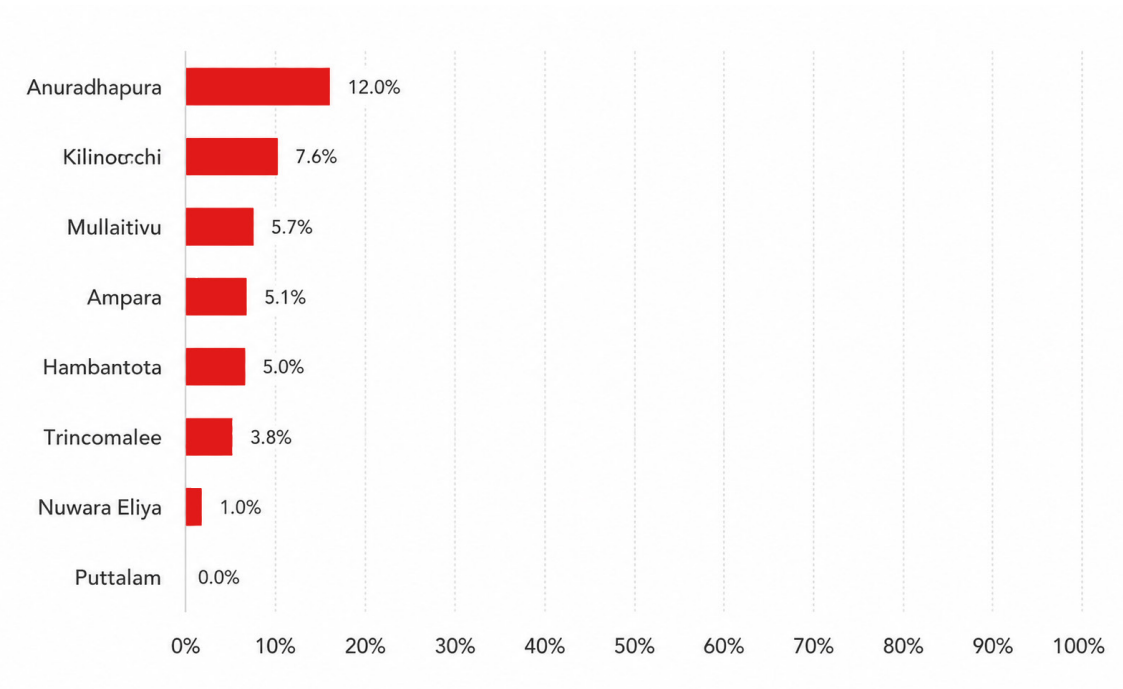
Further, the quality of legal assistance and representation for victim-survivors faces significant challenges that hinder effective justice delivery. Due to staffing and infrastructure limitations, LAC services may sometimes compromise confidentiality, discouraging victim-survivors (especially in SGBV cases) from disclosing crucial details.

As highlighted during KIIs and FGDs, many victim-survivors struggle to access qualified legal counsel, either because they are unaware of existing services or because the limited resources of service providers restricts accessibility. This often results in inadequate representation during court proceedings. This is compounded by systemic issues such as a lack of gender sensitivity training among legal practitioners and a justice system that often lacks understanding of the complexities surrounding SGBV. Additionally, financial constraints limit the ability of many victim-survivors to pursue legal action, as pro bono services are insufficient and not widely available.

4.3 Social Services

Social services play a vital role in supporting victim-survivors of SGBV. They encompass a range of assistance, including emergency shelters, safe housing, livelihood assistance, awareness and education, and financial assistance. These services provide immediate assistance and a safe haven for individuals seeking refuge from abusive situations.

Figure 19: Perceived availability of (short-term) emergency shelters within the community or beyond (Source: Interviewed women)



Emergency shelters that provide immediate and short-term accommodation are crucial for victim-survivors of SGBV, who often must leave their homes to escape abuse. The availability of these facilities is essential for their wellbeing and freedom.

As shown in Figure 19 above, however, only a small proportion of respondents reported awareness of safe shelters within or in the vicinity of their communities. The highest proportion, standing at a mere 12% is recorded in the district of Anuradhapura, followed by 7.6% in Kilinochchi. In Nuwara Eliya, only 1% believed safe shelters were available, while in Puttalam none did.

“There is one emergency safe house available. We adhere to the Ministry’s guidelines as well as the Safe Form guidelines.”

Non-state service provider, Nuwara Eliya

Figure 20: Perceived availability of (long-term) safe housing within the community or beyond
(Source: Interviewed women)

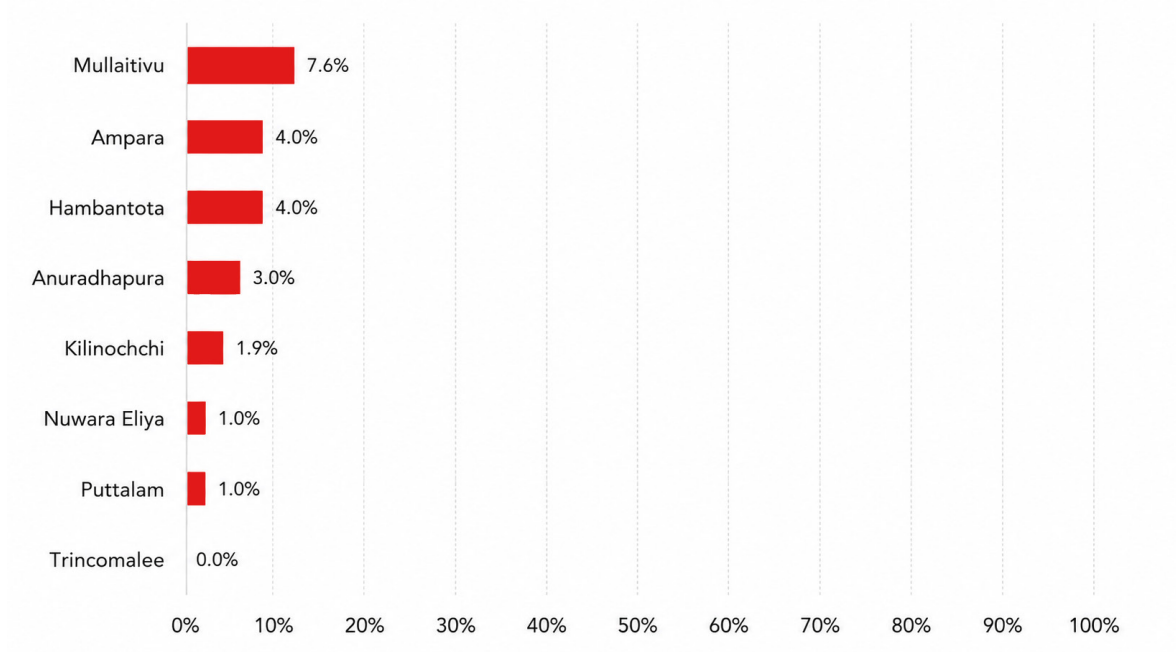


Figure 20 above depicts the responses on the availability of safe houses, i.e., long-term accommodation for victim-survivors, in the respondents' community or beyond.

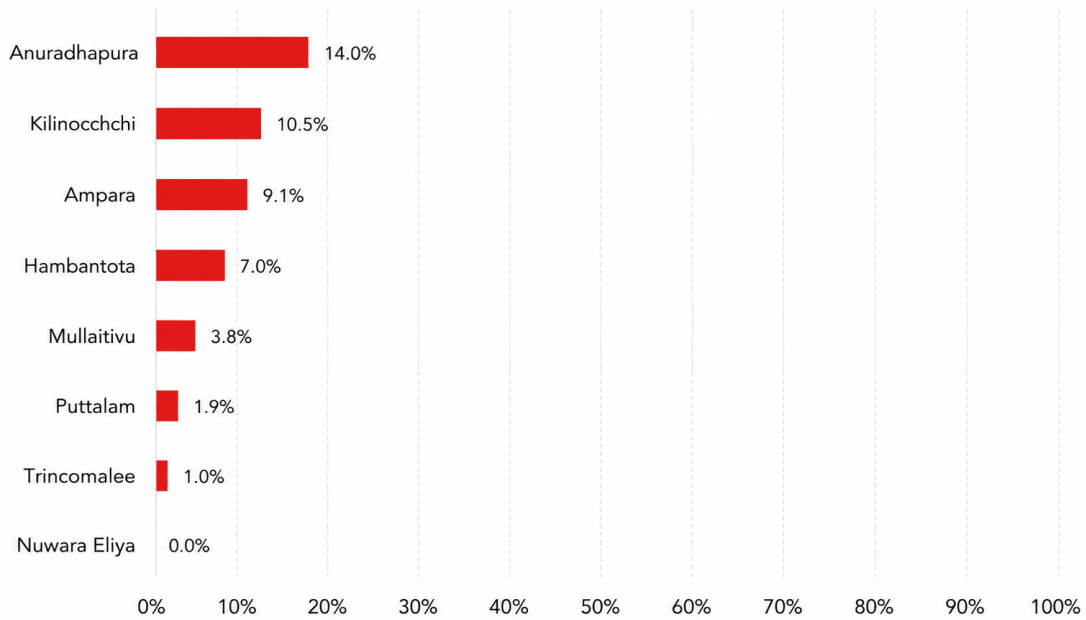
In Mullaitivu district, 7.6% of the respondents confirmed the availability of safe houses, while none in Trincomalee district reported that such services are available. Only 1% of respondents in the Nuwara Eliya and Puttalam believed safe housing was available within or beyond their community.

“There is no safe house here. There are some cases now where [victim-survivors] come and stay at our house. That’s not safe.”

Non-state service provider, Trincomalee

The findings also suggest an urban-rural disparity: 3.4% of urban respondents reported that safe housing is available, compared to 2.7% in rural areas.

Figure 21: Perceived availability of financial assistance for survivors within the community or beyond (Source: Interviewed women)



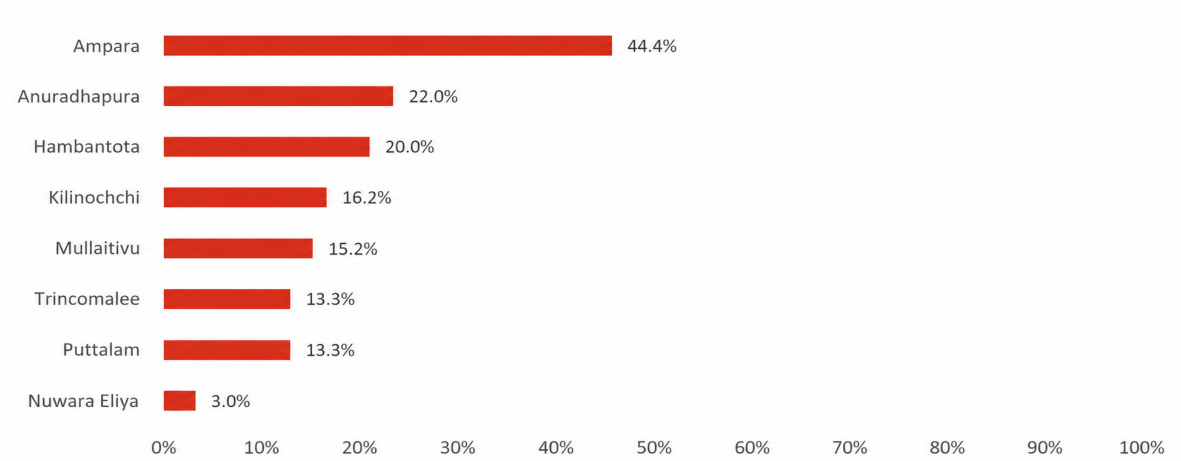
The provision of social services (such as financial assistance for transport, medical care, legal representation, self-employment and entrepreneurship) is important to support victim-survivors both in the immediate and long run.

A significant majority of respondents across all districts reported either an absence or a lack of awareness of such services being available to victim-survivors (see Figure 21 above). The highest proportion of respondents that reported availability of financial assistance was in Anuradhapura (14%), followed by Kilinochchi (10.5%). Less than 10% of respondents from all other districts indicated the same. A KI from Puttalam district mentioned that some religious organizations and NGOs had previously supported victim-survivors in finding employment upon request. However, she pointed out that due to the financial crisis, such organizations have gradually reduced their involvement because of funding constraints. Respondents further noted that they occasionally sought assistance from known individuals in their personal capacity to help the victim-survivors in need.

“I lived in a cemetery for days with my children because I had nowhere else to go.”

Victim-survivor, Hambantota

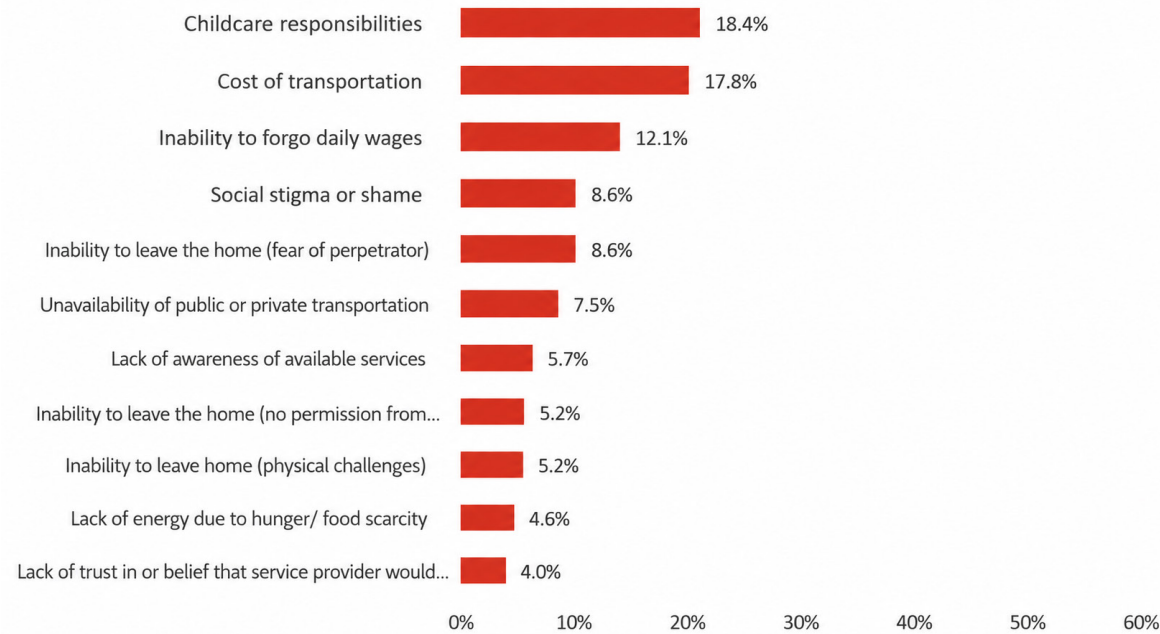
Figure 22: Perceived availability of food and other material assistance within the community or beyond
(Source: Interviewed women)

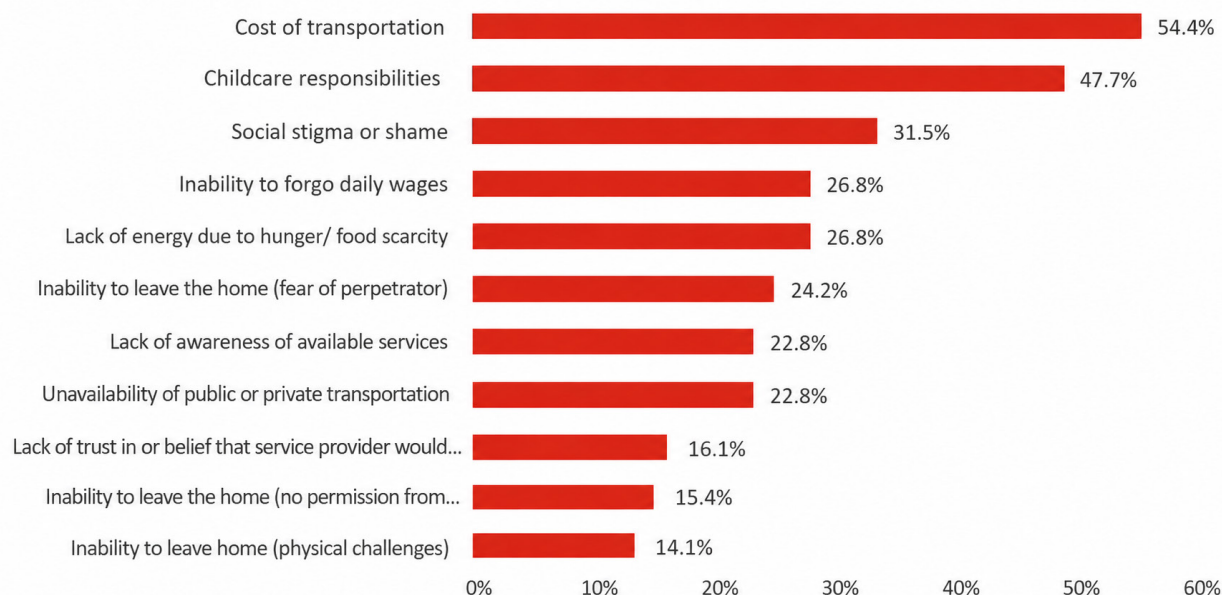


Among disadvantaged groups, consistent and reliable access to food and other in-kind assistance, such as hygiene kits, plays a crucial role in addressing immediate survival needs, while supporting long-term recovery and empowerment. Such assistance also helps reduce survivors’ dependence on SGBV perpetrators and facilitates pathways toward independence.

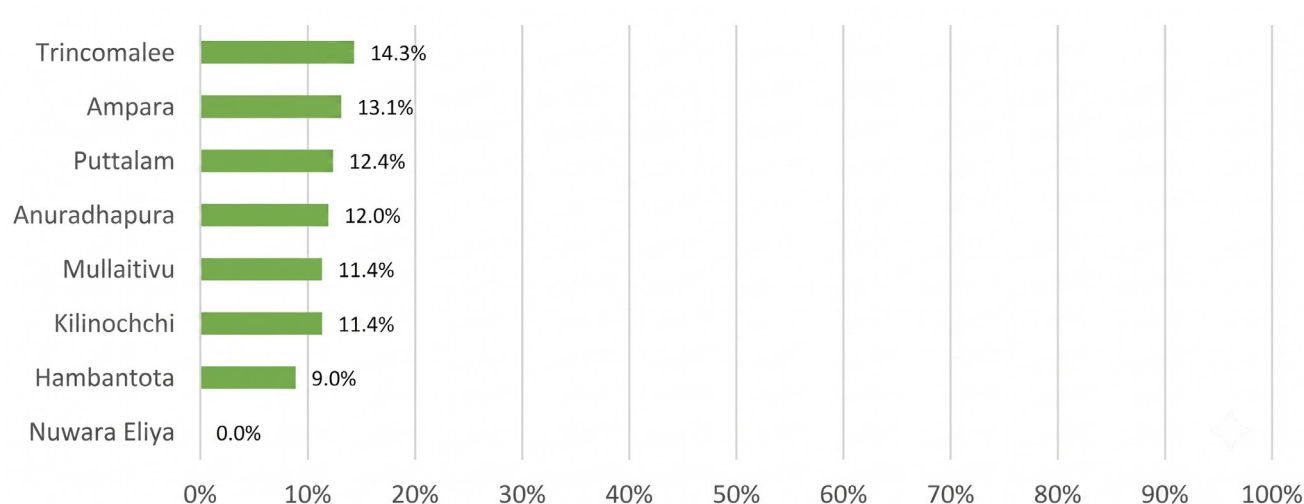
As shown in Figure 22 above, 44.4% of respondents in Ampara reported the availability of food and material assistance, followed by just 22% of respondents in Anuradhapura and 20% of respondents in Hambantota. Alarming, consistent with patterns observed for other services, only 3% of respondents in Nuwara Eliya confirmed the availability of such support.

