

Transitions  
in  
Mental Health and Psychosocial Support Services  
in Sri Lanka



A Decade in Review  
(2004 – 2015)





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# Foreword

It is with great pleasure that I contribute a message to commemorate the publication of The Asia Foundation's Transitional Studies on Mental Health and Psychosocial Support Services. During the past ten years, The Asia Foundation has been committed to helping Sri Lankan communities overcome the lasting effects of conflict related violence through our Mental Health and Psychosocial Support Programme, collaborating with both non-governmental and government organisations. The Victims of Trauma Treatment Programme II has sought to improve mental health and psychosocial supports services (MHPSS) provided by both state and non-state actors by implementing customised training programmes and creating greater awareness of MHPSS. During the course of our work we have documented most of what we have studied, allowing us to adapt and grow our interventions in accordance with Sri Lanka's unique needs. This publication is the culmination of the studies undertaken during the course of our work and is based on the knowledge gained through our programmes.

The Transitional Studies publication consists of six papers that detail the transition and growth of the MHPSS sector in Sri Lanka from 2004. The papers deal with the ever changing socio-political context and its impact on the MHPSS sector. We have selected particular case studies and identified issues that have surfaced over the years. For example, one paper on a community level gender based task force demonstrates the need to adapt to meet emerging needs within the country. There have been numerous enablers as well as deterrents during our programming and the publication highlights the importance of constant review and adaptation to ensure relevance to the needs of the community.

The Asia Foundation is a non-profit international development organisation committed to improving lives across a dynamic and developing Asia. Informed by six decades of experience and deep local expertise, our programmes address critical issues affecting Asia in the 21st century—governance and law, economic development, women's empowerment, environment, and regional cooperation. We are committed to Asia's continued development as a peaceful, just, and thriving region of the world.

The Asia Foundation's long term commitment to Sri Lanka has enabled us to be deeply invested in the needs of the MHPSS sector, to nurture it and support its growth and evolution during the past decade. After more than three decades of conflict, we see the continued importance of providing dependable support to a sector that must continue to grow and thrive to meet the evolving needs of the people. The Asia Foundation is proud to have been able to contribute to the sector's growth and development. This publication is an attempt to document some of our achievements. We remain strongly committed to the sector and to supporting the unwavering dedication of service providers, both state and non-state, as they rise to meet the challenge of serving the MHPSS needs of the people.

Dinesha de Silva Wikramanayake  
Country Representative  
The Asia Foundation





# Preface

The Asia Foundation adopts a psychosocial approach to its development work since 2005, particularly in relation to the Reducing the Effects and Incidences of Trauma (RESIST) project and the Victims of Trauma Treatment Programme (VTTP). The Psychosocial Working Group (PWG) recognises human capacity, social ecology, culture and values as key factors that affect the psychosocial wellbeing of individuals and larger social units. As a part of the RESIST project, the Psychosocial Assessment for Development and Humanitarian Interventions (PADHI) framework was developed through the University of Colombo. PADHI is a conceptual framework developed through fieldbased research conducted in two districts to understand the determinants of Psychosocial Wellbeing within a Sri Lankan context and established in 2006 to develop culturally relevant and contextually specific assessment methodologies and related tools. The PADHI framework identifies five domains of wellbeing: 1. accessing physical, material and intellectual resources 2. experiencing competence and self-worth, 3. exercising participation, 4. building social connections and 5. enhancing physical and psychological wellness.

The Asia Foundation's psychosocial approach is a response to the contextual changes that took place in the country transitioning from war, ceasefire, active combat, end of war, post war accelerated development and reconciliation. Under the RESIST and VTTP, the Foundation has found that psychosocial approaches to healing and improving well-being are effective in strengthening existing coping mechanisms that enable individuals, families, and communities to get on with their lives. Psychosocial approaches recognise that those who have survived war, conflict, and natural disasters not only suffer anxiety, but may also be severely affected by social, political, and economic breakdown. It takes a broader view of suffering to understand that it is not limited to individuals, but also extends to families and communities, which may continue years after the precipitating events.

The Asia Foundation's work in mental health and psychosocial support programming began with the non-governmental sector and currently is a collaboration between the non-governmental and state mental health and psychosocial support sectors including the ministries of Social Empowerment and Welfare, Women and Child Affairs and Health, Nutrition and Indigenous Medicine. This publication *Transitions in MHPSS Services in Sri Lanka 2004 – 2015: A Decade in Review*, looks at the growth and transitions of the mental health and psychosocial support (MHPSS) sector in Sri Lanka over the period of a decade to better understand what aspects have acted as enablers and what factors have been challenges to the development and growth of the sector. The objective of the six studies in this volume was to explore key themes related to the sustainability of MHPSS services in transition during and after conflict and disaster in Sri Lanka, and to identify the main thematic concerns in published and grey literature related to sustainability and transition in MHPSS during the last ten years in Sri Lanka.

