DESHAMANYA DR. SIVA CHINNATAMBY MEMORIAL ORATION 2026



Dr. Siva Chinnatamby

"Behind the Curtain of Care: An Obstetrician and Gynaecologist's journey in addressing Gender Based Violence in Northern Sri Lanka"

By

Dr. Kandiah Guruparan
MBBS (Jaffna), MD (Colombo)
Senior Lecturer and Specialist in Obstetrics & Gynaecology,
Department of Obstetrics & Gynaecology, Faculty of Medicine, University of Jaffna
Honorary Consultant, Teaching Hospital Jaffna.

The President and the distinguished members of the Council, SriLanka College of Obstetricians and Gynaecologists, respected seniors, esteemed colleagues, honored guests, and ladies and gentlemen—a very good evening to you all. It is a profound honor and privilege to deliver the Deshamanya Dr. Siva Chinnatamby Memorial Oration 2026 on a topic related to reproductive health.

"*Behind the Curtain of Care: An Obstetrician and Gynaecologist's journey in addressing Gender-Based Violence in Northern Sri Lanka"*

Preamble

Deshamanya Dr. Siva Chinnatamby is charismatic and pioneering leader in obstetrics and gynaecology. Dr. Sivacollunthu Chinnatamby was born on 8th of April, 1920 at Karaveddy, in Jaffna. She had her primary education in Karaveddy and secondary education in Jaffna Ramanathan College. In 1946, she graduated from the Ceylon Medical College. After receiving specialized training in the United Kingdom, she returned to Ceylon in 1953 and since then she dedicated her life to improving the health and well-being of women in Sri Lanka.

She was a founder member of the association of the Obstetricians and Gynaecologists of Ceylon and was fully devoted to the organization. She played an active role in the formation of the Association of Obstetricians and Gynaecologists of Ceylon in 1953 and served as

Secretary, Treasurer, and Editor on many occasions. When the Sri Lanka College of Obstetricians and Gynaecologists was established in 1967, she was elected as a secretary, a post she held for many years. She also served as its President from 1983 to 1985. During her tenure as the President of the SLCOG, Sri Lanka had the privilege of hosting the 10th AOFOG Congress in 1985. She was the first woman President of the AOFOG as well as the first Sri Lankan to acquire an honorary fellowship.

She was also an Honorary Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and chaired the Regional Medical Committee of the International Planned Parenthood Federation. She has done immense services in reproductive medicine, especially in contraceptive methods. She is known as the “Mother of the Pill” for her pioneering trial of the contraceptive pill in South Asia. She co-founded the Family Planning Association of Sri Lanka and led the position as the medical director for 25 years. Her contributions to women's health were recognized with the prestigious Deshamanya award. Gender Based Violence (GBV) violates basic human rights and affects sexual and reproductive health. I truly hope this oration honors the incredible legacy of Dr. Siva Chinnatamby, especially her groundbreaking work in reproductive medicine.

1. Introduction: Behind the Curtain of Care

I would like to begin with a story.

A 35-year-old woman, a bank manager, and her husband attended the subfertility clinic. The couple was asked to undergo several investigations. At the follow-up clinic visit, she came alone and looked a little worried, as she could not afford the investigations. She asked whether they could be done in the government sector. On further questioning, she started to cry and produced two discharge cards from a hospital.

The first discharge card mentioned a history of a fall at home, with bruises on her face and a fracture of the right arm. The other discharge card mentioned paracetamol poisoning. After a while, she calmed down and explained that she had many problems at home. She regretted having resigned from her job at her husband's request and said that she had now applied for divorce.

In this case, the real problem was hidden under the guise of subfertility. It was only during the second visit, after she had developed trust in the clinician, that the woman opened up about the real problems she was facing.

What we see in the consultation room is not always the whole story. Behind the curtain of care, there may be another history - a history that is rarely volunteered, often not asked about, and sometimes not recognized.

This is the central metaphor of today's oration: the invisible curtain may hide much more than the original presenting complaint I will discuss how I unveiled the curtain and managed the hidden problem.

The terms "gender-based violence" (GBV) and "violence against women" (VAW) are often used interchangeably, as most gender-based violence is perpetrated by men against women. GBV includes violence against men, boys, and sexual minorities or those with gender-nonconforming identities. Violence against women (VAW) is one type of GBV. While violence against the other groups mentioned is often rooted in the same gender inequalities and harmful gender norms, this presentation will focus on GBV in broader aspect. In Sri Lanka, the term GBV is widely used than VAW.

2. A journey from witnessing to action

The cases changed as my career progressed, but one question remained: why were we treating the consequences while so often failing to address what lay behind them?

As a medical student, I saw cases involving child physical and sexual abuse, rape, suicide attempts and injuries resulting from domestic violence.

At that stage, I encountered these cases without fully recognizing the wider problem behind them. But they

raised an important question in my mind: Why does violence happen?

During my internship in obstetrics and gynaecology and paediatrics, the spectrum of cases widened. Working alongside the police, Judicial Medical Officers and mental health team gave me a different perspective on the problem.

As a postgraduate trainee in obstetrics and gynaecology, repeated encounters with similar cases helped me to recognize the patterns and gravity of violence. My supervising consultants guided me in managing these cases, although my understanding of the wider dimensions of violence against the women was still developing. Overseas training broadened my perspective and taught me to see those affected as human beings, rather than patients.

When I became a consultant, I have both the responsibility and the opportunity to intervene.

Later, when I became a university academic cum clinician, the question became widened: Are we preparing the next generation of university graduates and healthcare professionals to recognize and respond appropriately to GBV?

3. GBV: from a global problem to our local reality

GBV is recognized by the World Health Organization as a major public health problem and a violation of human rights. It transcends social, economic and geographical boundaries and can have profound consequences for health, dignity, safety and autonomy. Sustainable Development Goal 5 focuses on achieve gender equality and empower women and girls [1,2].

Global burden

Globally, approximately one in three women (31.6%), representing around 840 million women and girls, have experienced physical and/or sexual intimate partner violence or non-partner sexual violence during their lifetime [3]. The burden remains particularly high in South Asia, where the prevalence of intimate partner violence is estimated at approximately 31% [4].