Figure 23: Barriers to accessing financial assistance for survivors
(Source: Interviewed women reporting that financial assistance is available in their community or beyond)



*Figure 24: Barriers to accessing food and other material assistance**(Source: Interviewed women reporting that food and other material assistance is available in their community or beyond)*

Among the 48 respondents who reported that food and other material assistance is available, 54.4% identified cost of transportation as a barrier to accessing these services. Moreover, 47.7% of respondents cited childcare responsibilities as another significant barrier.

*Figure 25: Perceived availability of livelihood development support (including skills training) within the community or beyond**(Source: Interviewed women)*

Economic empowerment is crucial to survivors of SGBV, as it facilitates recovery, reduces vulnerability to re-victimization, and promotes long-term independence. Livelihood development support and skill-building are essential components of this empowerment.

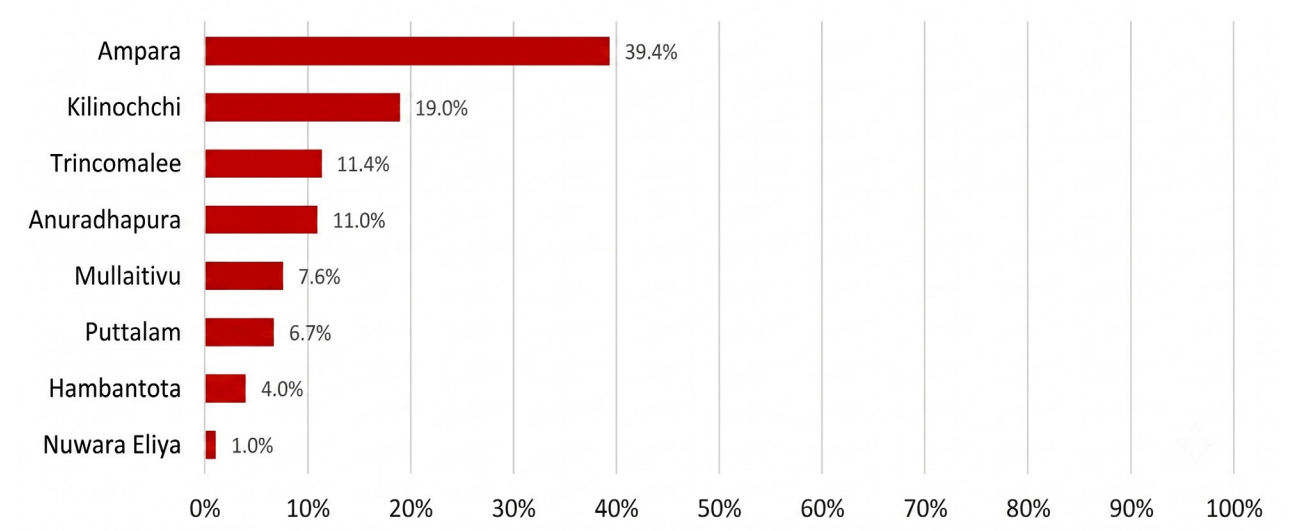
This enables survivors to gain financial autonomy and rebuild their lives free from stigma and dependence on abusers. Such services include vocational training, micro-enterprise development, financial literacy programmes, and job placement assistance.

Despite the critical importance of such services, their availability remains heavily limited across the surveyed locations (see Figure 25 above). Even the highest reported availability was only 14.3% in Trincomalee district and 13.1% in Ampara district. No respondents in Nuwara Eliya district reported the availability of such services.

However, there are some non-state institutions that provide livelihood support such as microfinance for victim-survivors in the Nuwara Eliya district (e.g. Palm Foundation).¹¹³ Therefore, the perceived absence of such services may partly be attributed to a lack of awareness among the respondents.

Women’s responses highlight the urgent need for increased investment in and expansion of livelihood development programmes for SGBV victim-survivors. This is particularly important in underserved regions, alongside efforts to strengthen outreach and communication to communities.

Figure 26: Perceived availability of awareness-raising on SGBV prevention within the community or beyond
(Source: Interviewed women)



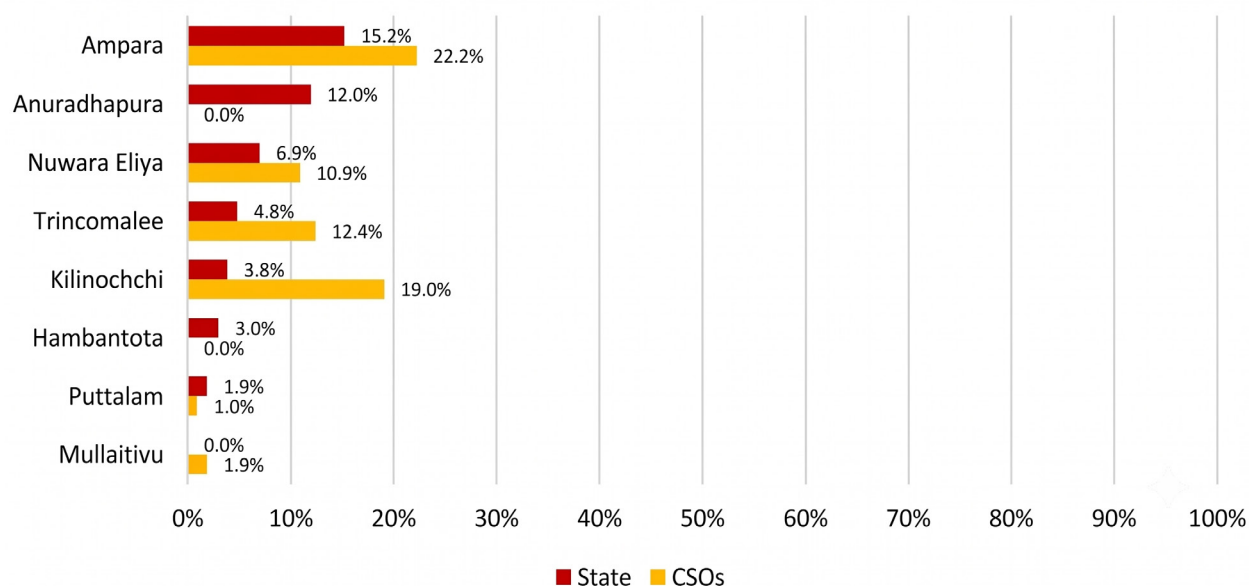
Awareness raising on SGBV prevention is extremely important to drive behavioral change, shifting social norms, and improving access to support services within communities. It serves as a cornerstone of any strategy aimed at eliminating SGBV. However, the availability of SGBV awareness and prevention services is reported to be extremely low (see Figure 26 above).

Ampara district reported the highest availability, with 39.4% of respondents confirming access to such services. This was followed by Kilinochchi at 19%, while Trincomalee and Anuradhapura both reported approximately 11%. In the remaining districts, less than 10% of respondents confirmed the availability of these services.

¹¹³ PALM Foundation: Fighting gender-based violence in Nuwara Eliya (2024-2027), <https://padem.org/en/cause/fighting-gender-based-violence-in-nuwara-elya/>

Notably, Nuwara Eliya recorded the lowest percentage, at only 1%. This lack of awareness in Nuwara Eliya is particularly concerning, as it can have detrimental impacts on victim-survivors. The findings may also suggest a broader issue of internalization and normalization of certain forms of SGBV within the community.

Figure 27: Perceived availability of rapid response/ emergency hotline services (state and non-state) within the community or beyond (Source: Interviewed women)



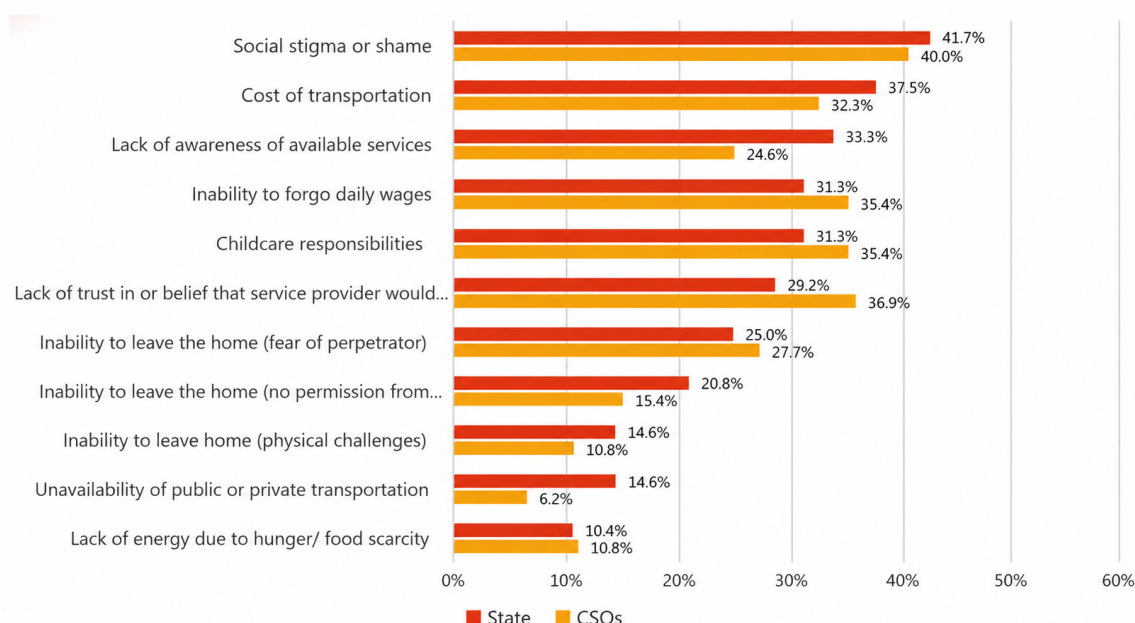
Rapid response and emergency hotline services expand and facilitate victim-survivors' access to SGBV response services and information. These services are particularly vital when direct access to in-person support is hindered by geographic distance, security concerns, inadequate infrastructure or financial constraints. In such situations, hotlines often become the only viable option for immediate assistance.

However, findings reveal that access to these critical services remains severely limited across all surveyed districts, with fewer than one-quarter of respondents reporting their availability.

According to Figure 27 above, hotlines operated by CSOs are reported to be more widely available than state-run hotlines. Availability was highest overall in Ampara (22.2% CSO-run, 15.2% state-run), Kilinochchi (19.0% CSO-run, 2.8% state-run), Trincomalee (12.4% CSO-run, 4.8% state-run), and Nuwara Eliya (10.9% CSO-run, 6.9% state-run).

In some regions, however, access to rapid response and emergency hotline services, primarily provided by the state, serve as the more feasible option. Respondents from Ampara had the highest reported level of availability (15.2%). In Anuradhapura, while no CSO-run hotlines were reported, 12.0% of respondents noted the availability of state hotlines. Only minimal percentages indicated hotline availability in Puttalam (both CSO-run and state-run), Hambantota (state-run only), and Mullaitivu (CSO-run only).

*Figure 28: Barriers to accessing rapid response/ emergency hotline services (state and non-state)
(Source: Interviewed women reporting that rapid response/emergency hotline services are available in their community or beyond)*



Respondents who confirmed the availability of hotlines also identified several barriers that hinder effective utilization (see Figure 28 above). Social stigma and shame emerged as a significant deterrent, with around 40% citing this as an obstacle to accessing both state- and CSO-run services. A lack of trust in service providers was another major concern, particularly in relation to CSO-run hotlines (36.9%). Other barriers included time constraints due to childcare responsibilities and concerns about interrupting work and losing daily wages, each reported by approximately one-third of respondents.

The perceived unavailability of hotlines and rapid response services, combined with these barriers, compounds the challenges faced by victim-survivors, especially for those with childcare responsibilities and engaged in precarious forms of work. These findings highlight the need for interventions that address societal attitudes surrounding SGBV, build trust in service providers, and offer practical support mechanisms to overcome barriers to accessing these essential services.

4.4 Barriers to Accessing SGBV Support Services

Overall, the field data discloses that women victim-survivors across all the study districts face similar barriers when accessing or attempting to access SGBV support services, with a few exceptions as highlighted below:

- Lack of awareness of available services:** A critical barrier to accessing support services for SGBV survivors is the lack of awareness regarding their availability. Without targeted outreach and education campaigns, potential beneficiaries remain uninformed about existing resources, including, counselling, legal aid, and medical services. Primary data confirmed a significant gap in awareness-raising related to available SGBV support services. Only 13% of respondents in both Ampara and Kilinochchi confirmed the existence of awareness-raising efforts, followed by 3% in Anuradhapura and Hambantota, and just 1% in Mullaitivu, Nuwara Eliya, and Puttalam. Notably, no respondents in Trincomalee reported any awareness activities.

“Domestic violence, specifically violence by husbands against wives, is not reported. Additionally, sexual violence committed by friends is also not reported.”

Non- state service provider, Trincomalee

- **Lengthy and repetitive processes:** Due to the lack of centralized inter-agency coordination mechanisms and clear standardized referral pathways, victim-survivors frequently have to repeat their stories to various authorities, such as the police, healthcare providers, and legal aid providers. This repetition not only causes emotional distress, but also discourages continued engagement with services. Due to the insufficient resources and delays in the judicial system, victim-survivors also face extremely long wait times to access justice or health services, which negates the positive impact of these services.

“I had to recount the entire story from beginning to end repeatedly.”

Victim-survivor, Nuwara Eliya

“Getting a judgment on these cases can take 15 to 20 years.”

Service provider, Nuwara Eliya

- **Geographic and economic barriers:** Many victim-survivors, especially in rural areas, must travel considerable distances to access services. Inadequate public transport options push some victim-survivors to expensive private transport options, which drives costs of access higher. This adds further financial and emotional stress on those accessing these services.

“We had to spend our own money for transportation, such as bus fares, to go to the police.”

Victim-survivor, Nuwara Eliya

“It’s hard to access services when we can’t even afford to travel.”

Victim-survivor, Anuradhapura

- **Lack of local services:** When there is limited availability of local services, this requires victim-survivors, especially from rural areas to travel long distances to access assistance. This can be particularly difficult for those without reliable transportation or financial means. Victim-survivors economically reliant on the informal economy (daily wage-earners) prioritize their work over accessing services. Seeking help outside one’s own community also disrupts

continuity of care, as infrequent contact with service providers makes it more difficult to establish trust and sustained support relationships.

“Having more local support services would be critical to get the help they need without traveling long distances.”

Victim-survivor, Nuwara Eliya

- **Social stigma and the fear of retaliation:** Social stigma and fear of retaliation significantly hinder help-seeking among victim-survivors. The data indicate that these societal attitudes foster an environment of fear and shame, discouraging victim-survivors from disclosing their experiences and accessing necessary support. Victim-blaming, as reported by survivors, exacerbates these negative feelings, often leading to internalization of trauma.

“Cultural and religious barriers are high in this region”.

State service provider, Puttalam

According to interviewed women, the absence of a supportive network, including instances of unsupportive or even hostile reactions from friends and family, further isolates them and discourages them from seeking assistance. Restrictive cultural and religious traditions and beliefs also contribute to the social stigma. The fear of retaliation, whether from the perpetrator or the wider community, compounds the impact of social stigma. Survivors identify this as a powerful deterrent to reporting the violence and seeking justice.

“Most individuals don’t come in person, as cultural factors and feelings of shame often discourage them.”

Non-state service provider, Nuwara Eliya

- **Language barriers:** Tamil speaking victim-survivors, especially those from the Northern and Eastern Provinces, as well as the Malaiyaga Tamil community, face significant language barriers when trying to access services. Notably, this issue is most prevalent in legal services, impeding their ability to communicate effectively, particularly with the police, and to understand legal processes. For many Tamil-speaking victim-survivors, the lack of legal assistance in their language has led to misunderstandings, feelings of frustration, and ultimately discouragement from pursuing justice.

“Most people complain directly to NGOs (such as Change Humanitarian Organization, MWDT and Viluthu), while others complain through the Grama Niladhari. Even though they know that they can complain directly to the police, many Tamil speakers do not go there. because they know they will not be able to communicate.”

Non-state service provider, Puttalam

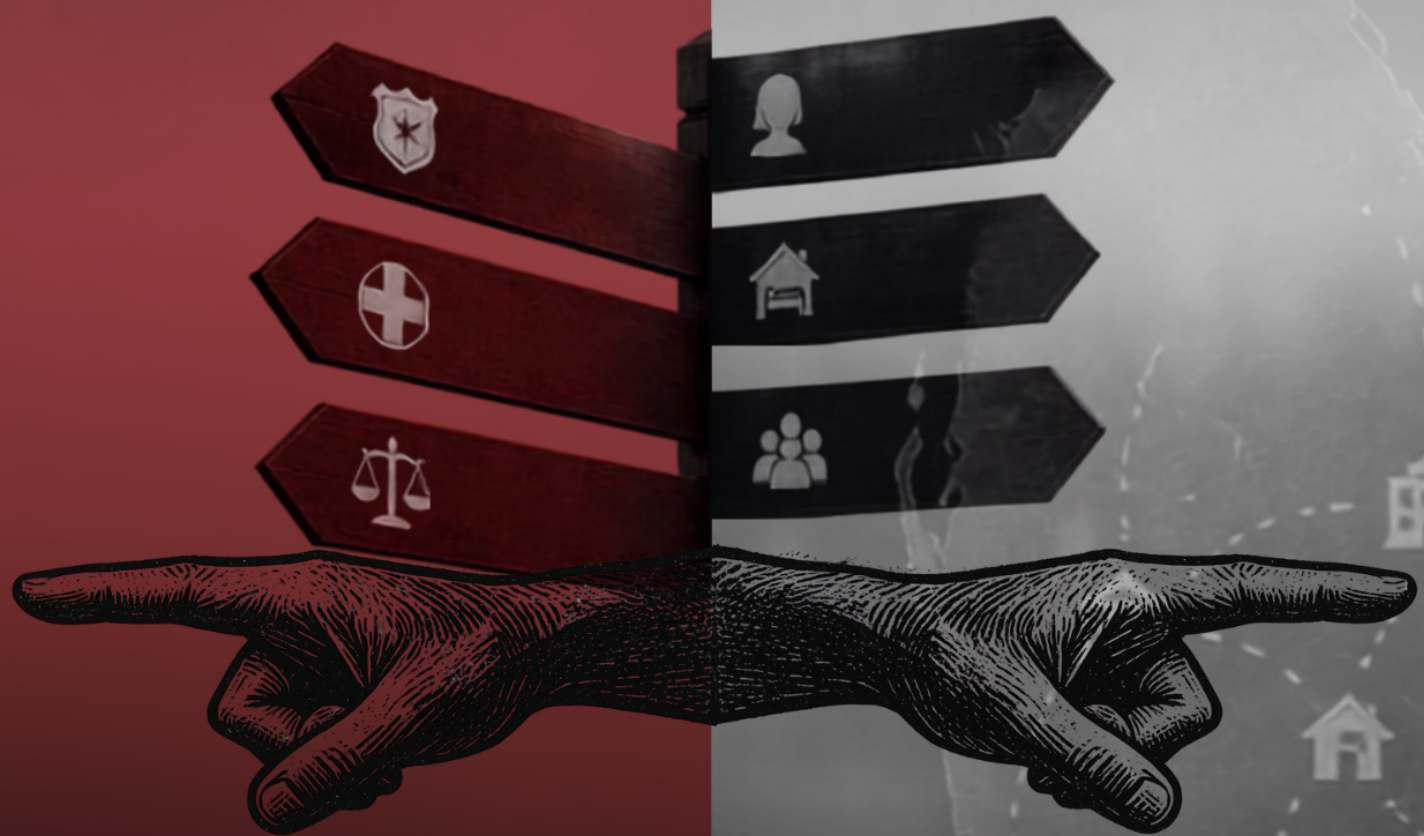
Conversely, Sinhala-speaking victim-survivors living in Tamil-majority areas of the Northern Province also encounter similar challenges when attempting to access services.