The first chapter *MHPSS Services in Sri Lanka: A Review of the Literature 2005-2015*, examines the history of the MHPSS sector and the development of MHPSS services from the

post-tsunami period to the present day, which includes the end of the ceasefire from 2005 to the post-war period. A wide range of individual and community-based interventions are practiced under the term ‘MHPSS Services’ in response to the number of collective crises and disaster situations the country has faced. The chapter documents the on-going discussion about what it means to intergrate services and transform MHPSS in Sri Lanka to a more community-based model of care. The chapter also highlights that while the need for coordination/networking/dialogue was considered important in the MHPSS sector, there has been little documentation of what was a critical dialogue at this time.

The second chapter, *Sustainability of Mental Health and Psychosocial Support Services after Disaster and Conflict in Sri Lanka: A Desk Review of the Literature*, examines how issues related to ‘sustainability’ have been explored and understood in the research and policy literature on MHPSS. The study reveals a limited focus on sustainability within the published and grey literature, but outlines both some of the assumptions around sustainability as well as more empirically based insights that have been documented.

Chapter three, *Mapping the Roles of Community-Level Government Service Providers Relevant to Mental Health and Psychosocial Support Services in Sri Lanka*, illustrates the wide range of service providers available at community-level in 2015, through the results of rapid mapping of personnel in two Divisional Secretariat divisions of Batticaloa District, Manmunai North and Koralaipattu North (Vakarai).

Chapter four, *Sustainability and Transitions in Coordination of Mental Health and Psychosocial Support Services, 2004-2014*, explores sustainability of mechanisms established to coordinate MHPSS services during and after conflict and disaster in Sri Lanka. The study of three coordination mechanisms in Jaffna, Vavuniya and Batticaloa highlights the key factors that impacted on their functioning and sustainability.

Chapter five, *Sustaining Non Governmental Organisation Services for Mental Health and Psychosocial Support During Transition Periods, 2004-2014*, provides insight into some key challenges associated with sustaining services in the context of post-emergency transitions, as well as identifies the factors that exacerbated and mitigated these with reference to non governmental organisation MHPSS service providers in Sri Lanka.

Chapter six, *Surviving Transitions: A Case Study of the Preventing Gender-Based Violence Task Force, Batticaloa, 2004-2015* examines the transitions that took place in the external context, politics and ideology, structure and functioning and leadership of the Preventing Gender-Based Violence Task Force in Batticaloa, illustrating some of the challenges of sustaining multi-agency, inter-sectoral cooperation during and after emergencies.

## Acknowledgements

The support and dedication of several individuals and institutions made this publication a reality. The Asia Foundation is indebted to the lead researchers Asha Abeyasekera (Lecturer/ Course Coordinator, Faculty of Graduate Studies, University of Colombo) and Ananda Galappatti (Director, The Good Practice Group) for their invaluable assistance in the conceptualisation of this study. The framework for the studies in this ‘Decade in Review’ publication was conceptualised by The Asia Foundation with Ananda Galappatti, and the Foundation is thankful for the contribution made by the research teams, study populations, key informants and officials towards this volume. The Good Practice Group carried out the field studies for chapters two, three, four and five. The Asia Foundation wishes to particularly acknowledge the role played by Ananda Galappatti in finalising chapters 2- 6. The many individual contributions are acknowledged within each chapter.

The ongoing investment and financial support of USAID is acknowledged with much gratitude, without which this publication would not be a reality. The Office for National Unity and Reconciliation is gratefully acknowledged for its part in facilitating the mapping of roles of service providers in the MHPSS sector. The Ethics Review Committee for Social Sciences and Humanities of the Faculty of Arts, University of Colombo, is acknowledged for granting ethical clearance to conduct the field research studies reported on in this volume. Roshni Alles is thanked for editing and putting the publication together. Gratitude is also extended to Gemunu Amarasinghe who contributed by capturing all photographs included in the publication. Dr. Shehan Williams, Prof. Gameela Samarasinghe and Prof. Daya Somasundaram played an invaluable role in reviewing and responding to draft findings for this publication.