Sri Lankan context

In Sri Lanka, the Women's Wellbeing Survey 2019 [4] revealed that one in five women (20.4%) had experienced sexual and/or physical violence by an intimate partner during their lifetime. In addition, one in four women (24.9%) had experienced sexual and/or physical violence since the age of 15 [4-6].

Northern Sri Lanka

When we look closer to Northern Sri Lanka, the magnitude of the problem becomes even more apparent. According to the Kilinochchi District Secretariat, with a population of approximately 100,000, around 300 GBV-related cases were recorded annually from 2022 to 2025—almost one reported case every day. The persistence of these numbers suggests that GBV is not an isolated event, but an ongoing problem within the community [7]. Similarly, in Jaffna District, with a population of approximately 675,000, around 420 GBV-related cases were recorded annually during the same period [8].

These recent figures demonstrate that GBV continues to be an important problem in Northern Sri Lanka. However, numbers alone tell us little about the people behind them. They do not tell us who was affected, what forms of violence they experienced, who the perpetrators were, what consequences followed, or how those affected came to the attention of healthcare services.

We analyzed a cohort of 883 clients who reported and received services from the Mithurupiyasa (Nadpu Nilayam) GBV help desk at Jaffna Teaching Hospital during 2022- 2023 [9].

The client characteristics are described in the table 1.

Table 1 Characteristic of clients

Characteristic	Category	Frequency	Percentage (%)
Age	<20 years	33	3.7
	20–40 years	671	76
	41–60 years	165	18.7
	>60 years	14	1.6
Gender	Female	797	90.3
	Male	86	9.6
Educational status	Primary education	378	42.8
	Secondary education	490	55.5
	Higher education	15	1.7
Employment status	Employed	691	78.3
	Unemployed	192	21.8

When we looked at the nature of the violence, physical violence was the most frequently reported, affecting 68.5% of clients. But visible injuries were only part of the story. Almost half experienced economic violence, 40% emotional violence and nearly 30% sexual violence. Around one-third had experienced more than one form of violence. (Figure 1)

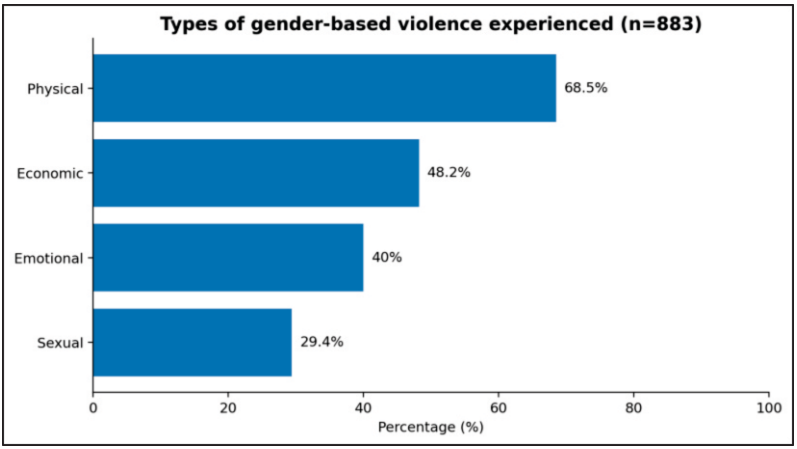


Figure 1 Types of violence

The relationship with the perpetrator was equally revealing. In 87.9% of cases, the alleged perpetrator was a husband, lover or partner, and nearly two-thirds of alleged perpetrators had a history of alcohol use.

The consequences extended well beyond the immediate episode of violence. Forty-five per cent experienced physical injuries, 44.8% reported financial constraints, one in four reported feeling depressed, 11.5% experienced family separation, and 7.3% reported suicidal tendencies. (Figure 2)

These findings reinforced an important lesson: GBV is not simply an injury to be treated and a patient to be

discharged. Its consequences extend into physical and mental health, economic security, relationships and family life.

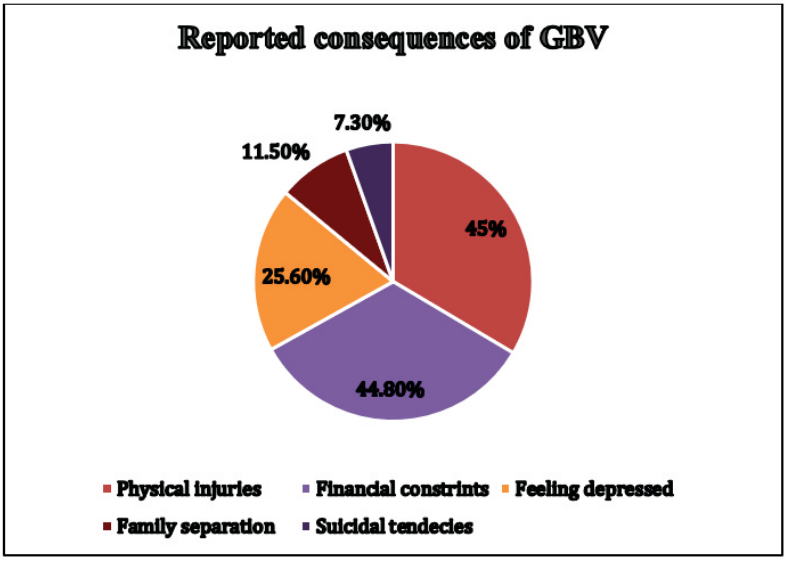


Figure 2 Reported consequences of violence

One finding particularly caught my attention. Almost 95% of the clients had been referred to the Help Desk from within the hospital. Though the purpose of GBV help desk (Nadpu Nilayam) at outpatient department was to serve help seeking individuals directly, very few had come directly.

Table 2 Mode of referral

Mode of Referral (n-883)		
Inward referrals	835	94.60%
OPD referrals	46	5.20%
Police	2	0.22%

They were already within our healthcare system, but someone had to recognize what might be hidden behind the presenting complaint. This brought me back to the central theme of this oration:

“What we see in the consultation room is not always the whole story.”

A physical injury may be visible, but emotional, economic and sexual violence may remain hidden unless someone recognizes the possibility and creates a safe space for disclosure. Having a GBV help desk service alone was therefore not enough; survivors had to be recognized, listened to and connected to that service.