- **Unpaid care responsibilities:** Many victim-survivors reported being the primary caregivers in their households, particularly for minor children, leaving them with little to no time to seek SGBV-related services or attend appointments. Unpaid care work also restricts their mobility, making it challenging to travel to service providers. Victim-survivors fulfilling these unpaid care roles also generally have limited financial independence. This economic vulnerability deters them from seeking assistance due to the associated indirect costs, such as transport and the expense of alternative childcare during their absence.

“It is very difficult for me to leave the house because I have nowhere to safely leave my children... Even to come here for this interview, I had to leave my children with my neighbor, and right now, this is where my mind is.”

Victim-survivor, Kilinochchi

In some cases, economic dependence on the abuser forces women to seek permission to access support services. This effectively prevents them from seeking assistance. The heavy burden of unpaid care can also lead to social isolation. This further reduces victim-survivors’ access to support networks and discourages them from disclosing their experiences or reaching out for help.



CHAPTER 5: COORDINATION AND REFERRAL PATHWAYS

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

5. COORDINATION AND REFERRAL PATHWAYS

Sri Lanka currently lacks policies, SOPs, or guidelines which are uniformly applicable to all service providers involved in responding to SGBV. Consequently, there are no formalized inter-agency coordination mechanisms or referral pathways that encompass all first responders and referral points across national, district, or divisional levels to ensure comprehensive, survivor-centered, timely, and quality service provision.

Furthermore, service providers do not consistently distinguish between different categories of users—such as first-time versus repeat service users—in order to tailor or refer them to appropriate, customized services. Despite the absence of a cohesive national framework governing inter-agency coordination and referrals, some state and non-state actors have independently developed their own informal or formal referral mechanisms.

At the national level, the Ministry of Health has issued the “Health Sector Response to Gender Based Violence National Guideline for First Contact Point Health Care Providers Sri Lanka” based on the United Nations ESP. This sets out a clear pathway of care for first responders in hospitals and first responders in preventive healthcare services.¹¹⁴ The policy also sets out guidance on making referrals to other services such as safety/security, legal, and psycho-social in addition to medical services. It recognizes that referrals should happen with the consent of the victim-survivor except in exceptional situations, such as¹¹⁵ when there is considerable risk to her safety from external threats, killing, or suicidal ideation. In these cases, referrals can be made to another actor (such as the police) without consent.¹¹⁶

The Guideline outlines several sector-specific referral pathways based on specific victim-survivors. Referrals for legal services are to be made to the police with the consent of the victim-survivor except in exceptional circumstances. Other recommended legal referral agencies are the LAC, Women in Need (WIN), and the Complaints Centre at the Ministry of Women and Child Affairs (Hotline 1938). For psychosocial support, referrals are recommended to the *Mithuru Piyasa/Natpu Nilayam* for befriending and basic emotional support; NGOs such as Sarvodaya and WIN; Complaints Centre at Ministry of Women and Child Affairs and other local organisations; psychiatrists, psychologists and professional counsellors (where available); Medical Officers of Mental Health; and the Counselling Assistants attached to the Women and Child Development units at the Divisional Secretariats. Referrals for social and economic support are made to officers attached to the Women and Child Development units at the Divisional Secretariats. These Guidelines also refer to the Family Health Bureau protocol for *Mithuru Piyasa/Natpu Nilayam* which provides guidance on referral pathways for clients.¹¹⁷ However, the content of the said Protocol is not available in the public domain for analysis.

In 2014 the UNDP and the Ministry of Women’s Affairs developed an updated referral pathway for victim-survivors of SGBV building on a multi-sectoral approach outlined in the Guidelines for Prevention and Response to SGBV against Refugees, Returnees and Internally Displaced Persons

¹¹⁴ UNFPA Sri Lanka, National Guidelines for Responding to Gender-Based Violence in Sri Lanka, Colombo: United Nations Population Fund, 2019, pp. 44–45. Available at: <https://srilanka.unfpa.org/sites/default/files/pub-pdf/National%20Guidelines%20Booklet.pdf> [Accessed 30 May 2025].

¹¹⁵ UNFPA Sri Lanka, National Guidelines for Responding to Gender-Based Violence in Sri Lanka, Colombo: United Nations Population Fund, 2019, pp. 44–45. Available at: <https://srilanka.unfpa.org/sites/default/files/pub-pdf/National%20Guidelines%20Booklet.pdf> [Accessed 30 May 2025].

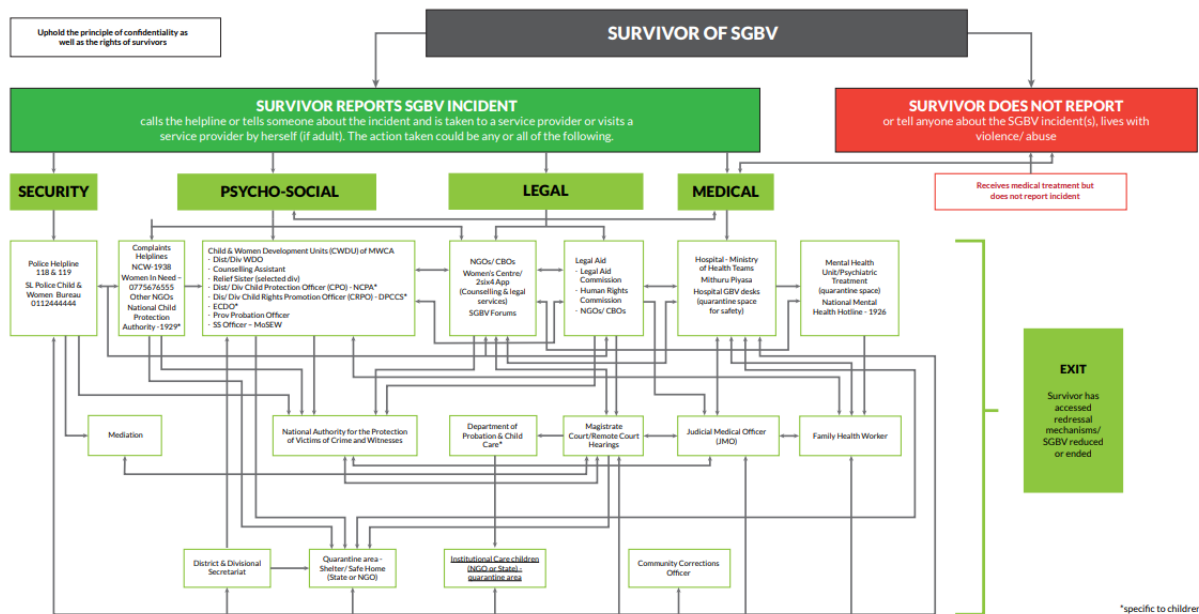
¹¹⁶ Ibid., p. 47.

¹¹⁷ UNFPA Sri Lanka, National Guidelines for Responding to Gender-Based Violence in Sri Lanka, Colombo: United Nations Population Fund, 2021, pp. 44–45. Available at: <https://srilanka.unfpa.org/sites/default/files/pub-pdf/National%20Guidelines%20Booklet.pdf> [Accessed 30 May 2025].

(UNHCR, May 2003), and drawing on a referral pathway previously developed by UNICEF Sri Lanka.¹¹⁸ However, the initial rollout of the mechanism was limited to three districts,¹¹⁹ with no information available on the current status of implementation of the referral pathway.

Figure 29: Referral Pathway for survivors of SGBV (2014 model updated in 2020 with COVID-19 safeguards)

(Source: UNDP)



A key activity of the SGBV Prevention National Action Plan 2016 – 2020 included the development of guidelines detailing referral pathways in all three official national languages.¹²⁰ Strengthening the referral system to respond to SGBV victim-survivors was a key programme of the Ministry of Women and Child Affairs, to enable better coordinated responses to victim-survivors.¹²¹ The review report of the SGBV National Action Plan, acknowledged that District Child Development Committees had been established at the district level, and these committees were responsible for referrals.¹²²

5.1 Data Collection and Sharing

Sri Lanka does not have a central database of SGBV cases. Some service providers such as the police, the National Women's Helpline (1938), and WIN maintain centralized databases at the institutional level. However, the use of these databases is confined to within the institutions and collates case information from connected service providers. District SGBV Forums also reportedly collect data on SGBV cases which are reported to the Forums. However, while no information is available on whether this data is digitized, such data is also not submitted to a centralized database.

The "Health Sector Response to Gender Based Violence National Guideline for First Contact Point

¹¹⁸ UNDP Sri Lanka, A Multi-Sectoral Referral System to Address SGBV, 23 June 2015. Available at: <https://undpsrilanka.exposure.co/a-multi-sectoral-referral-system-to-address-sgbv> [Accessed 30 May 2025].

¹¹⁹ Ibid.

¹²⁰ Ministry of Women and Child Affairs, National Policy on Gender Equality and Women's Empowerment, Colombo: Government of Sri Lanka, 2019, p. 29. Available at: <https://www.childwomenmin.gov.lk/uploads/common/sri-lanka-national-policy-gewe-english-compressed.pdf> [Accessed 30 May 2025].

¹²¹ Ibid., p. 9.

¹²² United Nations Development Programme (UNDP), Review Report on the National Action Plan to Address Sexual and Gender-Based Violence in Sri Lanka 2016–2020, October 2022, <https://www.undp.org/sites/g/files/zskgke326/files/2022-10/SGBV%20National%20Action%20Plan%202016-2020%20Review%20Report%20Final.pdf>.

Health Care Providers Sri Lanka” recognizes that sharing information even for the purpose of referral should protect the victim-survivors confidentiality to the largest extent possible. However, a thorough review of national frameworks, corroborated by the responses of key informants such as lawyers and state/non-state service providers, indicated that there were no formal policies and guidelines governing the sharing of information amongst agencies.

SGBV first responders develop and utilize their own templates to document initial victim-survivor reactions. These records are typically not digitized and are maintained as written hardcopy templates. These records were reportedly stored securely within their offices with access limited to concerned personnel to ensure confidentiality. Few service providers maintain electronic records which KIs indicated were password protected and accessible only to the relevant first responders. However, several key informants identified the lack of information technology (IT) infrastructure as a major challenge to service provision, including the ability to implement electronic record keeping systems.

The gaps associated with electronic entries were a concern voiced by both state and CSO KIs, who explained that the absence of secure databases posed a challenge not only in ensuring the privacy of client information, but also in documenting and correctly tracking case histories.

5.2 The Role of the State in Coordination of Services and Referrals

As discussed in Chapter 4, the state offers a limited set of essential services for SGBV victim-survivors, including healthcare, law enforcement, justice, safety and security, social welfare, and education. State service providers often refer victim-survivors to other state and non-state service providers, either formally or informally, when they are unable to provide necessary services.

However, the state does not appear to be playing a leading role in facilitating inter-ministerial and inter-agency coordination mechanisms to ensure effective collaboration across key sectors to promote integrated and streamlined responses to SGBV. While CSOs across the districts have set up informal, internal referral mechanisms, state convened formal inter-agency networks for service provision at national, district, and local levels are near absent. The state has also not made any concerted efforts to integrate non-state service providers into national coordination and referral systems.

The absence of coordinated inter-agency referral mechanisms has resulted in the lack of enforceable minimum service delivery standards across sectors. This gap hinders the monitoring of the quality, effectiveness, and timeliness of referrals and support services. In the absence of clear inter-sectoral protocols, service providers are at times uncertain about their roles, resulting in duplicated efforts or gaps in care. Additionally, the lack of state coordination and formal referral pathways leads to fragmented and inconsistent service delivery for victim-survivors of SGBV, with some non-state service-providers, who often fill critical gaps, operating in isolation without state recognition or support, limiting their reach and impact.

“Formal networking platforms are limited. If more networks or platforms are made available to continue discussions on SGBV service provision, response, and referrals, that would be extremely beneficial both to service-seekers, and to us as first responders.”

State service provider, Hambantota

At times, state entities convene or participate in case conferences, either independently or in collaboration with non-state providers, to ensure a coordinated response of effective support to victim-survivors. While these conferences may include both state and non-state actors, their ad-hoc nature limits their effectiveness as sustainable coordination mechanisms. At the same time, FGDs and KIs revealed that the involvement of state entities depends on individual initiatives and informal networks cultivated between and among the individual officers. The disadvantage of such an individual-driven approach is that these mechanisms may falter when the individuals involved, often in transferable positions within the public sector, vacate their roles.

Encouragingly, some districts have established formal district level coordinating bodies such as SGBV forums, to improve inter-agency collaboration. Key informants shared that centralized forums, such as the SGBV Forum convened by some District Secretariats, play a crucial role in coordinating and streamlining the referral and case management process, especially in harnessing the contributions of service-providers. These forums create a platform for collaboration between different state governmental and non-state stakeholders, ensuring that cases are addressed in a structured and organized manner. This centralization minimizes duplication of efforts and ensures that victim-survivors receive timely and appropriate referrals based on their specific needs. The SGBV Forum provides a standardized referral mechanism, bringing together key actors such as police, healthcare providers, counselors, and legal aid officers. Each organization within the Forum contributes their expertise, creating a comprehensive support system for victim-survivors.

“The SGBV Committee listened to me carefully and provided quick solutions. It was one of the few places where I felt supported... I only had to explain my situation once, and they helped me immediately.”

Victim-survivor, Anuradhapura

The GBV forum in Batticaloa exemplifies such coordination. It operates at both the district and divisional levels and comprises of CBOs, NGOs, and government institutions.¹²³ At the district level, it was reported that the forum meets at least quarterly and at the divisional level, monthly.¹²⁴ An independent initiative, the District Psychosocial Forum, has also been established to provide SGBV first responders with technical support.¹²⁵ However, the efficacy of these mechanisms depends on and varies according to the leadership provided by individual district secretaries, revealing the disadvantages of individual-driven approaches to coordination.¹²⁶ It was widely reiterated by KIs that formal methods of collaboration are limited. KIs recommended the introduction of mandatory, formalized, and state-convened networks or platforms to facilitate more efficient and consistent service provision.

Across all districts, state service providers reported regularly liaising with state and non-state institutions to facilitate access to medical, legal, and psychological services, despite the absence of documented formal referral pathways. Common referral destinations include the police, state hospitals *Mithuru Piyasa/Natpu Nilayam*, the LAC, and NGOs. Referrals to the police were made

¹²³ Eastern Social Development Foundation, 2018

¹²⁴ Ibid.

¹²⁵ United Nations Population Fund (UNFPA), State of World Population 2021: My Body Is My Own—Claiming the Right to Autonomy and Self-Determination (New York: UNFPA, 2021), https://www.unfpa.org/sites/default/files/pub-pdf/SoWP2021_Report_-_ENeb.3.21_0.pdf. * Examples of governmental actors cited by the KI included the WDO, CRPO, GN, RDO, and WRDO.

¹²⁶ Ibid.

for filing complaints and/or legal assistance. Referrals are made to hospitals and *Mithuru Piyasa/Natpu Nilayam* for medical attention and psycho-social support. To address immediate needs such as food, clothing, protection, and safe sheltering as well as longer-term needs such as for livelihood and vocational training, referrals were made to non-state actors. Regular referrals to these entities by way of letters have established referral pathways as a matter of practice.

In Ampara, state service-providers make referrals to both state service providers such as the LAC, Human Rights Commission of Sri Lanka (HRCSL), police, and state hospitals and non-state service providers such as The Social Architects, safe houses, community level organizations, and Affected Women's Forum (AWF). SGBV case conferences are also held to facilitate prompt resolution. If the victim-survivor is skilled, she is referred to the 100day job plan programme or for vocational training through the "Vidatha" Resource Centre.

In Hambantota, state service-providers make referrals to non-state service providers such as the Sambola Foundation and Women-in-Need. Such referrals may usually be made for shelter services and legal assistance.

According to KIs in Nuwara Eliya, the WhatsApp group of midwives and regional estate welfare officers reportedly created to address SGBV issues is currently inactive. The SGBV Forum in Nuwara Eliya comprising the Counselling Officer, Development Officer, Child Protection Officer, Medical Officer, Child Rights Officers, Education representatives, GS Officer, Labour Officers, and some non-state organizations appears to function more proactively. However, many non-state actors in the district were not aware of the existence of the SGBV Forum indicating the need to enhance visibility of the Forum and access to the Forum of a wider network of non-state actors.

In the districts of Puttalam, Kilinochchi, Mullaitivu and Trincomalee state-service providers make referrals to both state and non-state actors. In Mullaitivu, a KI mentioned that state service-providers make referrals to different organisations based on the severity of the issue and survivors' vulnerability. They are referred to service providers for medical, livelihood, legal, and psychological support. Accordingly, hospitals, mediation boards, the Family Rehabilitation Centre, the LAC, and the Center for Child Development serve as most sought-after referral points.

"There is a network that combines governmental and non-governmental organizations responding to SGBV. However, this is not legitimate. Service delivery continues to be ad-hoc, and is generally based on familiarity and mutual trust"

Non-state service provider, Mullaitivu

State service providers usually make referrals directly by way of a telephone call or by a letter. Some state service providers indicated they had capacity to follow up on referrals to ensure service delivery, while others lacked the capacity to confirm if the victim-survivors had received services. State service providers also indicated that referrals were contingent upon the consent of individual victim-survivors. However, when the victim-survivor is a child, referrals to the National Child Protection Authority (NCPA) are mandatory regardless of consent. Referrals may also be made without consent if an adult victim-survivor lacks the mental capacity to consent or according to some respondents, in cases of severe abuse or compromised mental health. Some service providers emphasized that they do not coerce victim-survivors into accepting referrals.

“The government didn’t provide any financial help. Only NGOs were there to support us.”

Victim-survivor, Ampara

In some districts despite referrals being made, victim-survivors expressed dissatisfaction with the overall level of service provision. Conversely, some victim-survivors may be reluctant to be referred to other service-providers due to fear of social stigma and confidentiality concerns. Limited knowledge of state service referral pathways was also identified as a challenge preventing victim-survivors from seeking assistance.