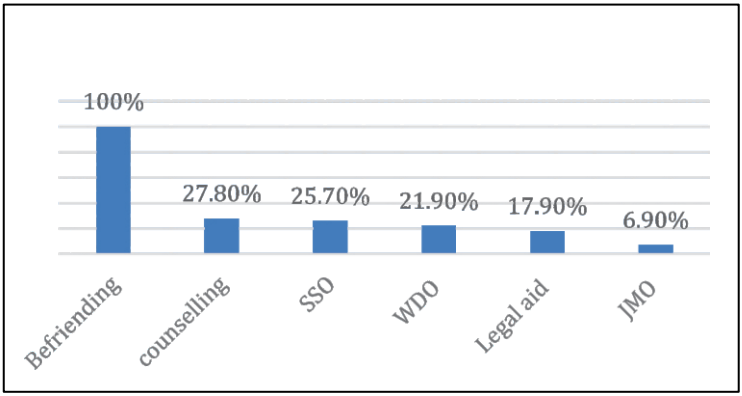


Figure 3 Services provided by the center

This raised another question: Are the people who we are training prepared adequately to recognize and respond to GBV?

To explore this, in 2025 we studied nursing students at the Nurses' Training School, Jaffna. More than half had never heard of GBV; only 32% could identify its different forms, 45% recognized important risk factors, and 42% were aware of available support services [unpublished data]. These findings revealed an important gap in the preparedness of future healthcare professionals and shifted our work from documenting the problem to strengthening the capacity to recognize and respond to it.

4. Understanding GBV

Over time, the focus has broadened from violence against women to the wider concept of gender-based violence. GBV refers to violence directed against a person because of their gender, gender identity or socially constructed gender roles [10].

Although women and girls are disproportionately affected, GBV is not confined to women. Men, boys and LGBTI persons may also experience gender-based violence. Ultimately, whatever terminology we use, at the centre is a person whose health, dignity, autonomy or safety has been compromised [11].

But how well is this broader concept understood?

To explore this within the academic setting, we assessed 43 participants enrolled in the Staff Development Programme. At baseline, only 47% demonstrated adequate knowledge of GBV, and only 31% demonstrated awareness in key areas such as recognizing different forms of GBV, responding appropriately to disclosure and knowing where to refer someone for support [unpublished data].

This highlighted an important point: we cannot assume that awareness of GBV comes automatically with higher education or an academic role. More importantly, the finding gave us an opportunity to act. We therefore incorporated GBV education into the Staff Development

Programme, focusing on recognition, appropriate response to disclosure, and available pathways for referral and support.

In this way, identifying a knowledge gap became an opportunity for education and capacity building.

5. **Why does violence happen—and why does it remain hidden?**

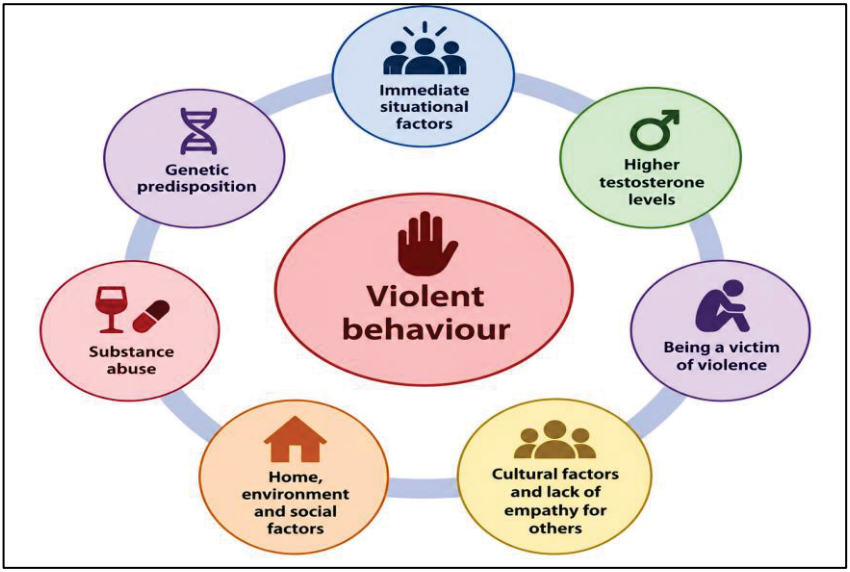
To understand why gender-based violence occurs, we need to look beyond the individual act of violence and consider the wider social environment in which it occurs.

Every society has socially constructed gender roles and expectations that influence how men and women are expected to behave, make decisions and interact with one another. When these roles become rigid and unequal, they can create differences in power, opportunities and decision-making.

In patriarchal societies, male dominance and unequal power relations may contribute to discrimination against women and increase their vulnerability to violence. More broadly, wherever gender inequality, discrimination and unequal power relations are accepted or tolerated, an environment may be created in which GBV is more likely to occur and persist.



However, GBV does not arise from a single cause. Violent behaviour results from a complex interaction of factors operating at different levels - from the individual and relationship level to the community and wider society. These interconnected risk factors are illustrated in the following diagram.



When considering GBV in greater depth, many of its contributing factors are deeply rooted in society. These include gender inequality, abuse of power, patriarchal

structures, economic inequality, harmful traditional practices, lack of education and weak enforcement of laws.

In the South Asian family context, women, girls and children may have limited opportunities to raise their concerns or speak openly about violence. Although the family structure can provide an important protective and supportive environment, it may sometimes discourage disclosure or place pressure on women to tolerate violence in order to preserve family unity.

In Northern Sri Lanka, the consequences of prolonged conflict may add further layers of vulnerability. War related trauma, displacement, changing family structures, loss of employment and income, economic pressures, alcohol and substance use, and changing community attitudes may interact with existing gender inequalities and contribute to the risk of GBV.

Ideas about the expected roles of women can also be seen in traditional literature and cultural narratives. In the *Ramayana*, Sita is often portrayed as an ideal wife, embodying qualities such as loyalty, sacrifice and endurance. In our culture, similar expectations may be placed on wives, daughters and mothers, with deviation from traditional roles viewed as disobedience.

Similarly, in the *Mahabharata*, Draupadi experiences humiliation, discrimination and violence at the hands of people known to her, while her ability to protect herself is constrained by the social and power structures surrounding her.

Although Sita and Draupadi continue to be honored and celebrated, their stories can also prompt us to reflect on women's experiences of suffering, powerlessness and gender-based injustice.

Kannaki, by contrast, represents a woman who openly challenged injustice and demanded accountability from the king. Her story provides another perspective on how women responded to injustice within South Asian cultural narratives though she herself was a victim of GBV in today's context.

Evidence from different historical societies also suggests that violence against women and children is not exclusively a modern phenomenon. However, such historical evidence should be interpreted within its particular social, cultural and religious context.

In societies where patriarchal structures and unequal power relations are deeply embedded, women's experiences and voices may remain overshadowed or unheard. At the same time, when perpetrators are not held

accountable, fear and silence may become further entrenched within families and communities.

6. GBV and health

The consequences of GBV can be devastating and extend far beyond the immediate act of violence. Survivors may experience physical injuries, sexual and reproductive health problems, mental health consequences and self-harm. They may also face victim-blaming, social exclusion, loss of employment, further violence or even retaliation for reporting their experiences.

Ultimately, GBV can deprive survivors not only of their health and dignity, but also of their autonomy.

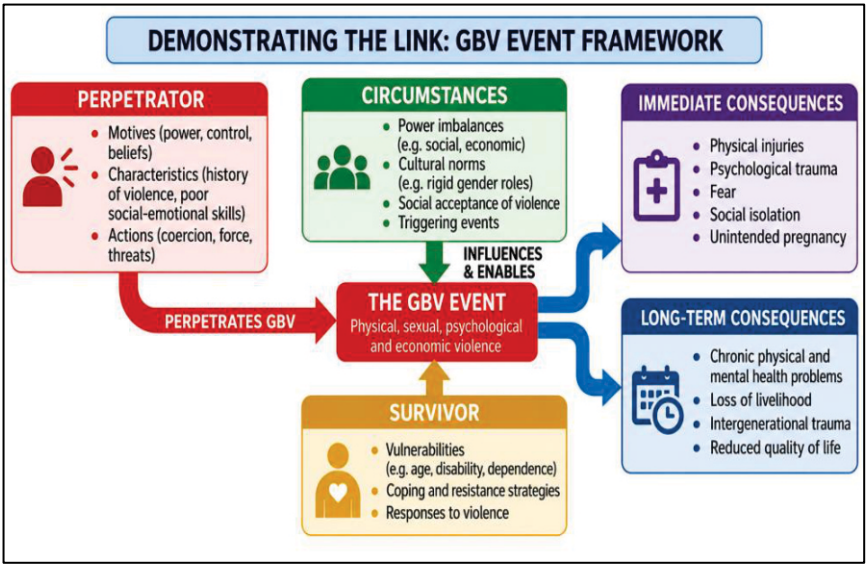
The WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This broader understanding of health is particularly relevant to GBV because its consequences affect every dimension of a survivor’s well-being.

Sexual and reproductive health may be particularly affected. Consequences can include unintended pregnancy, unsafe abortion, sexually transmitted infections, physical and sexual trauma, pregnancy-related complications, and loss of sexual and reproductive autonomy. The psychological consequences may include

anxiety, depression, post-traumatic stress and self-harm. Survivors may also experience legal and judicial challenges, loss of employment, financial difficulties and a reduced quality of life. But the consequences do not stop with the individual.

In many cultures, women - as mothers, wives, sisters and daughters—play a central role in the well-being of their families. When a woman experiences violence or harm, the effects may therefore extend beyond her own health and affect the emotional, social and economic well-being of the entire family.

The effects may extend further into the community. GBV can contribute to family breakdown, intergenerational trauma, increased financial and social-service burdens, fear and social isolation. When violence becomes tolerated or normalized, it can also undermine trust and weaken social cohesion. GBV therefore creates a ripple effect - from the survivor, to the family, and ultimately to the wider community.



"The bruises may disappear. The reproductive, psychological, social and intergenerational consequences may remain much longer." a 42-year-old female survivor of GBV in our Jaffna study. It was at this point that I began to look and listen more deeply to the untold stories behind the injuries, the silence and the suffering.

How did healthcare become a "fire assembly point" for survivors of GBV?

Healthcare services provide an important opportunity to identify and support survivors of violence. A survivor may attend a healthcare facility for an injury, pregnancy,

reproductive health concern or another medical problem without disclosing the violence behind it.

Antenatal and gynaecology clinics, in particular, may become important **"fire assembly points"** for survivors with sexual and reproductive health needs. Obstetricians and Gynaecologists and other healthcare professionals should therefore remain alert to possible signs of GBV, provide a safe and confidential environment for disclosure, and respond with sensitivity and appropriate support. For some survivors, the healthcare professional may be the first person to recognize what has remained hidden and the first safe person to listen.

7. The turning point: From a clinical mind to a research mind

Some clinical encounters revealed the harsh realities of GBV and became a turning point in my journey, prompting me to look beyond immediate clinical care and explore possible interventions using the resources available to us.

Case 1

A 28-year-old primigravida attended her booking antenatal visit. I noticed that she was dressed in clothing that completely covered her neck and both upper limbs down to the wrists. She appeared very anxious and was

accompanied by her mother-in-law. At her next clinic visit, she came alone and disclosed the story behind what I had observed. Following a dispute with her husband and mother-in-law over dowry-related issues, she had attempted to take her own life by setting herself on fire with kerosene. She survived with scars on chest, abdomen and on both upper limbs.

Case 2

A 20-year-old female university student was referred by a student counsellor because of poor engagement with her studies and frequent absence from lectures, often attributed to menstrual pain.
She appeared distressed and was initially reluctant to speak. With time, she disclosed that a senior male student had been repeatedly harassing her on campus and sending unwanted messages through social media. The experience had affected her studies to the extent that she was considering leaving the course. She was supported and advised to report the harassment to the university's Centre for Gender Equity and Equality.

Case 3

A 35-year-old mother of two children, admitted to surgical casualty with 90% burns. She was 32 weeks pregnant. Later the day she died. Her husband had set fire

to her in the kitchen after pouring kerosene on her from behind, following a family dispute.