5.3 Role of Non-State Actors in Coordination of Services and Referrals

No formal referral networks exist among CSOs and NGOs. Instead, they have informal referral mechanisms across each of the districts in this study. Individual service providers and organizations have developed informal collaborative networks with government hospitals, the police, the Children and Women’s Bureau, LAC, and NGOs for referrals and joint initiatives. KIIs, FGDs, and case stories reveal that more victim-survivors favour non-state service providers over state sector service providers. This may be due in part to the ability of non-state service providers to offer victim-survivors material support, and in part to the ease of access to these providers. In addition, it was noted that in Mullaitivu district non-state service providers often approach diaspora communities to obtain financial or in-kind support.

The NGOs acted quickly, but with government services, we waited for months with no response

Victim-survivor, Ampara

“Sometimes, we communicate with people abroad to get help to provide food, school supplies and other necessities for victim-survivors. We do this, informally through our contacts.”

Non-state service provider, Mullaitivu

In Puttalam, victim-survivors of SGBV have long relied on non-state actors for services such as safe houses, essential resources (food, clothing,) counselling, case management, as well as legal advocacy, and assistance. NGOs, like the Muslim Women’s Development Trust (MWDT) and Viluthu, fill a critical gap where state responses and resources are limited. In Puttalam, most referrals are directed to the MWDT, which provides a wide range of services including SGBV response, protection, legal aid and case management, livelihood support, life skills training, psychosocial support, and short-term shelter. State service providers routinely refer victim-survivors to these services.

“MWDT, provides excellent SGBV support. They shelter and protect victims through safe houses and provide whatever they need. Viluthu has also played an instrumental role in monitoring incidents from start to finish and ensuring that the women get justice.”

State service provider, Puttalam

Most non-state service providers conduct follow-ups of their referrals, which are crucial for ensuring the continued well-being and safety of victim-survivors. Regular follow-ups enable providers to identify potential barriers to accessing additional services and to offer guidance and resources tailored to each victim-survivor's situation. This ongoing support is essential for promoting healing and empowering victim-survivors on their path to recovery. However, some respondents indicated that follow-up mechanisms were deliberately limited to avoid causing further distress to victim-survivors.

“Given their emotional state frequent follow-ups can be intrusive or even distressing for the individuals, so we try to limit excessive contact.”

Non-state service provider, Nuwara Eliya

Although direct follow-ups are minimal, organizations maintain indirect monitoring systems to ensure that referred victim-survivors receive the necessary support. For instance, they rely on updates from partner organizations and service providers to track progress while respecting the survivor's privacy. On the other hand, limited resources and staff shortages can lead to delays or a lack of follow-up in some cases. This gap highlights the need for a more robust mechanism to ensure victim-survivors are not overlooked or neglected after referrals are made.

5.4 Sustainability of Networks and Referral Pathways

As discussed in the previous section, most existing coordination mechanisms and referral pathways are informal or semi-formal. These are also primarily individual-driven, which relies on the efficacy and interest of individuals for continuity instead of being institutional initiatives. The sustainability of such networks and referral pathways grapple with significant challenges.

“There is collaboration at the level of NGOs and the support received through such networks strengthens our service delivery...Formal networking platforms are limited. If there are networks or platforms available to continue discussions on this matter, that would be beneficial.”

State service provider, Hambantota

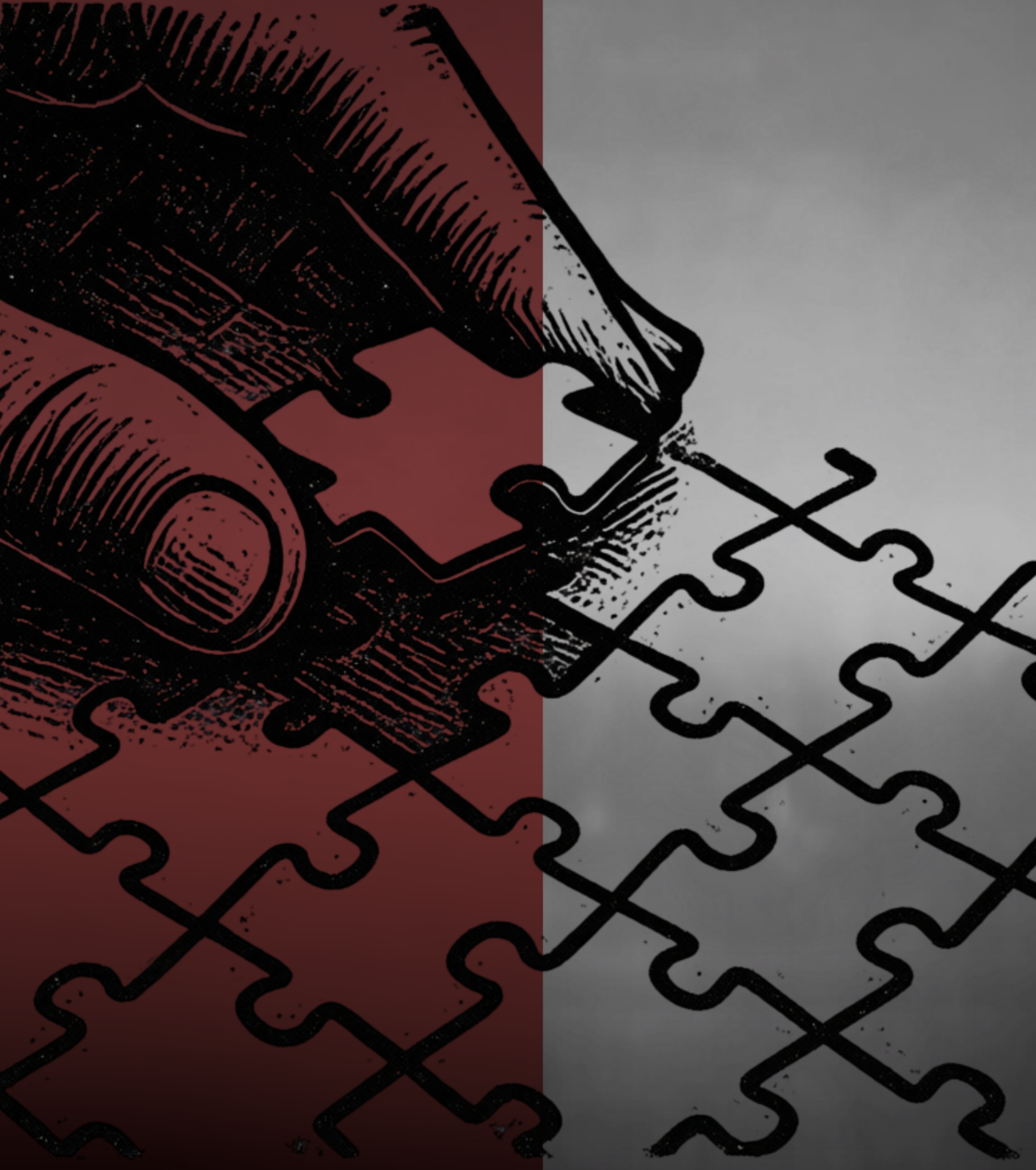
While these informal networks can provide immediate support and facilitate collaboration among service providers, their effectiveness is often reliant on the continued engagement of specific individuals. When these key players leave their positions or relocate, the continuity of services may be jeopardized, leading to disruptions in care and support for victim-survivors. Further, without institutional backing, these networks may lack the resources and stability necessary to adapt to evolving needs or to establish formalized protocols. Therefore, it is essential to integrate these informal networks into more structured frameworks that promote collaboration, enhance resource availability, and provide ongoing training and support for all stakeholders, in order to ensure long-term sustainability.

“We have support mechanisms such as group discussions with midwives or field visitors. We formed a group to address SGBV issues. This was formed including estate welfare officers at regional levels. Even though (WhatsApp group) exists this group is currently inactive.”

State service provider, Nuwara Eliya

“Currently, formal methods of collaboration are quite limited. There is only a certain extent of referrals made informally and individuals directly coming to access our services. If such formal methods and networks exist, it would be easier to provide services to those in need.”

State service provider, Hambantota



CHAPTER 6: GAPS AND CHALLENGES

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

6. GAPS AND CHALLENGES

The effectiveness of SGBV support services for victim-survivors in Sri Lanka is often hindered by various challenges related to the availability, accessibility, and quality of such services, as well as to gaps inherent in referral mechanisms and coordination between service providers. Addressing these challenges and gaps are important to improve the support services for the victim-survivors.

6.1 Availability, Accessibility, and Quality of Services

- Limitations in the legal framework:** Despite the existence of several laws that address SGBV, there are gaps in comprehensively covering all forms of violence. For instance, existing laws do not adequately address issues such as marital rape or other forms of domestic violence, leaving many victim-survivors without legal recourse. Similarly, existing digital laws in Sri Lanka focus primarily on broader cybercrimes and data privacy, rather than on the nuanced forms of gender-based abuse that occur online. As a result, victims of technology-facilitated SGBV often lack specific legal remedies or protections tailored to their experiences. This legislative gap leaves many forms of digital abuse under-addressed. As discussed in Chapter 3, existing laws also lack certain victim-survivor friendly provisions. Protection measures, such as protection orders, may not be effectively enforced as well, leaving victim-survivors vulnerable to further violence.

“Our country has adequate laws for the protection of women. But their non-implementation is more of a problem.”

Non-state service provider, Mullaitivu

“The insensitivities of the system that has never changed to address sexual and gender-based violence is something that we are really burdened by. The regular court system, whether it be criminal systems, civil systems, how the court functions; all that has not changed to adapt to sexual and gender-based violence concerns.”

Non-state service provider (legal), national level

- Limited availability of services across districts:** In many areas, especially rural or underserved regions, there is a scarcity of specialized services, such as shelters, counselling, legal assistance, and livelihood support. This lack of resources prevents victim-survivors from obtaining the help they need. These limitations exist primarily due to insufficient funding and the lack of adequate human and material resources among service providers, as discussed in the previous chapter.

“Having more local support services would help women get the help they need without traveling long distances.”

Victim-survivor, Nuwara Eliya

“The safe house located in Trincomalee can accommodate only 8 women at a time. Court approval is required to stay there. A person can stay there for a maximum of 3 months.”

State service provider, Trincomalee

“Conducting physical programmes incur high costs, and while there are mandatory courses beneficial for government servants, they are often too expensive to attend.”

Service provider, Nuwara Eliya

“As the hospital here has a male psychosocial counsellor, women do not want to discuss their SGBV issues with him.” “No SGBV related training is given to new officers when they are recruited for posts like WDO.”

Non-state service provider, Mullaitivu

- **Disparities in the quality of services:** The quality of support services vary significantly across districts. Insufficient training of staff, language barriers, lack of trauma-informed care, and inadequate facilities and resources such as disability access compromise the effectiveness of services. For instance, law enforcement agencies lack the training and resources needed to effectively implement SGBV-related legislation, leading to underreporting and inadequate responses to cases. As a result, victim-survivors may not receive the support they need, leading to further trauma.

“No disability access to most places. Requested and completed recently in DS and GN offices”

Service provider, Mullaitivu

“We have language issues at police stations. If the victim doesn’t know Sinhala and the perpetrator knows, is a big challenge to justice. Police never give us an opportunity to explain the issue in Tamil language.”

Victim-survivor, Trincomalee

“There’s no system in place to help people like me who are disabled. The facilities are not accessible.”

Victim-survivor, Ampara

The lack of robust mechanisms to ensure the safety of victim-survivors during legal proceedings is also a significant related concern, despite existing legal provisions. For example, as mentioned in a previous chapter, the law provides for the protection of victim-survivors and witnesses. However, law enforcement and court infrastructure have limited survivor-sensitive facilities,

such as private spaces to make complaints, private waiting areas or child-friendly spaces in courtrooms, and facilities for in-camera proceedings or remote testimony. As a result, victim-survivors often face threats, social stigma, and secondary victimization during the legal process, which can deter participation and compromise access to justice.

At the same time, due to limited training available to service providers, although gender sensitivity and confidentiality are integrated in the legal and health sector policies, FGDs and KIIs revealed that the police do not often adhere to these principles. A lack of gender sensitivity and respect for confidentiality could adversely impact the quality of service delivery.

“...Police officers should be properly trained to handle these cases respectfully, as some currently lack sensitivity and respect”

Victim-survivor, Nuwara Eliya

“We were made to feel like the abuse was our fault, which discouraged us from seeking help again.”

Victim-survivor, Ampara

As discussed earlier in this report, quantitative findings record mixed perceptions regarding the police. These findings call for more rigorous training and collaborative trust building efforts vis-a-vis the police.

“The police treated me with respect and gave me space to share my story.”

Victim-survivor, Nuwara Eliya

“Very recently we have had these women and children’s desk and that’s operational, so there is some safety. Women do feel some kind of ability to go and complain, but there are experiences where they also come and tell us, like, OK, this is how it was treated. So even though there’s a bit of space created, there’s also again that sensitivity that has not become institutionalized.”

Non-state service provider (legal), national level

- **Lack of trust in state service providers:** This is a particular challenge concerning law enforcement. Many victim-survivors have encountered unsatisfactory or harmful interactions with the police. Incidents of victim-survivor-blaming, inadequate responses, or dismissive attitudes have left a pervasive sense of distrust. Some victim-survivors noted how corruption and the negligence of the police have prevented them from approaching the police. KIIs with state and non-state service providers confirmed this concern of victim-survivors.

“They tried to mislead my child and point out my mistakes, which made me feel uncomfortable and unsafe.”

Victim-survivor, Anuradhapura

- **Regressive attitudes of some service providers:** Regressive attitudes among service providers dealing with SGBV pose a significant challenge in effectively supporting victim-survivors. These attitudes manifest as stigma, bias, or a lack of understanding regarding the complexities of SGBV. Service providers often appear to be unaware of their own regressive attitudes. This lack of self-awareness can lead to unintentional biases and behaviour. Such perspectives hinder the delivery of compassionate care, discourage survivors from seeking help, and perpetuate victim-blaming narratives and by extension, patriarchal social mores.

“Some police officers took our phone numbers and later called us for their personal needs instead of helping us.”

Victim-survivor, Ampara

“In the past, it was believed that a woman should be at least 3 years younger than a man in marriage. But now that belief has disappeared. But over time, the woman takes on an older appearance while the man stays young. Then it is the outward look that decides this doesn’t suit me anymore. As a result, marriages with those who are older crash halfway.”

Non-state service provider, Hambantota

- **Delays in services:** Overburdened healthcare and legal systems, both within the study districts and across Sri Lanka, struggle to meet high demand with limited resources, resulting in longer wait times. These wait times, which can worsen victim-survivors’ trauma, also deter them from accessing services due to additional costs involved in delays.

“Getting a judgment on these cases can take 15 to 20 years.”

Non-state service provider, Nuwara Eliya

“As the Legal Aid Commission has only one lawyer, investigations into many SGBV related cases are delayed.”

Non-state service provider Mullaitivu

“They think if you go to the police, it will take a long time to go to the court and get a solution there”.

State service provider, Puttalam

- **Fragmented service delivery:** The lack of coordination among various service providers has resulted in fragmented care, where victim-survivors struggle to navigate multiple systems. This lack of streamlined systems can lead to victim-survivors being expected to repeat their experiences to multiple service-providers, and gaps in support, making it difficult for victim-survivors to receive comprehensive care and assistance.

“I went to the hospital to get mental health support because I was under so much stress. Some doctors were kind, but others were harsh. I had to repeat my story to new doctors, which made me feel embarrassed.”

Victim-survivor, Anuradhapura

- **Limited knowledge of available services:** Many potential victim-survivors are unaware of the services available to them. Without targeted awareness campaigns, victim-survivors do not know what services are available or how to access those. The lack of tailored outreach to inform marginalized communities such as persons with disabilities or language minorities of their rights and available services, also hinders effective service delivery in the districts. One issue emphasized by multiple FGD respondents was the insufficient support and information available to women with auditory disabilities, especially the widespread lack of sign language interpretation services, which results in such women being deprived of access to information about available services.

“Unfortunately, 99% of people are unaware of the proper authorities to report to, and there’s a common belief that such matters shouldn’t be made public. Although there are hotlines for reporting these incidents, most people are unaware of them”

Victim-survivor, Nuwara Eliya

- **Unsustainability of funding available to non-state service-providers:** Funding for services provided by non-state actors is project-based, which means such funding is also time-bound. Such funding limitations are particularly concerning for non-state actors that provide pro bono legal assistance, as the length of the criminal justice process often surpasses the project’s timeframe. This puts a massive financial burden on organizations to continue providing its services to victim-survivors and to invest in follow-up on victim-survivors who use their services beyond project periods.

“Due to the lack of permanent funding, they (NGOs) cannot operate continuously. They perform well during periods when funding is allocated”.

Non- state service provider, Puttalam

- **Lack of funding for government institutions:** Funding issues prevail in the state sector too. The state sector often faces critical funding issues, which hinders the effective provision of services. In 2023, the government allocated 9.7 billion Sri Lankan Rupees for recurrent expenditure and 58 million Sri Lankan Rupees for capital expenditure to the Ministry of Women, Child Affairs and Social Empowerment. This budget line includes funds received from the UNFPA for the GBV prevention programme. This is a marked improvement from the previous year, i.e., 2022, when the Ministry’s allocation did not specifically cover SGBV related activities. In 2021, an allocation of 367 million Sri Lankan Rupees was made to the State Ministry of Women and Child

Development including for the expenditure pertaining to establishing a toll-free helpline for women and children. In 2020, the COVID-19 pandemic impacted the budgetary allocation leading to a diversion of funds, with no allocation being made for SGBV specific activities. This was a step down from the previous year of 2019, where 263 million Sri Lankan Rupees were provided to the Ministry of Women and Child Affairs and Dry Zone Development (including funding for a GBV programme by the UNFPA).

“The government allocates very little funds for SGBV related services.”

State service provider, Puttalam

Such inconsistent funding allocations weaken the ability of state sector institutions to implement and sustain comprehensive services. Budgetary constraints result in insufficient staffing, lack of specialized training, inadequate infrastructure (including safe spaces and shelter), and poor logistical support. This not only hampers timely and quality service provision but also affects the ability of institutions to monitor and evaluate their work, invest in long-term prevention strategies, and strengthen inter-agency coordination. The need for financial allocation was underscored by a non-state service provider in the following terms:

“There is a large gap. National authorities do not provide village-level services. They do not allocate the required funds. When problems develop, they discuss them over Zoom. Conducting national-level meetings and training on Zoom provides no meaningful benefits. Despite having enough skilled people, we do not receive adequate national-level training.”

Non-state service provider, Trincomalee

However, it is pertinent to note that the Ministry of Women, Child Affairs and Social Empowerment has launched the second multisectoral National Action Plan to Address SGBV from 2024-2028 on the 20th of December 2024.¹²⁷ It uses a multisectoral approach to address SGBV. In order to ensure victim-survivors of SGBV and their family members have access to social protection, referral mechanisms, legal aid, and other essential services through community and institutional support and to facilitate socio-economic reintegration, the National Action Plan has allocated 127 million Sri Lankan Rupees.

6.2 Coordination and Referral Pathways

- **Absence of SGBV service mapping at district or national levels:** The absence of comprehensive service mapping of SGBV services at the district and national levels have resulted in missed opportunities for collaboration among service providers due to the lack of awareness about service providers across sectors. This also results in fragmented service delivery, few referral pathways, duplication of efforts, and insufficient resource allocation as funding and support may not reach the areas or services that need it most.

¹²⁷ United Nations Development Programme (UNDP), “Government Launches Multi-Sectoral National Action Plan to Address SGBV in Sri Lanka - II (2024 - 2028)”, 23 December 2024, accessed 2 January 2025, <https://www.undp.org/srilanka/press-releases/government-launches-multi-sectoral-national-action-plan-address-sgbv-sri-lanka-ii-2024-2028>

- **Absence of a representative and formal coordination mechanism for SGBV service provision at district level:** This impacts streamlined service provision, and results in inconsistent standards and protocols for service delivery and referrals; siloed and ineffective advocacy efforts; inadequate data-sharing; and gaps in service delivery. The SGBV Forum in a majority of districts convened by the District Secretariat performs this function to a certain extent. However, the forums do not collaborate with or represent all service providers in a particular district. Therefore, their efforts at formal coordination are not comprehensive.
- **Lack of awareness or non-availability of clear referral protocols:** The KIIs revealed some service providers either do not have clear referral protocols or the staff are not aware of the procedures. Effective referral systems are essential to combat SGBV. Although the SGBV Prevention National Action Plan 2016 – 2020 included a clear referral pathway, the protocol is not clear. Without a proper protocol and lack of awareness, the service providers may manage the cases improperly. Poor case management and referral pathways could result in victim-survivors losing confidence in the system.
- **Insufficient data sharing:** The lack of mechanisms for sharing data and information among service providers has limited the ability to track referrals and outcomes. This may be due to the lack of clear national guidelines or policies on data sharing, including standardized protocols for obtaining informed consent from victim-survivors and safeguarding their confidentiality. In the absence of such frameworks, service providers remain uncertain about legal and ethical boundaries, which hinders collaboration and limits the potential for a coordinated, survivor-centered response. Even in the absence of formal coordination mechanisms, if data-sharing is streamlined and practiced, it will assist in follow-ups; in evaluating the effectiveness of services; and in identifying areas for improvement in service delivery. However, even though all service providers collect data of their own service users for documentation and follow-up purposes, they do not routinely and proactively share information amongst themselves, with a view to enhance service delivery.



CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

Mapping of Services to Address Sexual and Gender Based Violence (SGBV) in Sri Lanka

7. CONCLUSIONS AND RECOMMENDATIONS

SGBV is a widespread issue in Sri Lanka, affecting women across various socio-economic groups. While SGBV pervades every stratum of Sri Lankan society, the types of violence experienced by women may change based on where they live and their socio-economic status.

A key concern when mapping services and service provision that address SGBV in Sri Lanka is the level of knowledge among women and service providers on SGBV and its various forms. A majority of respondents in the research reported some awareness, with higher knowledge linked to higher levels of education. The literature suggests that, among diverse forms of SGBV, domestic violence and intimate partner violence are most prevalent, and they are often exacerbated by factors like early marriages and substance abuse. The findings also indicated a shift in SGBV from the physical to the virtual, placing children and young girls at risk of cyber/technology facilitated violence. Moreover, sexual violence continues to be a common form of SGBV whilst verbal abuse/harassment often remains a hidden form of SGBV. Encouragingly, some survey respondents did identify verbal harassment as a form of SGBV. Other commonly identified forms of violence, both in the literature and through KIIs and FGDs, include physical violence, sexual violence, psychological/emotional violence, economic violence, cyber/technology-facilitated violence, FGM, harassment in public spaces, human trafficking, and femicide.

Several factors influence the continued prevalence of SGBV in Sri Lanka. Economic dependence on men is a significant factor, as many women lack financial autonomy, making them vulnerable to exploitation and abuse. The COVID-19 pandemic exacerbated this issue, pushing many women into poverty, with some turning to sex work to support themselves. These women are often at high risk of sexual violence in the course of their work. Additionally, increasing exposure to social media and online platforms, especially during the pandemic's shift to online education, has led to a rise in online SGBV. These factors collectively contribute to the growing prevalence of SGBV in Sri Lanka.

The reporting of SGBV cases is low, with social stigma, shame, and fear of retaliation being major barriers. The survey findings interestingly indicated that women in rural settings were more likely to report SGBV than women in urban areas. These challenges are further compounded by a number of other factors such as increased poverty levels, economic dependence, the fear of being misunderstood or further exploited, the increase in uninformed exposure to social media, the police's preference to mediate rather than take legal action, and delays in legal processes. Awareness programmes and community vigilance are helping to improve reporting in some areas.

Sri Lanka has ratified or acceded to most of the key international treaties in relation to addressing SGBV. However, the domestic legal framework addressing SGBV against women in Sri Lanka is fragmented, and could be found across several sources. Several laws have been enacted to penalize the perpetrators of SGBV and protect victim-survivors, however, their implementation has been weak. Victim-survivors face several challenges when accessing the criminal justice process including accessibility barriers, financial constraints and patriarchal attitudes of service providers within the criminal justice system. As a result, progressive laws introduced to protect the rights of victim-survivors are under-utilized. Most recently, the Women's Empowerment Act was introduced with the objective of introducing mechanisms to give effect to Sri Lanka's commitments under CEDAW, to implement steps to prevent violence against women and to make recommendations for law reforms to prevent the discrimination of women. The full implementation of this law will overcome the challenges of fragmented protections for victim-survivors.

Both state and non-state providers offer services to SGBV victim-survivors. The delivery structures of state-sector services are largely uniform across all districts, but vary in quality across districts. Non-state service providers, while not uniform, offer a wider range of services, particularly in areas

like emergency shelter, livelihood training, and legal support, aided by better funding and informal referral systems. There was a noted discrepancy in the availability and accessibility of services in post conflict locations. In areas previously affected by war, non-state service providers play a crucial role in service provision. They enhance and complement limited state services by addressing the psychosocial, financial, legal, and protective needs of victim-survivors. At the same time, findings also revealed several challenges that victim-survivors face in accessing SGBV services. Common challenges observed across all services include childcare responsibilities, transportation costs, social stigma and shame, and the inability to forego daily wages. Aside from these challenges, the research also disclosed that some victim-survivors lack awareness of services available to them, as many communities are not informed about available resources like shelters, counseling, legal aid, and medical care. Additionally, lengthy and repetitive processes, revictimize victim-survivors and discourage them from accessing services. Language was a major barrier for Tamil-speaking victim-survivors in some districts. As a result, Tamil speaking victim-survivors struggle to communicate effectively with police or understand legal processes.

Similar to discrepancies in service provision, the level of referrals and coordination mechanisms between both state and non-state service providers varies across districts. Sri Lanka lacks a national policy for coordinating and referring SGBV victim-survivors between service providers. While state and non-state organizations have developed internal referral systems, there is no centralized database or formal guidelines for sharing information. Some service providers maintain localized databases, but these are not connected across institutions. Ad-hoc case conferences and district-level SGBV forums exist to coordinate responses, but their effectiveness varies across districts.

The effectiveness of SGBV support services for victim-survivors in Sri Lanka is often hindered by various challenges related to their availability, accessibility, and quality. A key challenge is the limited availability of services in rural areas, due to a lack of funding and resources. Additionally, there are disparities in service quality, with inconsistencies across districts due to insufficient resources, trained staff, and language barriers. There is also a lack of trust in state service providers, particularly the police, as victim-survivors often face victim-blaming or dismissive attitudes when approaching law enforcement. This is compounded by a lack of gender sensitivity on the part of service providers. Delays in services and fragmented service delivery are further problems, with victim-survivors having to navigate multiple systems and wait long periods due to overburdened healthcare and legal systems. Finally, unsustainable funding for both non-state and state providers, coupled with a lack of service mapping at district or national levels, has resulted in ineffective coordination and missed collaboration opportunities.

Based on the above findings and conclusions, the study offers several key recommendations for strengthening SGBV service provision specifically in the sample districts, and more broadly across Sri Lanka. These recommendations must be implemented in a coordinated manner, as the effectiveness of one aspect often relies on the successful execution of others. For instance, increasing awareness and accessibility of services will only be effective if there are sufficient resources and trained personnel to meet the demand. Therefore, a holistic approach is essential, where each recommendation supports and reinforces the others, creating a comprehensive and effective system for addressing SGBV and providing support to victim-survivors.

7.1 Ministry of Women and Child Affairs

As the nodal ministry for women's affairs, primary recommendations have been directed to the Ministry of Women and Child Affairs. However, recommendations made to the Ministry should be implemented in collaboration with other SGBV service providers including those that do not fall under the Ministry's mandate such as the police, JMOs, LAC, Department of Social Services, district and divisional level development officers, local government authorities etc.

- Launch targeted awareness campaigns to inform potential victim-survivors about their rights and available services, with a focus on marginalized groups. Utilize multiple communication channels, including social media, community outreach, and partnerships with local organizations or groups, to enhance visibility and accessibility, taking into consideration the unique challenges and barriers faced by these groups in accessing SGBV services. Ensure that awareness campaigns are not one-time events but are ongoing initiatives. Plan for periodic updates or follow-up campaigns to maintain visibility and reinforce messages. These campaigns should aim to reduce stigma around seeking help and encourage community members to support victim-survivors.
- Actively involve men and boys as allies in preventing SGBV against women in Sri Lanka. This requires:
 - Developing targeted awareness campaigns that educate men and boys about SGBV, its impact on communities, and the importance of their role in prevention. It is necessary to leverage relatable narratives and positive role models to challenge stereotypes and encourage proactive behaviour.
 - Creating training programmes that focus on healthy masculinity, consent, and respectful relationships. This requires involving male community leaders and influencers to facilitate discussions that resonate with their peers.
 - Establishing peer education programmes where young men educate their peers about SGBV prevention. This approach leverages social networks to promote positive behavior and attitudes.
 - Involving men and boys in the development of policies and programs related to SGBV prevention. Their input can provide valuable insights and foster a sense of ownership and responsibility.
 - Encouraging men and boys to participate in SGBV prevention projects at community level. These initiatives can foster teamwork, build solidarity, and promote a community-wide commitment to change.
- Increase funding and resources (human, physical, and infrastructural) for specialized services in rural and underserved areas to ensure equitable access to SGBV support services.
 - Conduct comprehensive needs assessments in rural and underserved areas to identify specific gaps in SGBV services. Engage with local residents, victim-survivors, and service providers to gather insights on barriers to access.
 - Invest in the establishment and maintenance of safe spaces and service centers that provide confidential support, counseling, legal assistance, and medical care for victim-survivors. Ensure these facilities are equipped with trained staff who understand the unique challenges faced by rural and underserved populations.
 - Develop mobile units that can travel to remote areas, providing on-site support and resources. These units can offer counselling, legal advice, and educational workshops, making services more accessible to those who may have difficulty traveling to urban or more centralized locations. It is essential that these mobile units are staffed with personnel

- who speak the local languages to effectively address any language barriers.
- Advocate for and allocate increased government funding specifically earmarked for SGBV services in these regions. Develop grant programmes that prioritize projects aimed at enhancing support mechanisms in rural areas.
 - Provide training for local healthcare providers, law enforcement, and community leaders on SGBV issues, response protocols, and referral systems.
 - Collaborate with local NGOs and community groups that have established trust within the community, to facilitate outreach efforts and expand service delivery by leveraging existing networks.
 - Encourage local governments and organizations to integrate SGBV support into their budgets and planning processes. Develop partnerships with local organizations to expand service reach and capacity, especially in remote districts.
- Provide ongoing training and capacity-building for service providers, focusing on trauma-informed care and cultural competency, particularly for Tamil-speaking victim-survivors. Training should cover identifying different types of SGBV, techniques for creating safe environments, recognizing trauma responses, implementing strategies that empower victim-survivors, and understanding cultural norms, values, and communication styles that affect interactions with victim-survivors.
 - Standardize service quality across districts to ensure all victim-survivors receive consistent and effective support regardless of location. This involves establishing clear guidelines and protocols for service delivery and ensuring that all support staff are adequately trained and equipped to handle the unique needs of victim-survivors. Uniform standards ensure that resources, such as counselling, language assistance, legal assistance, and emergency services, are accessible and of high quality in every district. This approach eliminates disparities in service provision and fosters trust within communities.
 - Introduce an enforceable coordinated referral mechanism. This should include the development of standardized protocols for data sharing among service providers to reduce fragmentation and simplify access for victim-survivors, ensuring that information flows seamlessly between agencies while upholding confidentiality and privacy standards. Clear referral pathways will ensure victim-survivors are quickly connected to the appropriate resources—such as medical care, legal assistance, and counselling—without having to navigate a complex web of services independently. Standardized protocols will also help service providers communicate effectively, share best practices, and track outcomes, ultimately improving the quality of care offered.
 - Increase budgetary allocations for social support services essential to the recovery and empowerment of victim-survivors of SGBV. Funding should prioritize a comprehensive range of services, including livelihood assistance such as skill development programmes, job training, in-kind assistance to set up small businesses, and employment opportunities that enable victim-survivors to achieve economic independence and stability; skills development such as investing vocational training and workshops, equipping victim-survivors with valuable skills that enhance their employability and self-sufficiency; emergency shelters in all districts; long-term safe housing that offer secure and stable environments for victim-survivors, facilitating their healing and reintegration into the community; and direct financial assistance to victim-survivors, helping cover essential living expenses or legal fees, thereby reducing financial barriers to accessing support and services.
 - Establish effective monitoring and evaluation (M&E) mechanisms to regularly assess the effectiveness of referral pathways, identify gaps, and inform continuous improvements in service delivery. Regular data collection and analysis should be conducted allowing stakeholders to pinpoint specific challenges or bottlenecks within the referral process.

Feedback mechanisms, such as surveys and interviews with victim-survivors and service providers, can provide valuable insights into the user experience and highlight areas where changes are necessary.

- Establish accountability mechanisms for law enforcement service providers to address victim-blaming and negligence. These mechanisms should include clear policies and procedures that outline expectations for respectful and empathetic treatment of victim-survivors. Additionally, implementing a transparent complaint process allows victim-survivors to report instances of neglect or inappropriate behaviour without fear of retaliation. Oversight committees, including representatives from community organizations and victim-survivor advocacy groups, can review complaints and recommend disciplinary actions when necessary.
- Utilize the recently enacted Women Empowerment Act to suggest reforms to the law and amend existing laws to comprehensively address all forms of SGBV, including marital rape. Consolidate the various fragmented laws related to SGBV into a comprehensive framework, such as compendiums, and ensure these are disseminated to service providers and victim-survivors in accessible and user-friendly formats.
- Develop comprehensive directories of available services and ensure they are disseminated widely, particularly to underserved communities. These directories should include detailed information about various services, such as counselling, legal aid, medical assistance, and shelter options, together with contact details and eligibility criteria. It's essential to disseminate these directories widely, particularly to underserved communities that may lack awareness of available resources in order to maximize their impact. This can be achieved through partnerships with local organizations, community centres, schools, and healthcare providers, ensuring that the information reaches those who may benefit most.
- Launch a centralized database, at least at district level, that tracks referrals and services provided, allowing for real-time updates and reducing duplication of efforts. Comprehensive records of referrals and services can help identify gaps in care and prevent duplication of efforts among service providers. This coordination will facilitate a more efficient allocation of resources and ensure that victim-survivors receive consistent and continuous support. The centralized database may also include data analytics features to monitor trends, evaluate the effectiveness of services, and inform policy decisions. This evidence-based approach will enhance overall service delivery and improve outcomes for victim-survivors.

7.2 Police

- Invest in the establishment and maintenance of safe spaces for victim-survivors within all police stations. Ensure these facilities are equipped with trained officers who understand the unique challenges faced by rural and underserved populations.
- Establish internal accountability mechanisms for law enforcement to address victim blaming and negligence. These mechanisms should include clear policies and procedures that outline expectations for respectful and empathetic treatment of victim-survivors. Additionally, implementing a transparent complaint process allows victim-survivors to report instances of neglect or inappropriate behaviour without fear of retaliation.
- Launch a centralized database that tracks referrals and services provided by the police, allowing for real-time updates and reducing duplication of efforts. Comprehensive records of referrals and services can help identify gaps in care and prevent duplication of efforts among service providers.
- Provide training for police officers on SGBV issues, response protocols, and referral systems. Provide ongoing training and capacity-building for service providers, focusing on trauma-informed care and cultural competency, particularly for Tamil-speaking victim-survivors. Training should cover identifying different types of SGBV, techniques for creating safe environments, recognizing trauma responses, implementing strategies that empower victim-

survivors, and understanding cultural norms, values, and communication styles that affect interactions with victim-survivors.

- Standardize service quality of the area police across all districts to ensure all victim-survivors receive consistent and effective support regardless of location. This involves establishing clear guidelines and protocols for complaints handling and referrals to necessary service and ensuring that all support staff are adequately trained and equipped to handle the unique needs of victim-survivors. Uniform standards ensure that services are accessible and of high quality in every district.
- Collaborate with local NGOs and community groups that have established trust within the community, to facilitate referrals and expand service delivery by leveraging existing networks.
- Provide mandatory interpreter services and/or translation tools to enable victim-survivors to lodge complaints and seek assistance in their preferred languages. This initiative should prioritize hiring qualified interpreters who understand both the linguistic nuances and cultural contexts relevant to the survivors and create a safe and supportive environment where survivors feel respected and understood, ultimately encouraging them to come forward and seek the help they need.

7.3 Legal Aid Service Providers

- Launch targeted awareness campaigns to inform potential victim-survivors about the services available through the LAC, with a focus on marginalized groups. Utilize multiple communication channels, including social media, community outreach, and partnerships with local leaders, to enhance visibility and accessibility, taking into consideration the unique challenges and barriers faced by these groups in accessing SGBV services. Ensure that awareness campaigns are not one-time events but are ongoing initiatives. Plan for periodic updates or follow-up campaigns to maintain visibility and reinforce messages.
- Implement robust enforcement mechanisms for protective measures and ensure the safety of victim-survivors during legal proceedings through dedicated support systems.
- Provide training for LAC officers on identifying SGBV issues, response protocols, and referral systems. Provide ongoing training and capacity-building for service providers, focusing on trauma-informed care and cultural competency, particularly for Tamil-speaking victim-survivors.
- Standardize service quality across districts to ensure all victim-survivors receive consistent and effective support regardless of location. This involves establishing clear guidelines and protocols for service delivery and ensuring that all support staff are adequately trained and equipped to handle the unique needs of victim-survivors. Uniform standards ensure that legal aid services are accessible and of high quality in every district.

7.4 Healthcare, Psychosocial, and Psychiatric Service Providers

- Launch targeted awareness campaigns to inform potential victim-survivors about services available through healthcare, psychosocial, and psychiatric service providers, with a focus on marginalized groups. Ensure that awareness campaigns are ongoing initiatives. Plan for periodic updates or follow-up campaigns to maintain visibility and reinforce messages.
- Increase funding and resources for specialized services in rural, plantation, and other underserved areas to ensure equitable access to SGBV support services.
- Invest in the establishment and maintenance of safe spaces and service centres that provide counselling, medical care, and psychiatric assistance for victim-survivors. Ensure these

facilities are equipped with trained staff who understand the unique challenges faced by rural and underserved populations.