Case 4

A 20-year-old unmarried girl, admitted to medical casualty with fever. As her fever was not settling despite of antibiotics initially, she underwent further investigation and imaging. There was evidence for peritonitis and suspected bowel perforation. She underwent laparotomy and treated for small bowel perforation with uterine damage. After spending several days in ICU, she was discharged. She didn't open her mouth regarding the events culminated in her condition. On the follow up visit, she mentioned that she was in relationship with her boyfriend. When she became pregnant, he did not want to continue the pregnancy. She was forced to undergo termination of pregnancy by a person which resulted in all the consequences of septic abortion she experienced. She remembered that she experienced intolerable pain during the procedure.

Case 5

A 35-year-old mother of three, had repeated admissions to medical, surgical and gynaecology wards with multiple complaints and injuries. A medical officer at the outpatient clinic recognized the pattern of admissions and referred her for psychiatric assessment. Further

evaluation revealed that she was experiencing domestic violence for a long time which escalated following financial difficulties in her husband's business. Her school-going son had recently died by suicide after an argument with his father. She was referred to Mithurupiyasa GBV help desk. A case conference with multidisciplinary team was arranged and multimodal assistance was initiated. In this case, a hidden story of domestic violence was associated with her frequent hospital admissions.

In dealing with such cases since 2010, I have observed a similar pattern of untold stories. An individual's problem which was closely connected to the family and community would often go unnoticed and thus remain unmasked if service providers were not alert enough to pick up patterns and the untold stories behind them.

On further questioning and analysis, these cases gave a clear picture of a long-standing social problem. Victims come from all brackets of society regardless of their social and educational status, the jobs they hold, their income, gender or age.

My medical radar started to catch the events and identified the pathophysiology of GBV. There is a pathogen (perpetrator) causing a disease (GBV) with immediate symptoms and signs with long term consequences in a patient (victim or survivor) when the host becomes

immunocompromised or physically weak (poor social protection).

A detailed assessment, investigations and acute and long-term management is helpful. Like in other areas of medicine, a multidisciplinary team (MDT) approach worked well in these cases.

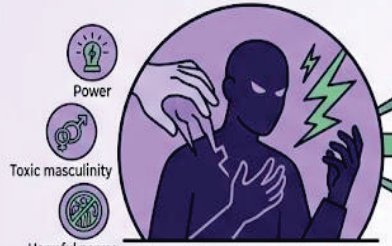
Acute cases should be dealt with by proper teams with support from all aspects of care services.

To eradicate the GBV disease, preventive measures need to be taken at the individual and community level. To immunize against GBV, awareness programmes and community empowerment are essential.

Long term follow-up is with social services and the judicial system to ensure there will be no relapses and recurrence.

As GBV behaves like an infectious disease, preventive measures should be taken as for Dengue or Malaria. Regular eradication programmes are essential to keep the community free of GBV.

GENDER-BASED VIOLENCE (GBV) AS A DISEASE MODEL: AN EPIDEMIOLOGICAL FRAMEWORK



THE AGENT: PERPETRATOR
(Pathogen)

Causes harm and drives the disease through power, control, and abuse.



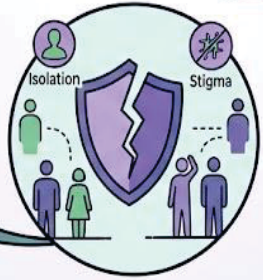
THE HOST: VICTIM/SURVIVOR

Experiences consequences: Trauma, health issues, loss of agency. Reduced capacity to resist without support.



WEAKENED HOST IMMUNITY
(Poor Social Support)

Enables disease progression. Lack of help, resources, or intervention leaves host vulnerable.



**This model adapts biological disease concepts to social issues.*

8. From research to response

Working as an Obstetrician and Gynaecologist at the District General Hospital, Kilinochchi, during the post war resettlement period gave me the opportunity to encounter GBV and its consequences in everyday clinical practice there. As these cases accumulated, I began to recognize recurring patterns and realized that we needed to understand the problem more systematically. Many survivors first presented to the hospital with injuries, physical symptoms or other health concerns. Treating the presenting complaint alone was not enough.

This became a turning point. In 2014, a separate setting was established to provide confidential and coordinated care, which later evolved into the Mithurupiyasa GBV Help Desk in the District General Hospital, Kilinochchi.

Initially three female health volunteers were recruited to the GBV help desk and provided the services. We developed a multidisciplinary approach, bringing together medical, surgical, medicolegal, psychiatric and social services. With the support of the Government Agent and district authorities, links between services were strengthened through referrals, regular meetings and case discussions.

We conducted awareness sessions on GBV and referral pathways to the health staff attached to DGH Kilinochchi

and RDHS office. We arranged similar sessions for the staff of the district and divisional secretariats in Kilinochchi.

In 2015, after establishing the GBV help desk, we conducted a clinical audit of GBV-related services at the Kilinochchi District General Hospital. The number of reported clients had increased from 233 in 2014 to 460 in 2015. Majority of the clients were women, and the consequences extended beyond physical injuries to psychological, social and economic difficulties. All the cases were managed by the GBV help team with Multidisciplinary input.

These findings showed the increased usage of the GBV help desk in the hospital following our initial awareness sessions.

The Kilinochchi experience demonstrated to me that a coordinated response to GBV could be developed even in a resource-limited setting. GBV cannot be addressed by the health sector alone, however a well-coordinated multisectoral response is essential to combat it.

A wider system of support

In Sri Lanka, support for people affected by GBV involves the Ministry of Health, Ministry of Women and Child Affairs, Police, social services, legal services, NGOs, GBV Help Centres and helplines.

At the national level, the Ministry of Health strengthened the health-sector response through the Gender and Women's Health Unit of the Family Health Bureau, together with guidelines, training and capacity-building initiatives.

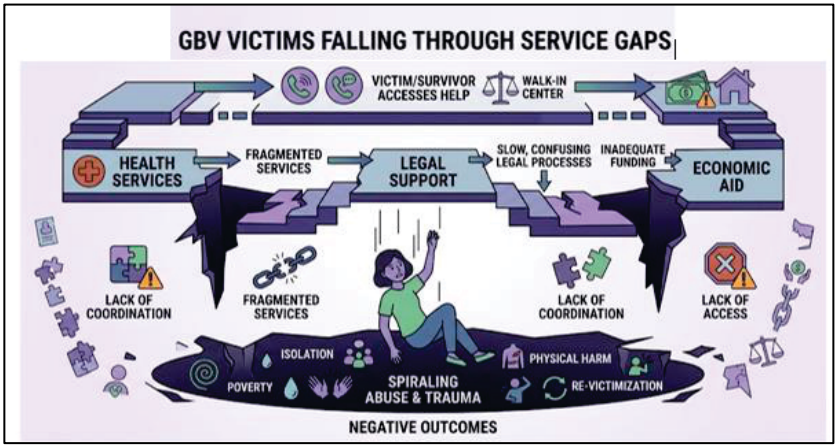
The services existed. The challenge was to connect them and make them accessible to those who needed them.