- Establish integrated healthcare and psychosocial services, allowing victim-survivors to access medical and mental health support in one location for a more streamlined experience.
- Develop mobile units that can travel to remote areas, providing on-site healthcare assistance or health-related educational workshops, making services more accessible to those who may have difficulty traveling to urban or more centralized locations. It is essential that these mobile units are staffed with personnel who speak the local languages to effectively address any language barriers.
- Develop peer support programmes that connect victim-survivors with trained individuals who have similar experiences, providing a safe space for sharing and healing.
- Advocate for and allocate increased government funding specifically earmarked for healthcare services for victim-survivors of SGBV in underserved regions.
- Provide ongoing training and capacity-building for healthcare service providers, focusing on trauma-informed care and cultural competency. Training should cover techniques for creating safe environments and recognizing trauma responses.
- Standardize service quality across districts to ensure all victim-survivors receive consistent and effective healthcare services regardless of location. This involves establishing clear guidelines and protocols for service delivery, and ensuring that all support staff are adequately trained and equipped to handle the unique needs of victim-survivors.
- Collaborate with local NGOs and community groups that have established trust within the community, to facilitate referrals and expand service delivery by leveraging existing networks.
- Establish accountability mechanisms for health-sector service providers to address victim-blaming and negligence. These mechanisms should include clear policies and procedures that outline expectations for respectful and empathetic treatment of victim-survivors. Additionally, implementing a transparent complaint process allows victim-survivors to report instances of neglect or inappropriate behaviour to first-responder healthcare providers without fear of retaliation.

7.5 International Non-Government Organizations and International Development Agencies

- Advocate for long-term funding models that support non-state service providers beyond project cycles, promoting financial sustainability.
 - Advocate for multi-year funding agreements with donors. Long-term agreements can provide a stable financial foundation, enabling organizations to plan and implement long-term programs effectively.
 - Encourage non-state service providers to diversify their funding sources by exploring partnerships with the private sector, philanthropic organizations, and crowdfunding initiatives. This approach can reduce reliance on a single funding stream and enhance financial resilience. However, it is essential to implement strong accountability measures within implementing agencies to foster transparency and demonstrate commitment to responsible financial management.
 - Provide training and resources to non-state service providers on effective fundraising strategies, grant writing, and financial management. Enhancing their capacity to secure funds can lead to greater sustainability and impact.

- Engage in advocacy efforts to influence policy changes that recognize and support the vital role of non-state service providers in the SGBV response framework. This could include lobbying for government budgets specifically allocated for these organizations.
- Facilitate the formation of coalitions among service providers to collectively advocate for funding and share best practices. Collaborative efforts can amplify voices and strengthen the case for long-term support.
- Encourage collaboration among non-state providers to share resources and expertise, reducing individual financial burdens and enhancing service continuity.
- Facilitate ongoing training and capacity-building for service providers, focusing on SGBV issues, response protocols, referral systems, trauma-informed care and cultural competency etc.
- Increase long-term financial support for social support services essential to the recovery and empowerment of victim-survivors of SGBV. This funding should prioritize a comprehensive range of services, including livelihood assistance such as skill development programmes, job training, in-kind assistance to set up small businesses, and employment opportunities that enable victim-survivors to achieve economic independence and stability; skills development such as investing vocational training and workshops, equipping victim-survivors with valuable skills that enhance their employability and self-sufficiency; emergency Shelters in all districts; long-term safe housing that offer secure and stable environments for victim-survivors, facilitating their healing and reintegration into the community; and direct financial assistance to victim-survivors, helping cover essential living expenses or legal fees, thereby reducing financial barriers to accessing support and services.

7.6 Civil Society Organizations

- Launch targeted awareness campaigns to inform potential victim-survivors about their rights and available services, with a focus on marginalized groups. Utilize multiple communication channels, including social media, community outreach, and partnerships with local leaders, to enhance visibility and accessibility, taking into consideration the unique challenges and barriers faced by these groups in accessing SGBV services. Ensure that awareness campaigns are not one-time events but are ongoing initiatives. Plan for periodic updates or follow-up campaigns to maintain visibility and reinforce messages.
- Actively involve men and boys as allies in preventing SGBV against women in Sri Lanka. This requires:
 - Developing targeted awareness campaigns that educate men and boys about SGBV, its impact on communities, and the importance of their role in prevention. It is necessary to leverage relatable narratives and positive role models to challenge stereotypes and encourage proactive behaviour.
 - Creating training programmes that focus on healthy masculinity, consent, and respectful relationships. This requires involving male community leaders and influencers to facilitate discussions that resonate with their peers.
 - Establishing peer education programmes where young men educate their peers about SGBV prevention. This approach leverages social networks to promote positive behaviour and attitudes.
 - Involving men and boys in the development of policies and programmes related to SGBV prevention. Their input can provide valuable insights and foster a sense of ownership and responsibility.
 - Encouraging men and boys to participate in SGBV prevention projects at community level.

These initiatives can foster teamwork, build solidarity, and promote a community-wide commitment to change.

- Lobby for long-term funding models that support CSOs beyond project cycles, promoting financial sustainability.
 - Lobby for multi-year funding agreements with donors. Such agreements can provide a stable financial foundation, enabling organizations to plan and implement long-term programs effectively.
 - Explore strategies to diversify their funding sources by exploring partnerships with the private sector, philanthropic organizations, and crowdfunding initiatives. This approach can reduce reliance on a single funding stream and enhance financial resilience. However, it is essential to implement strong accountability measures within implementing agencies to foster transparency and demonstrate commitment to responsible financial management.
 - Engage in advocacy efforts to influence policy changes that recognize and support the vital role of non-state service providers in the SGBV response framework. This could include lobbying for government budgets specifically allocated for these organizations.
 - Proactively form coalitions among service providers to collectively advocate for funding and share best practices. Collaborative efforts can amplify voices and strengthen the case for long-term support.
- Develop comprehensive directories of available services and ensure they are disseminated widely, particularly to underserved communities. These directories should include detailed information about various services, such as counselling, legal aid, medical assistance, and shelter options, together with contact details and eligibility criteria. It's essential to disseminate these directories widely, particularly to underserved communities that may lack awareness of available resources in order to maximize their impact. This can be achieved through partnerships with local organizations, community centres, schools, and healthcare providers, ensuring that the information reaches those who may benefit most.
- Introduce a comprehensive database for CSOs, that tracks referrals and services provided by them, allowing for real-time updates and reducing duplication of efforts. Comprehensive records of referrals and services can help identify gaps in care and prevent duplication of efforts among service providers.
- Provide ongoing training and capacity-building for CSOs, focusing on trauma-informed care and cultural competency, particularly for Tamil-speaking victim-survivors. Training should cover identifying SGBV issues, response protocols, and referral systems, techniques for creating safe environments, recognizing trauma responses, implementing strategies that empower victim-survivors, and understanding cultural norms, values, and communication styles that affect interactions with victim-survivors.
- Effective M&E approaches to evaluate the effectiveness of referrals to identify gaps and areas for improvement continuously. Regular data collection and analysis should be conducted allowing stakeholders to pinpoint specific challenges or bottlenecks within the referral process. Feedback mechanisms, such as surveys and interviews with victim-survivors and service providers, can provide valuable insights into the user experience and highlight areas where changes are necessary.

ANNEXURES

ANNEX 1: DATA COLLECTION TOOLS

Please access the data collection tools used in the study via the link or QR code below.

Data Collection Tools Used:

- Initial Consultations Guide
- Survey Questionnaire
- Case Study Guiding Questions for Women
- Focus Group Discussion (FGD) Guidelines for Women
- Focus Group Discussion (FGD) Guidelines for Non-State Service Providers
- Key Informant Interview (KII) Guidelines for State, Non-State Service Providers
- Key Informant Interview (KII) Guidelines for National Level Stakeholders

Web link: www.viluthu.org/publications



ANNEX 2: CASE STORIES

The following narratives are drawn from interviews conducted as part of this study. All names used here are pseudonyms and details that could reveal the identities of the respondents have been removed. These stories were recorded with the permission of respondents and a concerted effort made to remain true to their narrative in the retelling.



CASE STORY 1 – “KAUSHALYA”

Kaushalya, a 25-year-old Sinhala woman living in a rural village in the Kilinochchi District has endured long-term and layered forms of hardship and violence. Originally from Galle, she was raised by her grandmother after her mother left the family. In her early teens, she was sent to live with her mother, where she was raped and abused by her stepfather. Out of fear and isolation, she remained silent until eventually confiding in her sister, who filed a police complaint. Following the complaint, she was placed in a rehabilitation centre, where she received counselling and vocational skills training that helped her gradually rebuild her confidence.

At the age of 17, Kaushalya began working and later married a man from Kilinochchi. She relocated to the Northern Province with him. However, her marriage quickly became another source of trauma. Her husband struggled with substance dependency and exhibited violent behaviour. Kaushalya was subjected to physical abuse and psychological harm, even needing medical attention at times. Kaushalya’s husband eventually abandoned her and their two children—both of whom were born with health complications. She now lives in poverty in a temporary shelter, with no means to feed and care for herself and her children.

One of the hardest parts of her experience was the repeated rejection and inaction she faced from law enforcement. Despite reporting the abuse to the police multiple times, she was dismissed with remarks that it was a “family matter.” Although she is able to speak in Sinhala and thus faced no language barrier in communicating her complaint, no official record of her complaints was ever provided and her trauma was trivialized by police officers. In contrast, medical staff and community health workers treated her with care. A midwife connected her to Viluthu, who referred her to the Women Development Officer (WDO), who then supported her to attend court by linking her with the Legal Aid Commission (LAC).

Still, structural challenges remain. Her appeals for housing and livelihood support through the Grama Niladhari and Samurdhi officers have not been met. She continues to live in unsafe conditions with little to no support, balancing the care of her children with her own mental and physical wellbeing.

Kaushalya’s story reveals the deep and lasting impact of sexual and gender-based violence, beginning in childhood and continuing into adulthood. It highlights the urgent need for sensitive and responsive law enforcement, long-term survivor-focused services, and targeted support for women and children in high-risk, rural contexts.



CASE STORY 2 – “SAHANA”

Sahana a 42-year-old self-employed woman in the Ampara District, has endured long-term and severe domestic violence. Married at the age of 15, Sahana’s marriage was marked by persistent instability and abuse. By the age of 17, while working abroad, she developed vision impairment following a serious illness. Upon her return to Sri Lanka, her husband remarried and largely abandoned his responsibilities toward Sahana and their children.

Sahana reconciled with her husband from time to time, though her husband engaged in substance abuse, maintained extramarital relationships, and provided minimal support to the family. Over time, Sahana experienced multiple forms of violence, including physical, sexual, psychological, economic, and social abuse. The psychological abuse was particularly damaging, with her husband frequently subjecting her to verbal harassment, public humiliation, and derogatory remarks, often referring to her as “disgusting,” “ugly,” “one-eyed,” and “a prostitute.” He openly expressed shame in acknowledging her as his wife, refused physical proximity, and regularly accused her of infidelity without cause.

Physical violence included severe incidents such as an attempt to suffocate her by pressing a pillow over her face while she was asleep. Sexual coercion and economic abuse were also ongoing. For example, when under the influence of alcohol and cannabis, her husband frequently coerced her into unwanted sexual activity, which had a profound and lasting impact on her sexual and emotional well-being. Sahana’s husband failed to contribute to household expenses. He also undermined her livelihood by selling her livestock without consent and misappropriating the proceeds. While Sahana worked abroad, he borrowed money using her name without permission, leaving her responsible for repayment. Socially, she faced stigma and defamatory remarks within her community, which further isolated her.

Initially, Sahana’s family discouraged her from reporting the abuse, fearing repercussions for her children’s futures. However, Sahana ultimately chose to seek help and reported her case to local service providers, including two Police Stations, the Divisional Secretariat’s Women’s Development Division, the Quazi Court, and religious leaders at the main mosque. Although her husband initially provided false information to some authorities, which delayed appropriate intervention, once Sahana was able to present her account directly, the Women’s Development Division and other officials acknowledged the seriousness of her situation.

Sahana reported that she was treated with dignity by service providers, who offered private spaces for consultation, making her feel safe. The Women’s Development Unit assigned a case manager to ensure continuity in handling her case. Immediate counselling and some support services were provided, though proceedings at the Quazi Court have experienced repeated delays. Despite these interventions, Sahana continues to face significant challenges. Her key issues remain unresolved. She has not been able to access financial assistance or self-employment development programs and remains unable to obtain disability allowances despite submitting the necessary documentation. Ongoing financial hardship restricts her ability to access essential medical care and to support her son’s education. Additionally, travel to essential services remains costly and difficult, often requiring reliance on neighbours for transport.

Sahana's experience highlights the complex interplay between domestic violence, disability, social stigma, and systemic barriers in accessing sustained protection and support.



CASE STORY 3 – “NIMALI”

Nimali, a 25-year-old woman from the Anuradhapura District, has experienced prolonged and multiple forms of abuse within her marriage. Following the loss of her father at age eight, her education was disrupted. At 15, Nimali entered into a marriage through a personal relationship. Over time, this relationship became a source of repeated violence, coercion, and neglect.

Throughout her marriage, Nimali faced various forms of abuse, including physical mistreatment, psychological distress, social exclusion, and financial hardship. Her husband formed an extramarital relationship with another woman and eventually left Nimali and their children during her fifth pregnancy. Her husband subjected her to frequent physical assaults, often using sticks and other implements. On one occasion, while she was pregnant, she was confined in a water tank and assaulted. The abuse was not only physical but also psychological and sexual. Her husband openly maintained an extramarital relationship and would engage in sexual acts with his mistress in Nimali's presence. He also refused to use contraception and dismissed her concerns about repeated pregnancies, further contributing to her physical and emotional exhaustion.

Nimali's economic situation remains extremely challenging. The sole caregiver to five young children, Nimali lives in a one-room mud house without reliable access to basic necessities. Her daily income depends on irregular manual labour, which barely covers the cost of food. Complicating her situation further, her children do not possess birth certificates, preventing their enrolment in school and limiting access to state services. While efforts to obtain these documents were initiated with support from a local CSO, administrative delays have left the issue unresolved. She has reported experiencing unwelcome advances and comments from men in her community and from some service providers. Despite repeated exposure to difficult circumstances, she continued to endure the situation, largely out of concern for the well-being and security of her children.

Her attempts to seek institutional support were met with further distress. When she approached the police to report the abuse, her complaints were often disregarded. On several occasions, officers insulted her character, labelling her as promiscuous or likening her to a sex worker. She was also met with sexual suggestions and advances. In one instance, she was asked to provide her mobile phone number under suspicious pretences. The process of reporting required her to repeat her traumatic experiences to multiple officers, which deepened her psychological vulnerability. Nimali also described feeling ashamed and uncomfortable in court, noting that women who seek legal recourse are sometimes judged unfairly by others. As a result, she expressed a sense of futility and humiliation in seeking legal redress, stating that the process yielded no meaningful solutions.

In contrast, some service providers offered her a more supportive response. The Women Development Officer at the local Divisional Secretariat listened to Nimali's case and referred her to the CSO offering integrated support. Through this referral, Nimali accessed basic food relief, assistance in the application process for her children's birth certificates, and guidance on opportunities for sustainable income generation. With the help of the Legal Aid Commission, Nimali was able to file a maintenance claim against her husband. She was assigned a caseworker who provided continuity and oversight. In addition, Nimali sought mental health care from a government hospital. Although treatment was initiated promptly, she struggled to afford the prescribed medication, which had to be purchased from

private vendors. The CSO again stepped in to cover these expenses, ensuring her access to ongoing care.

Despite these pockets of support, Nimali continues to face serious structural and social barriers. Requests for housing assistance have gone unanswered, and no secure employment opportunities have materialized.

Nimali's story exposes several gaps in SGBV service provision in Sri Lanka. It emphasizes the value of gender-sensitive and safe responses, as well as the need for sustained legal, financial and psychological support for victim-survivors.



CASE STORY 4 – “ANUSHA”

Anusha, a 48-year-old married woman living in the Mullaitivu District has endured long-term and severe intimate partner violence. She is the mother of four children, three of whom are now married. Her youngest daughter is currently studying for her A/Ls. Married at the age of 14, she has been subjected to multiple forms of violence by her husband since then. Her husband, who is eight years older than her, frequently consumes alcohol and becomes aggressive and abusive.

Anusha has been subjected to severe physical violence, including repeated incidents of being beaten on her head, legs, and stomach. One such incident left her with a deep head wound that required stitches at a local hospital. At another time, her husband hit her in the stomach, resulting in menstrual issues such as bleeding twice a month and extreme physical weakness. Doctors later told her that one of her ovaries was damaged and needed removal.

Sexual violence has also been a constant part of Anusha's life. Her husband frequently forces her to have sex when intoxicated. When she hid in her neighbor's homes to avoid this, he would seek her out and force compliance, harassing the neighbors too. She did not consent to the birth of any of her children and all her pregnancies were the result of marital rape.

This violence has also been accompanied by psychological abuse as well. Her husband has insulted her in front of their children several times, mocking her appearance and insinuating that she was involved with other men. These verbal attacks caused extreme mental distress. He also publicly shamed her, creating social stigma that isolated her even from her own siblings, who stopped visiting due to his aggressive behavior.

Anusha also experienced economic violence. She was dependent on her husband's income, but he would often use his earnings on alcohol. She has received some support from NGOs in the past, including fishing equipment, housing grants, and a goat for livelihood. However, she lost her livelihood when some goats were stolen and she has not been able to grow the support she received into sustainable income. She now works at a local NGO to support her family.

Despite experiencing long-term abuse, Anusha has kept silent for fear that her children will be affected. She was economically dependent on her abuser for some years as well. She also did not report the violence to the police or other authorities due to fear of retaliation. She is still concerned that service providers would reveal her complaint to her husband, leading to further violence. She did share her experiences with trusted individuals, including her sister-in-law, brother, and children, which she says brought her some relief. Her son filed a police complaint once, but during the police inquiry, she was subjected to degrading and inappropriate questioning, including being asked whether she refused sex and being blamed for her husband's violence. She also mentioned barriers such as the Grama Niladhari not performing his duties properly and favouring those he knows personally.

Anusha reports a more positive experience with state medical care. When she sought medical treatment at the local hospital for a head wound inflicted by her husband, she reported it as an injury caused

by a falling tree. However, healthcare providers assessed the cause for the injury and advised her to obtain treatment at the district hospital—which was better equipped—and file a complaint with the police. Yet, she rejected their advice and opted to undergo treatment and receive stitches there without anaesthesia. She notes that hospital staff were caring and attentive, providing her with food and tea, and treating her kindly during her treatment. Although she was asked to repeat her story several times, she understood it as part of an effort to keep her safe. When she visited the district hospital for a menstrual issue resulting from her husband's abuse, she received counselling was then referred to a hospital closer to her home for further counselling.

Today, Anusha remains without formal legal protection, financial aid, or psychosocial support. She reports feeling safe at her current workplace, which employs only women, and appreciates that her daughter was supported by a local institution, which provided meals and tuition support, reducing her daily caregiving burden. However, she continues to face psychological distress and economic hardship. Even during the interview, she asked repeatedly if her husband would be called for an inquiry and expressed fear that she would be at risk of further violence. She did not consent to an audio recording of her interview.

Anusha's experience illustrates the complex and interlinked challenges of domestic violence, marital rape, poverty, social stigma, and systemic failures in providing sustained protection and support to victims of SGBV. Her fear—even to be interviewed—reveals the deep trauma that victim-survivors are subjected to and reinforces the need for long-term support services that are sensitive and confidential.