9. Building an effective GBV response Centre in a resource-limited setting.

"If services already existed, why were survivors still falling through the gaps?"

The answer became apparent from our experience. Many services were available only during office hours, making access difficult during nights, weekends and public holidays. Staffing was limited, staff safety was sometimes a concern, and coordination between individual service providers was often inadequate.

The health sector, however, offered several practical advantages. Hospitals were accessible around the clock, had multidisciplinary staff, could provide immediate medical care and temporary safe shelter when required, and already worked with many other service providers. This placed the health sector in a strong position to coordinate a multisectoral response to GBV.



The Kilinochchi Model: Starting with what we had

Once the scale of the problem became clearer, the Regional Director of Health Services and the Hospital Director supported the establishment of a dedicated GBV Help Desk. A team visited Teaching Hospital Batticaloa and local NGO centres to observe how their GBV services were organized and delivered.

Rather than waiting for ideal infrastructure, we identified a small unused space at the District General Hospital Kilinochchi and began with the resources already available. Three health volunteers, together with staff from the psychiatric clinic, supported counselling, coordination and meetings. Staff participated in Ministry of Health training programmes and gradually developed

their skills and confidence. The network subsequently expanded with the involvement of the Government Agent, NGOs, the Legal Aid Commission and other relevant services. The Kilinochchi experience demonstrated that a coordinated GBV service could be developed even within significant resource constraints.

I realized that the first intervention did not necessarily require a new building, sophisticated technology or a large budget. Sometimes, what was most urgently needed was a trained person, a safe space and a pair of listening ears.

Kilinochchi GBV Help Desk Model (5S model)

I found the Kilinochchi GBV help desk model is valuable in low resource settings to deal GBV. It has 5 Components.

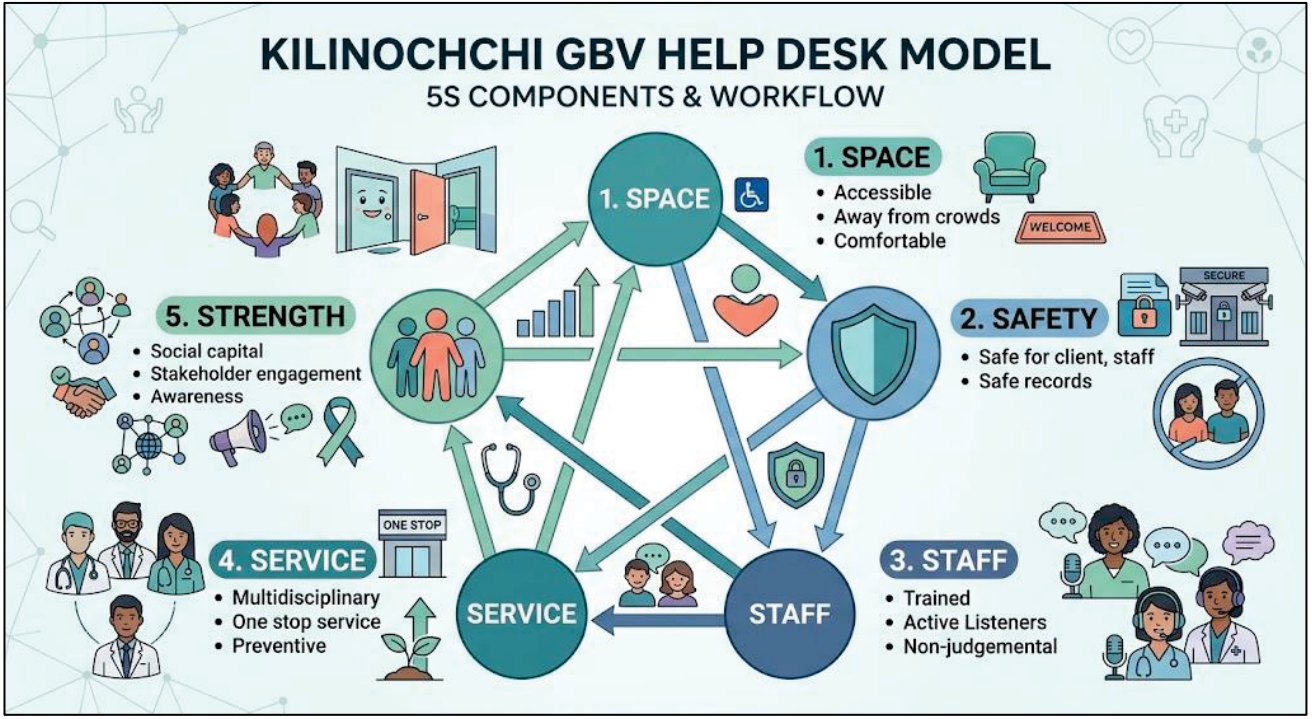
1. Space
Easily accessible, away from patient crowds, well-lit and ventilated, comfortable for clients and not a routine clinic set up

2. Safety
Safe atmosphere for the client to speak, safe to the staff and safe record keeping

3. Staff
Health volunteers, easily approachable, trained in client handling, active listeners, non-judgmental attitude and good communicators

4. Service
Multidisciplinary input, one stop service, cure with preventive measures

5. Strength
Strong social capital, regular stake holder discussions and continuous awareness programmes.


KILINOCHCHI GBV HELP DESK MODEL
5S COMPONENTS & WORKFLOW
1. SPACE
• Accessible
• Away from crowds
• Comfortable
WELCOME
2. SAFETY
• Safe for client, staff
• Safe records
SECURE
3. STAFF
• Trained
• Active Listeners
• Non-judgemental
4. SERVICE
• Multidisciplinary
• One stop service
• Preventive
ONE STOP
5. STRENGTH
• Social capital
• Stakeholder engagement
• Awareness
SERVICE
STAFF

10. Concept roll out

The next question was whether this model could be adapted to a larger institution?

From Kilinochchi to Teaching Hospital Jaffna

GBV-related services had been provided at Teaching Hospital Jaffna by psychiatrists and their teams for many years. However, shortages of staff across several categories created difficulties in developing the proposed Mithurupiyasa (Nadpu Nilayam in Tamil) as a separate service. In 2015, elements of the Kilinochchi model were therefore adapted to strengthen the GBV response at Teaching Hospital Jaffna.

A multidisciplinary team involving psychiatrists, obstetricians and gynaecologists, judicial medical officers, nurses, counsellors and other support staff worked together with Women Development Officers, Probation Officers and NGOs. Mithurupiyasa (Nadpu Nilayam) subsequently became the focal point for this coordinated response.

An important principle was that it should not function merely as another routine hospital clinic. A trained non-medical staff member could provide the survivor with a safe and supportive first contact—someone with *"listening ears"*—before coordinating further assessment

and referral to the appropriate members of the multidisciplinary team.

Regular training programmes were conducted for hospital staff, and the referral pathway was simplified so that house officers and junior medical officers could readily refer a GBV victim to the Mithurupiyasa (Nadpu Nilayam).

Extending the model beyond the hospital: University of Jaffna

In 2016, the University Grants Commission introduced initiatives to strengthen responses to gender-based violence, sexual harassment and ragging within universities [12]. The Vice Chancellor of University of Jaffna appointed a team of academics to develop SGBV policy and by-laws to the University of Jaffna.

I took the lead as the chairperson of the committee and established the Centre for Gender Equity and Equality (CGEE) in the university health centre based on the experience of the Kilinochchi GBV Help Desk model. With the University Grants Commission Guidance, we developed institutional Sexual and Gender Based Violence (SGBV) policies and by-laws to provide a structured framework for prevention, support and referral in the University of Jaffna. Later, our university model

became the blue print for other Sri Lankan state universities to develop their own GBV centres.

A major focus of the CGEE has been raising awareness within the university community. Regular awareness programmes and workshops are conducted for undergraduate students and university staff on understanding GBV, available support services and appropriate referral pathways. The Ministry of Health also supported this initiative, recognizing the university as an important platform for extending GBV awareness and education to the wider community.

Alongside awareness activities, the CGEE has promoted research on GBV and gender-related issues among staff and students. Its educational role has further expanded through a Certificate Course in Women's Studies, conducted in collaboration with the Women's Education and Research Centre, Colombo.

Thus, an approach that began with responding to survivors in a resource-limited hospital setting gradually extended beyond hospital walls - into awareness, education, research and prevention within the university community.

11. What has this journey taught me?

“Looking back, this journey hasn’t been without its challenges. We often had limited space, limited staff, limited funding and difficulties with transport and referrals. But perhaps the greatest challenge was not the lack of resources—it was bringing people and services together.”

We learned to work with what was available. We built multidisciplinary teams, strengthened referral pathways, worked with social services and NGOs, identified people who were willing to take responsibility, and, most importantly, found champions who were prepared to carry the work forward. We built social capital.

Five feedback lessons from the journey

I would distil the findings to these *five memorable lessons*

1.The survivor must remain at the centre of every response.
Services should respond to their needs, safety, dignity and choices—not require them to fit around the convenience of the system.

2.Violence is often hidden.
A survivor may present with pain, injury, depression or another seemingly unrelated complaint. Recognition requires awareness and training.

3.Listening is an intervention—but listening alone is not enough.
Staff need basic communication and counselling skills, a non-judgmental attitude and the ability to connect the survivor with appropriate services.

4.Healthcare can be an important entry point.
Hospitals are widely accessible, operate around the clock and allow people to seek help without necessarily disclosing publicly why they have come. A GBV Help Desk should therefore be accessible, confidential and located away from crowded clinical areas.

5.No single profession or institution can manage GBV alone.
Healthcare, social services, police, legal services, NGOs and community organizations must be connected through clear referral pathways. Fill the service gaps and coordinate the response.

12.The way forward: From individual effort to mainstream practice

GBV is deep rooted in the community and from time to time, various measures are taken to deal it. To tackle GBV in this era of social media and Artificial Intelligence, we should plan our strategies to cater to the needs and demands of current lived reality.

Therefore, we need to focus on the following main domains at the *local, regional and national level* to strengthen the GBV related services:

1.Awareness on GBV and preventive measures

We need to include the concept of GBV, its impact on life and preventive mechanisms in the higher school and university curricula. This will empower the majority of the younger population. Regular awareness programmes and activities need to be continued.

2. Gender Mainstreaming policy

There should be a state policy on gender mainstreaming for all the institutions. This will help to achieve gender equality in long term in the community.

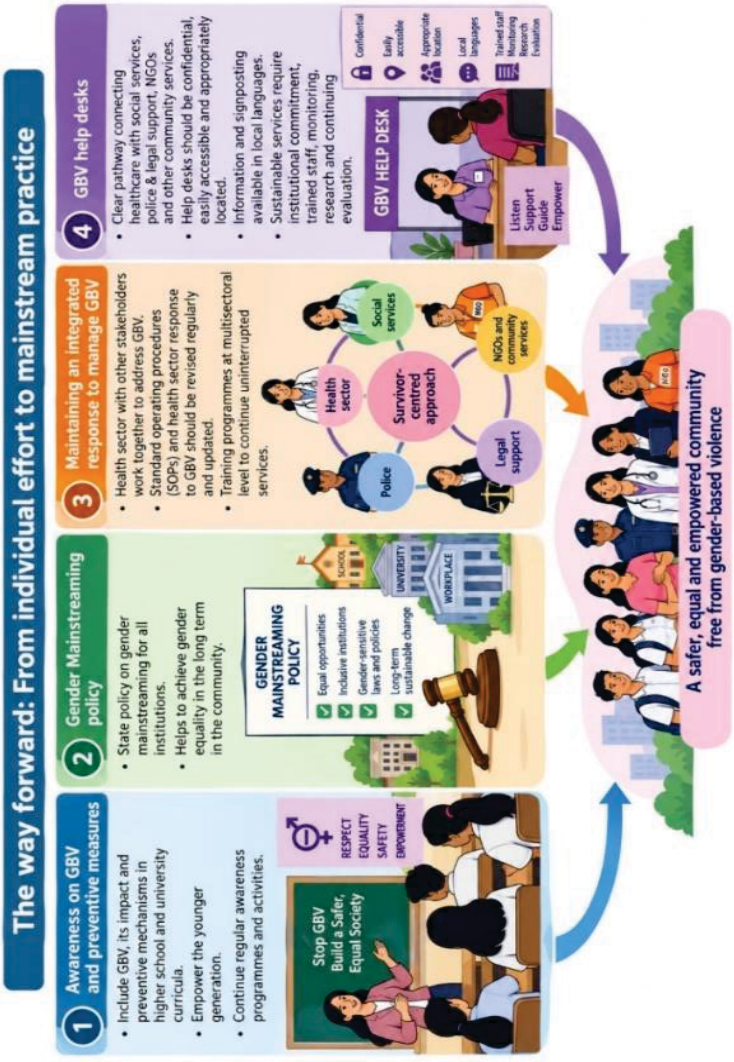
3.Maintaining an integrated response to manage GBV