CASE STORY 5 – “KAVITHA”

Kavitha, is a 38-year-old mother of three from a rural village in the Nuwara Eliya District. Despite appearing to lead a stable family life, Kavitha's marriage of over 13 years has been marked by emotional neglect, infidelity, and abuse. At age 25, while working in Colombo as a pharmacy trainer, Kavitha was introduced to her future husband via telephone. Despite familial opposition, she pursued the relationship and eventually married him. However, following the birth of their children and a series of estate relocations driven by her husband's employment as a field officer, tensions began to surface when Kavitha learned of her husband's affair with another estate worker.

Physical and emotional abuse followed. Kavitha endured multiple physical assaults, culminating in a violent altercation between her husband and brother, which left her hospitalised with a head injury. In another incident, her husband drank petrol and threatened to take his own life, claiming he couldn't live without her. Her husband also manipulated their children, asking them to call his mistress “amma” (mother) as an act of revenge, which emotionally distressed Kavitha. Kavitha and her children were left to suffer in a home without basic amenities like electricity, and they often relied on the kindness of neighbours for shelter. She also faces some financial difficulties as her husband often fails to meet even the court-ordered child support of 15,000 LKR. She, therefore, supplements the household income through tutoring and home gardening.

Kavitha approached the police but received little assistance from them. When dealing with the police, Kavitha was made to feel unsafe, as in her experience, they are often biased and more concerned with reaching a compromise. In her case, the police even suggested that her husband would look after both her and his other wife. The police classified her case as a family matter and referred her to the Mediation Board; however, this did not improve the situation. Her case reached the District Court, where she was granted limited child support. She was assisted by a lawyer from the Human Rights Commission. During the court process, her husband's behaviour worsened; he would drink and engage in verbal and physical altercations. The Court has been dismissive of her struggles, treating her as if she were bringing a new story each time. In such a context, Kavitha feels that the

decisions given by the court were unfair.

Kavitha also began engaging with a local CSO as a participant and later a women's group leader. Through this CSO, she found a platform to share her story, support others, and rebuild her confidence. Today, Kavitha continues to navigate legal, financial, and emotional challenges while centring her life around her children's safety and education.

Kavitha's story highlights the need for more targeted training in trauma-informed care across all SGBV support services, especially among state service providers. It also underscores the significance of CSOs that offer support to victim-survivors at the grassroots level.



CASE STORY 6 – “SARANIYA”

Saraniya, a 24-year-old woman from the Trincomalee District experienced psychological and sexual violence during her adolescence, which disrupted her education and severely impacted her mental health. Her early life was marked by tragedy—her father, a peon at the Department of Social Services, and her elder brother were both shot dead by the Sri Lankan army when she was just seven years old. Raised by her mother on her father's pension, she lived with her elder sister's family in Kanniya after her sister remarried.

At the age of 14, Saraniya was subjected to repeated sexual harassment and assault by her sister's second husband. The abuse occurred over several months, but she was scared to confide in anyone because he threatened to kill her mother. In one instance, while returning home from the store, he attempted to pull her into the bushes but released her after she screamed. In another instance, he sexually assaulted her, resulting in a torn dress. Her mother confronted him but did not initially file a complaint. However, when her menstruation was delayed that month, her mother feared she was pregnant. A neighbour assisted them in obtaining a pregnancy test from a local pharmacy. The positive result led her mother to recognize the seriousness of the situation and file a complaint at the police station. Although hospital tests later confirmed she was not pregnant, rumours spread throughout the village. She was blamed and scolded by her sister and ostracized by her relatives. Teachers at school treated her differently, and her classmates began avoiding her. She withdrew from school and became deeply depressed.

When her mother lodged a complaint with the police, Saraniya was taken for medical examinations and received counselling services. Legal proceedings were initiated, but the process was slow and humiliating. She was repeatedly called to court, only to be given new dates without resolution. Her mother passed away a few years later, and eventually the perpetrator was released. Saraniya now resides with her aunt's daughter, after a spending two years working in the Middle East.

Saraniya reported mixed experiences with service providers but also observes that she did not understand much of what was happening because she was very young at the time. At the police station, she was afraid and could only answer briefly. At the hospital, she was treated respectfully in a private setting and received counselling. In court, due to her being a minor at the time, inquiries were held in a separate room.

She emphasized the importance of increasing public awareness about available services and encouraging women affected by SGBV to come forward and seek justice. She also called for greater protection for women and children in the community and for better sexual and reproductive health education for young girls. Additionally, she highlighted the need to eliminate drug use as a means of improving women's safety and suggested that schools incorporate self-defence training for girls to empower them and build resilience.

Saraniya's story highlights the need for greater awareness-building about SGBV service provision

among victim-survivors and for support services to ensure that victim-survivors understand the processes they are taken through, especially those subjected to violence at a young age.



CASE STORY 7 – “HAFEEZA”

Hafeeza, a 25-year-old woman from a village in the Puttalam District, experienced sustained and severe intimate partner violence after her marriage at the age of 20. Raised in a loving household, her life changed drastically after marriage. Her husband, a Sinhala man who had converted to Islam, initially proposed through her brother. Though the marriage was accepted by both families, violence began just three months later. When she was four months pregnant, she discovered her husband was in a relationship with another woman. He did labor work in fishing, masonry, or woodcutting, and would often disappear for days on the pretext of work. He also sold all of her jewellery under the pretence of starting a business, spending the money on drugs instead. Eventually, he remarried. She is now raising her four-year-old son with the support of her elderly parents and siblings, sustaining herself by sewing and preparing meals for local boutiques. Currently, she is also seeking employment outside the home.

Hafeeza faced repeated and extreme forms of violence—physical, psychological, and economic. Her husband beat her to the point of unconsciousness on several occasions and caused lasting physical injuries, including numbness on the left side of her head. He pulled her hair, smashed her against walls, and physically assaulted her even during postpartum recovery. Verbal abuse was constant. He stole from her and her parents to feed his drug use.

Initially, Hafeeza kept silent, fearing the violence she was subjected to would distress her family. In November 2023, with her sister’s support, she filed a police complaint. Her first interaction with the police was traumatic. Since she did not understand Sinhala and the officer did not understand Tamil, another visitor to the police station was asked to interpret her story. Her Sinhala-speaking husband and mother-in-law attended the inquiry. The police refused to record her complaint and instead verbally insulted her after hearing the other party’s side of the story. They dismissed her and challenged her to approach the Quazi Court¹²⁸ if she could.

She then sought support through the Mediation Board, who observed her injuries and advised her to record a complaint with the police. She also approached the mosque after learning about her husband’s second marriage a few months later. Again, she was directed to the police, and from there, to court. She hired a lawyer and filed a case at the Quazi Court. However, when her husband requested a divorce, the Quazi judge granted it without listening to her case. She was instructed to observe Iddah for three months, during which she received no financial support. When she asked for the Iddah allowance, her ex-husband claimed he had no money.

Throughout this ordeal, Hafeeza experienced serious gaps in justice and service provision. Language barriers and systemic bias severely affected her ability to access fair treatment. She reported feeling safe only at the Mediation Board, where officials treated her respectfully. In contrast, she described her experience at the police and Quazi Court as denigrating and unjust—marked by public humiliation, bribe-taking, and denial of her right to speak.

She also faced significant economic hardship. The cost of travel to police stations and courts (Rs. 700 one way) was often unaffordable. At times, she borrowed money or walked long distances. She had to take loans from acquaintances, repaying them with income from her tailoring work.

She believes service providers must engage with victim-survivors in their preferred language and called for respectful treatment of women in legal forums. She also emphasized that violence against women must be punished effectively to create safer communities.

¹²⁸

A court established under the Muslim Marriage and Divorce Act

Hafeeza's story underscores the intersection of violence, poverty, language discrimination, and institutional bias and the need for improved, survivor-centered SGBV responses in Sri Lanka.



CASE STORY 8 – “NALINI”

Nalini, a 39-year-old divorced woman from a rural area in the Hambantota District, has endured multiple forms of violence and significant economic hardship following her separation. Formerly employed as a nurse at a government hospital, Nalini currently lives with and cares for her three children on a limited income, after a marriage marked by domestic abuse and abandonment.

Her husband, an army officer, would often physically assault her. Her husband's jealousy escalated when he discovered that she worked with a male doctor at the hospital. This suspicion culminated in him prohibiting her from working and physically assaulting the doctor. After the birth of her second child, Nalini separated from her husband due to his extramarital affair. Despite this, Nalini gave birth to a third child, whose paternity her husband initially refused to acknowledge. Eventually, she was forced to leave the marital home, left to survive with her children in a rented house on a very limited income.

Nalini faced a range of abuses including physical violence, emotional and psychological harm, economic deprivation, and social isolation. Her husband's baseless suspicions and controlling behavior resulted in her losing stable employment, heightening her vulnerability. His failure to provide maintenance for the children further exacerbated her situation, prompting Nalini to file a maintenance case through the police. However, this was to no avail as her husband was incarcerated due to non-payment of maintenance. Nalini, therefore continues to face acute financial hardships.

In seeking assistance, Nalini engaged with several service providers, including the police's Children and Women's Desk, the Legal Aid Commission, and the Divisional Secretary's Office. She reported being treated with respect and dignity, with the police providing a safe environment to share her experience and promptly connecting her to legal aid services. The Legal Aid Commission and the Divisional Secretary's Office also responded efficiently.

Despite these positive engagements, Nalini continues to face significant unmet needs. She struggles to secure stable housing for her family, surviving on a modest maintenance allowance that barely covers rent and daily expenses. She lacks financial support for self-employment opportunities, which she believes are essential for rebuilding her livelihood. Travel costs and childcare responsibilities further restrict her ability to access additional services or employment. Moreover, due to the absence of a permanent residence, Nalini's children experience educational instability due to frequent school transfers.

While reinforcing the value of sensitive and responsive SGBV service provision, Nalini's experience draws attention to the need for robust systems to meet the financial and material needs of victim-survivors.

පර්යේෂණයේ සාරාංශය

1 ශ්‍රී ලංකාවේ ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසන

කාන්තාවන් හතර දෙනෙකුගෙන් එක් අයෙකු හිංසනයට ලක්වන අතර, කාන්තාවන් පස් දෙනෙකුගෙන් දෙදෙනෙකුට ආසන්න ප්‍රමාණයක් පුළුල් පරාසයක ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසන (SGBV) අත්විඳිති.

මූලාශ්‍රය: ශ්‍රී ලංකා ජනලේඛන හා සංඛ්‍යාලේඛන දෙපාර්තමේන්තුව - ශ්‍රී ලංකා කාන්තා යහපත්වත්ම පිළිබඳ සමීක්ෂණය 2019 (අවසාන වාර්තාව).



24.9%

වයස අවුරුදු 15 සිට ඉහළට කාන්තාවන්ගේ 24.9% ක් ලිංගික සහ/හෝ ශාරීරික හිංසන අත්විඳ ඇත.



39.8%

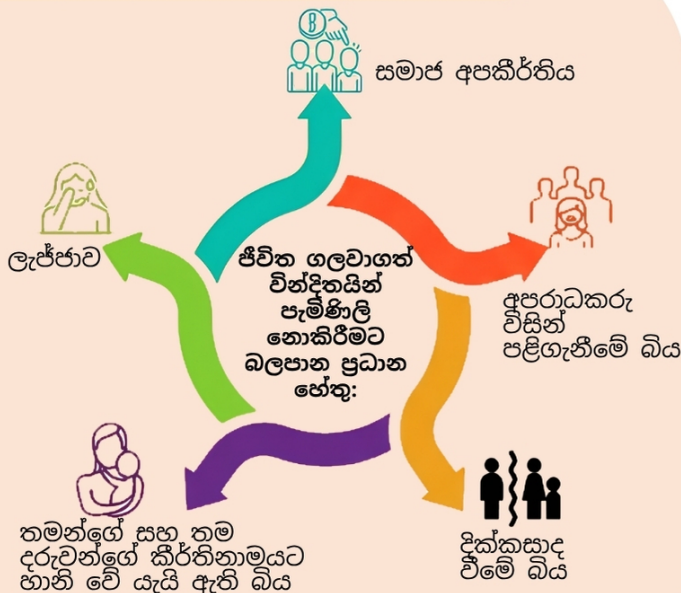
කාන්තාවන්ගේ 39.8% ක් තම ජීවිත කාලය තුළ සහකරුවෙකු විසින් සිදු කරන ලද ශාරීරික, ලිංගික, මානසික/චිත්තවේගීය, ආර්ථික හිංසනය සහ/හෝ පාලනකාරී හැසිරීම් අත්විඳ ඇත.

2 ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසන සිදුවන (SGBV) ආකාර

ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසනය (SGBV) ශාරීරික හානිත් සිට ආර්ථික හා සයිබර් තාක්ෂණය මගින් සිදුකරන අපයෝජන දක්වා විවිධ ආකාර ගනී.



3 ශ්‍රී ලංකාවේ ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසනය (SGBV) වාර්තා කිරීමේ ප්‍රවණතා

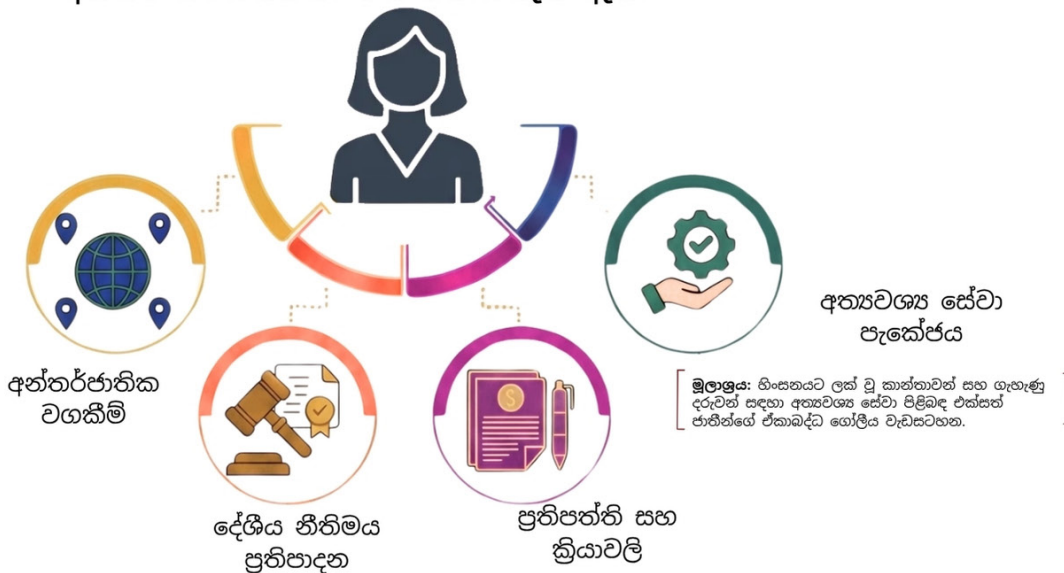


4 බහුලව භාවිතා කරන වාර්තා කිරීමේ ක්‍රම



5 ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසනයට ලක්වූවන් හට ඇති පහසුකම්

වින්දිතයා කේන්ද්‍ර කරගත් සහාය පද්ධතිය අන්තර්ජාතික වගකීම්, ජාතික නීති, ප්‍රතිපත්ති සහ සේවා රාමු අතර ඇති අන්තර් සම්බන්ධතා මත ගොඩනැගී ඇත.



6 ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසනය (SGBV) සඳහා වන සහාය සේවාවන්ට ප්‍රවේශ වීමට ඇති බාධක

ව්‍යුහාත්මක, සමාජීය සහ ප්‍රායෝගික බාධක රැසක් හේතුවෙන් වින්දිතයින්ට සහාය සේවාවන් වෙත ප්‍රවේශ වීමට අපහසු වේ.



7 ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසනය (SGBV) සඳහා වන සහාය සේවාවන් සැපයීමේදී ඇතිවන ප්‍රධාන අඩුපාඩු සහ අභියෝග

සේවාවන් ලබාගැනීමේ පහසුව, එහි ගුණාත්මකභාවය, නීතිමය රාමු, සම්බන්ධීකරණය සහ විශ්වාසය සම්බන්ධ සැලකිය යුතු අඩුපාඩු නිසා SGBV සඳහා එලදායී ප්‍රතිචාර දැක්වීමට බාධා වේ.

සේවාවන්හි ලබාගත හැකි බව, ප්‍රවේශ වීමේ හැකියාව සහ ගුණාත්මකභාවය සම්බන්ධයෙන්:

- නීතිමය රාමුවේ පවතින සීමාවන්
- දිස්ත්‍රික්ක අතර සේවාවන් සීමිතව පැවතීම
- සේවාවන්හි ගුණාත්මකභාවයේ විෂමතා
- රාජ්‍ය සේවා සපයන්නන් පිළිබඳ විශ්වාසයේ හිඟය
- සමහර සේවා සපයන්නන්ගේ පසුගාමී ආකල්ප
- සේවා සැපයීමේ ප්‍රමාදයන්
- බණ්ඩන සේවා සැපයීම

- පවතින සේවාවන් පිළිබඳ සීමිත දැනුම
- රාජ්‍ය ආයතන සඳහා ප්‍රමාණවත් මූල්‍ය ප්‍රතිපාදන නොමැති වීම
- රාජ්‍ය නොවන සේවා සපයන්නන් සඳහා පවතින මූල්‍ය ප්‍රතිපාදනවල තීරසාරභාවය නොමැති වීම

සම්බන්ධීකරණය සහ යොමු කිරීමේ මාර්ග සම්බන්ධයෙන්:

- දිස්ත්‍රික් හෝ ජාතික මට්ටමින් SGBV සේවා සිතියම්ගත කිරීමක් නොමැති වීම
- දිස්ත්‍රික් මට්ටමින් SGBV සේවා සැපයීම සඳහා නියෝජනාත්මක හා විධිමත් සම්බන්ධීකරණ යාන්ත්‍රණයක් නොමැති වීම
- පැහැදිලි යොමු කිරීමේ ක්‍රියාමාර්ග පිළිබඳ දැනුවත්භාවයේ හිඟය හෝ ඒවා නොපැවතීම
- ප්‍රමාණවත් දත්ත හුවමාරුවක් නොමැති වීම

කාන්තා හා ළමා කටයුතු අමාත්‍යාංශය

පොලීසිය

නීති ආධාර සේවා සපයන්නන්

සෞඛ්‍ය, මනෝසමාජීය සහ මානසික, චෛද්‍ය සේවා සපයන්නන්

අන්තර්ජාතික රාජ්‍ය නොවන සංවිධාන සහ ජාත්‍යන්තර සංවර්ධන නියෝජිත ආයතන

සිවිල් සමාජ සංවිධාන

8 ප්‍රධාන පාර්ශවකරුවන් සඳහා වූ ඉලක්කගත ක්‍රියාමාර්ග

බහු ක්ෂේත්‍ර සම්බන්ධීකරණය මත පදනම් වූ ප්‍රතිචාරයක් මගින් වැළැක්වීම, සහාය සැපයීම සහ වින්දිතයන් සඳහා යුක්තිය ඉටු කිරීම ශක්තිමත් වන අතර, එය එක් එක් ප්‍රධාන පාර්ශවකරුගේ කාර්යභාරයට අනුව සකස් කර ඇත.