Health sector with other stake holders can work together to deal GBV. Standard operating procedures and health sector response to GBV should be revised regularly and updated. Training programs should be conducted at multisectoral level to continue uninterrupted services.

4.GBV help desks

Every GBV service setting needs a clear pathway connecting the Healthcare with social services, police & legal support, NGOs and other community services. GBV Help desks should be confidential, easily accessible and appropriately located, with information and signposting

available in languages understood by the local community. Sustainable services require institutional commitment, trained staff, monitoring, research and continuing evaluation.



13. Closing: Return behind the curtain

My journey began with individual women whose stories were often hidden behind the curtain of clinical care. Over the years, those stories became questions; the questions led to research; the research demanded action; and action taught me that meaningful change does not always begin with enormous resources. Sometimes it begins with a small room, a trained person, a safe space and a pair of listening ears. But listening must lead to action—through healthcare, social support, legal protection, education and prevention.

This reminded me the *Learning Health System theory* where knowledge generation processes are embedded in daily practice, data maintenance with validation to improve individual and community health. This results in improved health care delivery.

"*Our ultimate goal should be a society in which violence is recognized early, survivors are heard without judgement, services are connected, and prevention becomes everybody's responsibility.*"

Glossary

Biological sex	Male or female assigned at birth by physical and other biological characteristics.
Gender	Socially constructed roles, behaviours and expectations associated with women and men; these vary across cultures and over time.
Gender-based violence (GBV)	Harmful acts directed against a person because of their gender, including physical, sexual, psychological and economic violence.
Violence against women (VAW)	Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women.
Sexual violence	Any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion.
Intimate partner violence (IPV)	Behaviour by a current or former intimate partner that causes physical, sexual or psychological harm, including controlling behaviour.
Domestic violence	Violence or abuse occurring within a domestic or family relationship, including physical, sexual, psychological and other forms of abuse.
Survivor	A person who has experienced violence.
Perpetrator	A person who commits an act of violence or abuse.

References

1.World Health Organization. Violence against women prevalence estimates, 2023: global, regional and national prevalence estimates for intimate partner violence against women and non-partner sexual violence against women. Geneva: World Health Organization; 2025.

2.UN Women (2026) Country Gender Equality Profile: Sri Lanka - Policy Brief. Available at: https://asiapacific.unwomen.org/sites/default/files/2026-04/lk-20260470900-cgep-policy-brief.pdf (Accessed: October 6, 2026)

3. Jayaratne S, Wijewardena K. Gender-based violence against men, a southeast Asian qualitative study. SAGE Open Med. 2025;13:20503121251335145. doi: 10.1177/20503121251335145.

4. Department of Census and Statistics and UNFPA Sri Lanka (2020) Women's wellbeing survey 2019: Findings from Sri Lanka's first dedicated national survey on violence against women and girls. Colombo: United Nations Population Fund Sri Lanka. Available at: https://srilanka.unfpa.org/sites/default/files/pub-pdf/womens_wellbeing_survey.pdf (Accessed: 6 October 2026).

5.Family Health Bureau, Ministry of Health, Sri Lanka. Information Booklet for Health Care Providers on Gender-Based Violence. Colombo: Family Health Bureau, Ministry of Health; 2012.

6.Family Health Bureau (2023). Annual Report 2023. Ministry of Health, Sri Lanka. Available at the Family Health Bureau Annual Report 2023 Portal.

7.Performance Report, Kilinochchi District Secretariat. http://www.kilinochchi.dist.gov.lk/index.php/en/performance-report/20-performance-report.html (Accessed: 6 October 2026).

8.Statistical Hand book 2025. District secretariat, Jaffna.

9.Guruparan K, Kumar R, Guruparan Y, Muhunthan K. Gender-based violence help desk services at Teaching Hospital, Jaffna, Sri Lanka. Jaffna Med J. 2023;35(2):31–35. doi:10.4038/jmj.v35i2.192.

10.The Policy Framework and National Plan of Action to Address Sexual and Gender-Based Violence (SGBV) in Sri Lanka (2016–2020)

11.Carannante A, Pitidis A, Fondi G, et al. Gender-based violence against women and girls aged ≥15 years presenting to European emergency departments: a multinational, cross-sectional analysis. Lancet Public Health. 2026;11(4):e253-e263. doi: 10.1016/S2468-2667(26)00030-7.

12.University Grants Commission (UGC) Sri Lanka: Prevalence of Ragging and Sexual and Gender Based Violence in Sri Lankan State Universities. You can access the document directly through the UGC Centre for Gender Equity and Equality Portal or via UNICEF Sri Lanka Reports.

Acknowledgements

I would like to express my sincere gratitude to the President and the Council of the Sri Lanka College of Obstetricians & Gynaecologists for inviting to deliver the Dr. Siva Chinnatamby Memorial Oration 2026.

I would extend my appreciation to Professor K. Muhunthan, Professor S. Sivayokan and Thulasi Muttulingam (freelance journalist) for their reviews and inputs on the manuscript.

I would thank Dr.P.G Mahipala (WHO Consultant) and Professor Kumuthu Wijewardena for their encouragement and inputs on preparing this oration.

I am indebted to all the clients, staff and other well-wishers who traveled along me in this long journey dealing GBV.