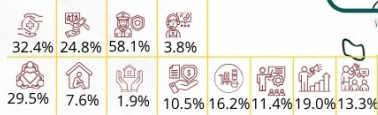
ලිංගික හා ස්ත්‍රී පුරුෂ සමාජභාවය මත පදනම් වූ හිංසනය (SGBV) සම්බන්ධ සේවාවන්

	රාජ්‍ය වෛද්‍ය ප්‍රතිකාර සේවා
	නොමිලේ නීති ආධාර සේවා
	පොලීසිය
	ක්ෂණික ප්‍රතිචාර සේවා / හදිසි දුරකථන ඇමතුම් සේවා

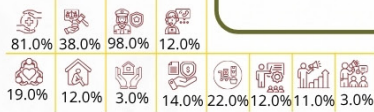
අනෙකුත් ප්‍රධාන සේවාවන්

	මනෝසමාජීය සහ මානසික වෛද්‍ය සහාය
	හදිසි නවාතැන් හෝ ආරක්ෂිත රැඳවුම් මධ්‍යස්ථාන (කෙටි කාලීන)
	ආරක්ෂිත නවාතැන් (දිගු කාලීන)
	මූල්‍ය ආධාර
	ආහාර සහ අනෙකුත් භෞතික ආධාර
	කුසලතා පුහුණුව ඇතුළුව ජීවනෝපාය සංවර්ධනය කිරීමේ වැඩසටහන්
	SGBV වැළැක්වීම පිළිබඳ දැනුවත් කිරීම
	SGBV සහාය සේවාවන් පිළිබඳ දැනුවත් කිරීම

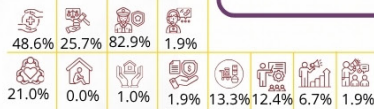
කිලිනොච්චිය



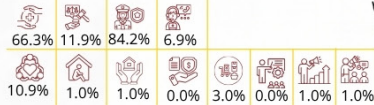
අනුරාධපුරය



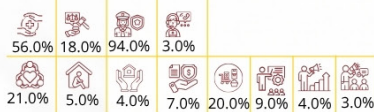
පුත්තලම



නුවරඑළිය



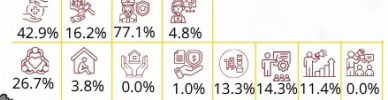
හම්බන්තොට



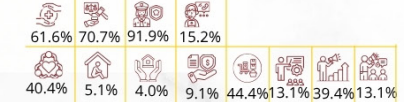
මුලතිව්



ත්‍රිකුණාමලය



අම්පාර



ஆய்வின் சுருக்கம்

1 இலங்கையில் பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறையின் (SGBV) பரவல்

நான்கு பெண்களில் ஒருவர் வன்முறையை அனுபவிக்கிறார்; ஐந்து பெண்களில் கிட்டத்தட்ட இருவர் பரந்தளவில் பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறையை (SGBV) அனுபவிக்கின்றனர்.

[ஆதாரம்: இலங்கை தொகை மதிப்பு மற்றும் புள்ளிவிபரத் திணைக்களம் - இலங்கை பெண்கள் நல்வாழ்வு ஆய்வு 2019 (இறுதி அறிக்கை).]



24.9%

பெண்கள் 15 வயது தொடக்கம் பாலியல் மற்றும்/அல்லது உடல் ரீதியான வன்முறைகளை அனுபவித்துள்ளனர்



39.8%

பெண்கள் தங்கள் வாழ்நாளில் துணையால் மேற்கொள்ளப்பட்ட உடல், பாலியல், உளவியல்/ உணர்ச்சி, பொருளாதார வன்முறை மற்றும்/ அல்லது கட்டுப்படுத்தும் நடத்தைகளை அனுபவித்துள்ளனர்.

2

பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறையின் (SGBV) வடிவங்கள்

பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறையானது (SGBV) உடல் ரீதியான சேதத்திலிருந்து பொருளாதாரம் மற்றும் இணையத் தொழில்நுட்பம் வழியாக மேற்கொள்ளப்படும் துஷ்பிரயோகங்கள் வரை பல்வேறு வடிவங்களில் காணப்படுகிறது.



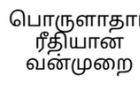
உடல் ரீதியான வன்முறை



பாலியல் வன்முறை



உளவியல் / உணர்ச்சி ரீதியான துஷ்பிரயோகம்



பொருளாதார ரீதியான வன்முறை



இணைய / தொழில்நுட்ப வழியில் மேற்கொள்ளப்படும் துஷ்பிரயோகம்



பெண் பிறப்புறுப்பு சிதைப்பு



வாய்வழி துஷ்பிரயோகம்



பொது இடங்களில் தொல்லைக்கு உட்படுத்தப்படல்



பெண்கொலை



மனிதக் கடத்தல்

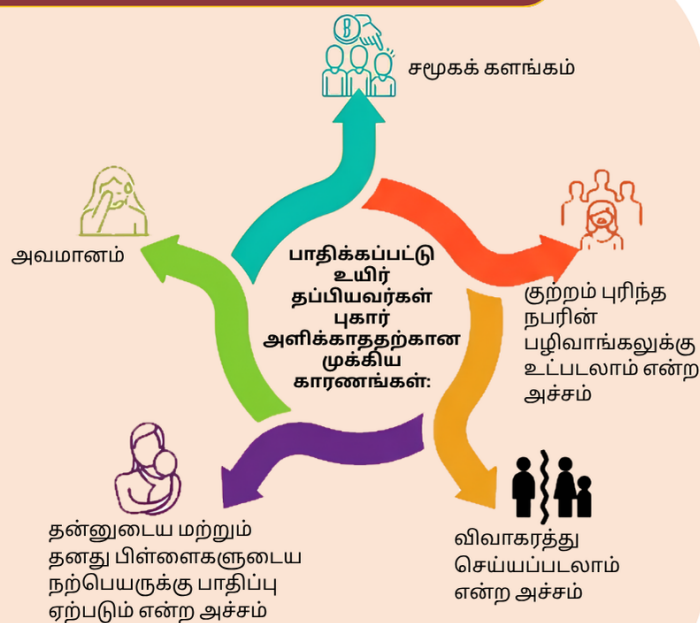


குடும்ப வன்முறை



நெருங்கிய துணையால் மேற்கொள்ளப்படும் வன்முறை (IPV)

3 இலங்கையில் பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறை (SGBV) தொடர்பாக புகாரளித்தல்



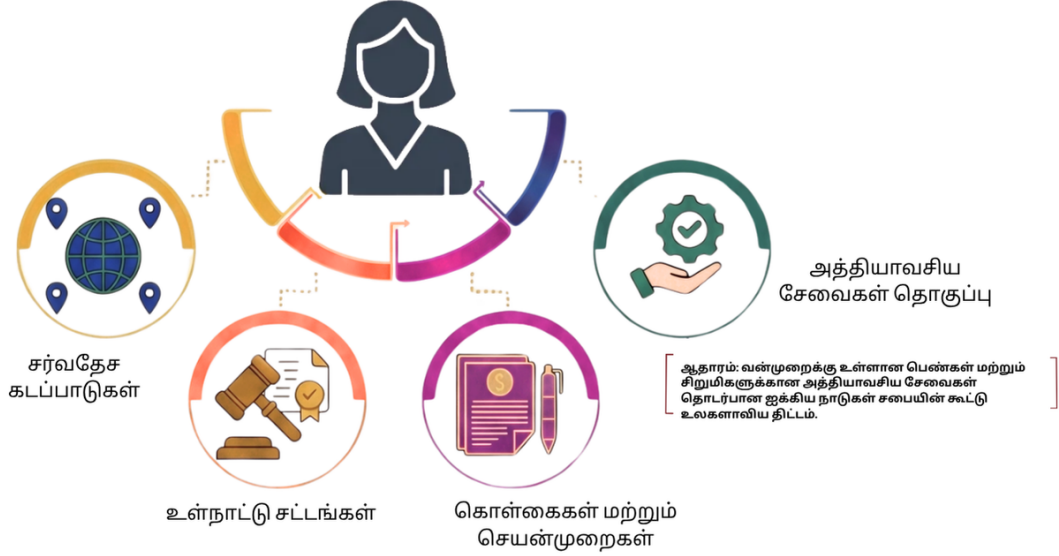
4 அதிகமாக பயன்படுத்தப்படும் புகாரளித்தல் வழிமுறைகள்



5

பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறைக்கு (SGBV) உட்பட்டோருக்கு ஆதரவளிக்கும் கட்டமைப்பு

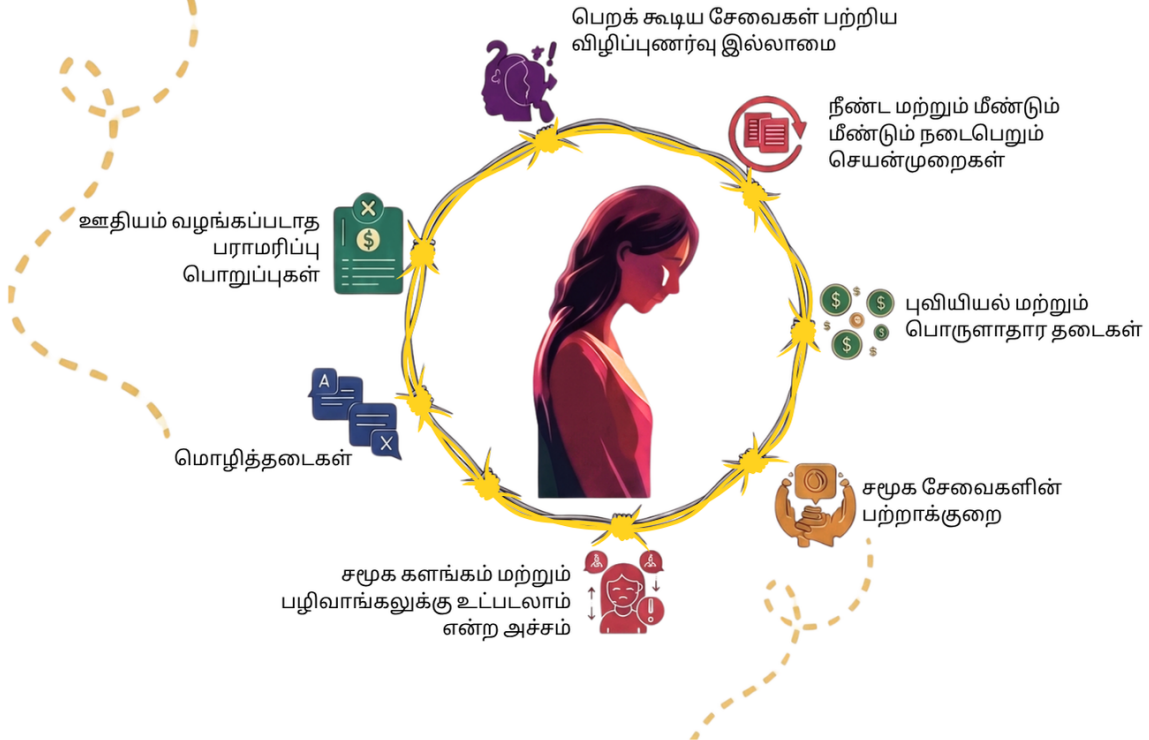
பாதிக்கப்பட்டவரை மையமாகக் கொண்ட ஆதரவு முறைமையானது ஒன்றோடொன்று தொடர்புடைய சர்வதேச கட்டப்பாடுகள், தேசிய சட்டங்கள், கொள்கைகள் மற்றும் சேவை கட்டமைப்புகளின் அடிப்படையில் உருவாக்கப்பட்டுள்ளது.



6

பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறை (SGBV) ஆதரவு சேவைகளை அணுகுவதற்கான தடைகள்

கட்டமைப்பு, சமூக மற்றும் நடைமுறை சார்ந்த பல தடைகள் காரணமாக, பாதிக்கப்பட்டவர்கள் ஆதரவு சேவைகளை அணுக முடியாமல் உள்ளனர்.



7

பாலியல் மற்றும் பாலின அடிப்படையிலான வன்முறை (SGBV) ஆதரவு சேவைகளில் காணப்படும் முக்கிய இடைவெளிகள் மற்றும் சவால்கள்

சேவைகளின் கிடைப்புத்தன்மை, தரம், சட்ட கட்டமைப்புகள், ஒருங்கிணைப்பு மற்றும் நம்பிக்கை ஆகியவற்றில் காணப்படும் குறிப்பிடத்தக்க இடைவெளிகள், SGBV-க்கு எதிரான பயனுள்ள பதிலளிப்பைத் தடுக்கின்றன.

சேவைகளின் கிடைப்புத்தன்மை, அணுகல்தன்மை மற்றும் தரம் தொடர்பாக:

சட்ட கட்டமைப்பில் உள்ள வரம்புகள்

மாவட்டங்களுக்கிடையில் சேவைகள் குறைந்த அளவில் கிடைப்பது

சேவைகளின் தரத்தில் காணப்படும் வேறுபாடுகள்

அரசு சேவை வழங்குநர்களின் மீது நம்பிக்கை இல்லாமை

சில சேவை வழங்குநர்களின் பிற்போக்கான மனப்பான்மைகள்

சேவைகள் வழங்கப்படுவதிலான தாமதங்கள்

சிதறிய சேவை வழங்கல் முறை

கிடைக்கக்கூடிய சேவைகள் குறித்த வரையறுக்கப்பட்ட அறிவு

அரசு நிறுவனங்களுக்கு போதுமான நிதி இல்லாமை

அரசு சார்பற்ற சேவை வழங்குநர்களுக்குக் கிடைக்கும் நிதியின் நிலைத்திருக்கக்கூடிய தன்மையின்மை

ஒருங்கிணைப்பு மற்றும் பரிந்துரை (Referral) வழிமுறைகள் தொடர்பாக

மாவட்ட அல்லது தேசிய மட்டத்தில் SGBV சேவைகள் கண்டறியப்படாமை

மாவட்ட மட்டத்தில் SGBV சேவை வழங்கலுக்கான பிரதிநிதித்துவமிக்க மற்றும் முறையான ஒருங்கிணைப்பு அமைப்பு இல்லாமை

தெளிவான பரிந்துரை நடைமுறைகள் பற்றிய விழிப்புணர்வு இல்லாமை அல்லது அவை கிடைக்காதிருத்தல்

போதுமான தரவு பகிர்வு இல்லாமை

மகளிர் மற்றும் சிறுவர் அலுவல்கள் அமைச்சு

பொலிஸ்

சட்ட உதவி சேவை வழங்குநர்கள்

சுகாதார, உளசமூக மற்றும் மனநல மருத்துவ சேவை வழங்குநர்கள்

சர்வதேச அரசு சார்பற்ற அமைப்புகள் மற்றும் சர்வதேச அபிவிருத்தி முகமைகள்

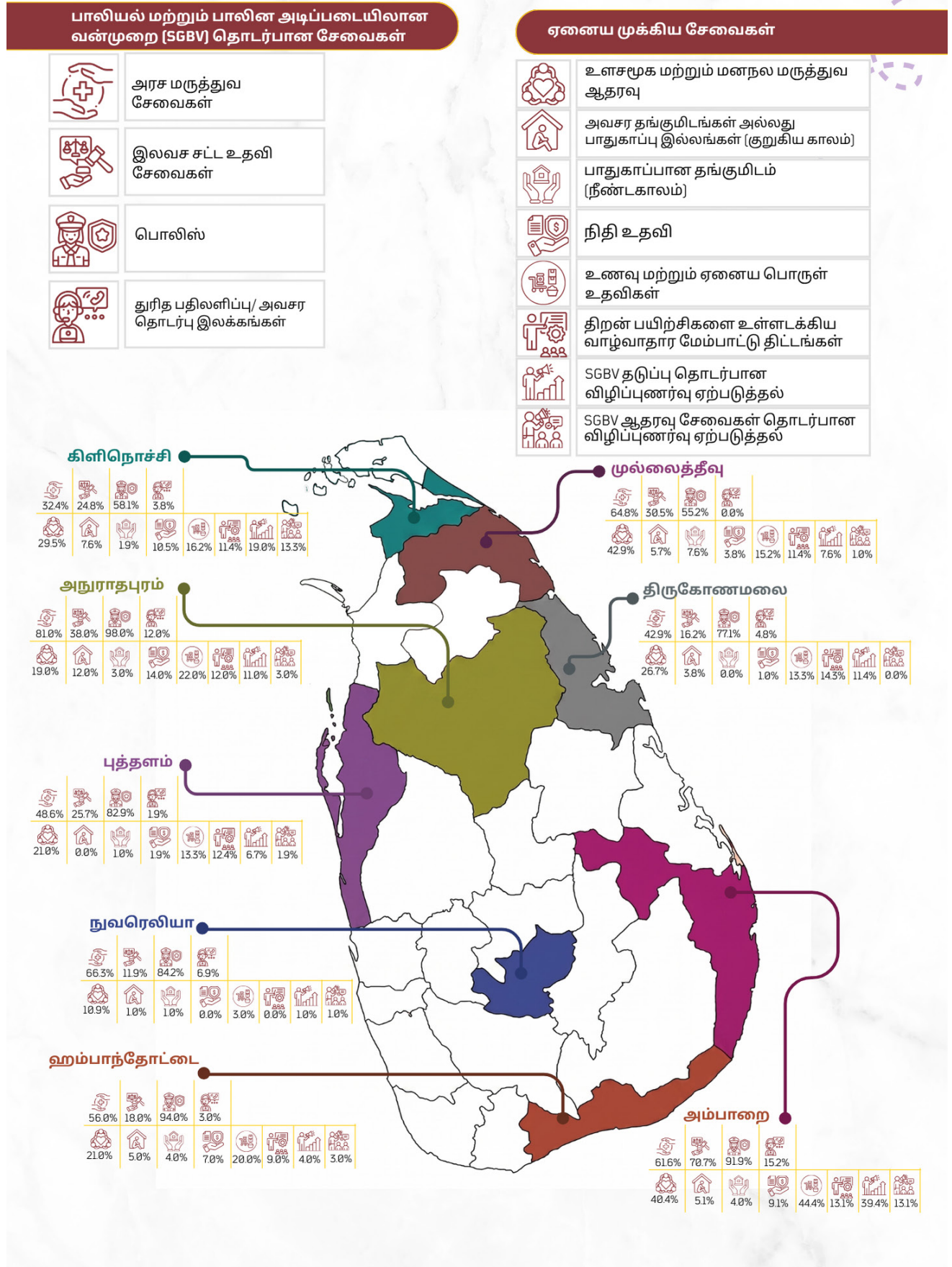
சிலில் சமூக அமைப்புகள்

8

முக்கிய பங்குதாரர்களுக்கான இலக்குவைக்கப்பட்ட நடவடிக்கைகள்

பல்துறை ஒருங்கிணைந்த பதிலளிப்பானது, ஒவ்வொரு முக்கிய தரப்பினரின் பங்கிற்கேற்ப வடிவமைக்கப்பட்டுள்ள தடுப்பு நடவடிக்கைகள், ஆதரவு மற்றும் நிதியை பாதிக்கப்பட்டவர்களுக்காக வலுப்படுத்துகிறது.





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 Notes

This image shows a full page of white paper with horizontal dashed lines, typical of primary-ruled notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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