# Acronyms

CBT	Cognitive Behavioural Therapy
CPN	Community Psychiatric Nurse
CSO	Community Service Organisation
DLTF	Divisional Level Task Force
DPDHS	Deputy Provincial Director of Health Services
DLPF	District Level Psychosocial Task Force
DLPTEC	District Level Psychosocial Technical Evaluation Committee
DPCC	Department of Probation and Child Care Services
DPDHS	Deputy Provincial Director of Health Services
DS	Divisional Secretariat
EVAW	Ending Violence Against Women Network
FHW	Family Health Workers
FRC	Family Rehabilitation Centre
GA	Government Agent
GBV	Gender Based Violence
HHR	Home for Human Rights
IASC	Inter Agency Steering Committee
INGO	International Non-Governmental Organisation
IRD	Institute for Research and Development
LLRC	Lessons Learnt and Reconciliation Commission
LTTE	Liberation Tigers of Tamil Eelam
MCDWA	Ministry of Child Development and Women's Affairs
MFE	Ministry of Foreign Employment
MH	Mental Health
MHPSS	Mental Health and Psychosocial Support
MHTF	Mental Health Task Force
MIM	Ministry of Indigenous Medicine
MSW	Ministry of Social Welfare
MoE	Ministry of Education
MoH	Ministry of Health
MOH	Medical Officer of Health
MoJ	Ministry of Justice
NCPA	National Child Protection Authority
NewArow	Network for Advocating Requirements of Women
NDDCB	National Dangerous Drugs Control Board
NGO	Non-Governmental Organisation
NIMH	National Institute of Mental Health
PGBV	Prevention of Gender Based Violence
PHC	Primary Health Care
PS	Psychosocial
PSP	Psychosocial Support Programme

PSF	Psychosocial Forum
PTSD	Post Traumatic Stress Disorder
RDHS	Regional Director of Health Services
SEED	Social, Economical and Environmental Developers
TF	Task Force
TMVP	Tamil Makkal Viduthalai Pulikkal
TPO	Transcultural Psychosocial Organisation
UNFPA	United Nations Population Fund
VAW	Violence Against Women
WCDM	Women's Coalition for Disaster Management
WDO	Women's Development Officer
WTPSP	War Trauma and Psychosocial Support Programme

## Mental Health and Psychosocial Support Services in Sri Lanka: A Review of the Literature 2005-2015

by Asha L. Abeyasekera and Kusala Wettasinghe<sup>1</sup>

### 1. Introduction

Sri Lanka, has a long history of development and humanitarian interventions due to its classification as a ‘Third World’ and ‘developing nation’. Humanitarian interventions, particularly, became more significant from the early 1980s due to the escalating ethnic conflict which continued until 2009. The devastation caused by the tsunami of December 2004 further reinforced Sri Lanka’s place on the ‘Humanitarian Crisis’ map. While the ethnic conflict and the tsunami tend to frame the discussion on mental health in Sri Lanka, the nation has been on the ‘mental health map’ due to high rates of suicide that date back at least to the 1950s (Knipe et al. 2014; Marecek and Senadheera 2012; Sirisena 2015). However, it was as a result of the ethnic conflict that significant efforts were made from the late 1980s firstly, by non-governmental actors and later by state services to respond to the suffering caused by both the armed conflict and natural disaster in Sri Lanka. The aftermath of the December 2004 Indian Ocean tsunami saw an unprecedented expansion of mental health and psychosocial support services (MHPSS) primarily in the war-affected Northern and Eastern Provinces, as well as in the coastal regions in the South (Galappatti 2010). In tandem, there has been a shift to recognise and respond to the mental health and psychosocial needs of communities *in general*, thereby broadening the scope of the MHPSS field, for instance in the areas of care and protection of children, sexual and gender based violence, serious mental disorders, disability and other forms of adversity such as social discrimination or injustices (Galappatti 2013).

The international debate in the field of post-emergency mental health and psychosocial support between the ‘Trauma’ (biomedical) approach versus the ‘Resilience’ (or community-based or social) approaches to interventions in situations of conflict and disaster, gained momentum in Sri Lanka during this time. The ensuing result was a significant shift in MHPSS service provision—a moving away from psychological support to a psychosocial framework in the provision of mental health care in the early years of the new millennium and more specifically in the aftermath of the December 2004 tsunami (Galappatti 2014). It became evident that individual-focused therapeutic interventions were not always adequate

<sup>1</sup> The assistance extended to the authors by Jehan Abhayaratne and Sapna Seneviratne is gratefully acknowledged.

and often inappropriate in the context of poverty (Ager 1999; Honwana 1999; Jareg 1996; Lawrence 1998; McCallin 1996). Broader interventions including providing shelter and economic support, skills building, and mobilising and strengthening social networks were also recognised as being important in alleviating distress (PADHI 2009). These discussions also reflected the growing emphasis within international development on promoting wellbeing and improving quality of life. Many organisations working on mental health in Sri Lanka, thus, focused not only on the psychological, mental, and emotional dimensions of people, but also on their social relations and material conditions. Programmes ranged from medical and therapeutic interventions to livelihoods support, from interventions that combine counselling with micro-credit schemes for women to setting up play-centres for children (Galappatti 2003; Psychosocial Forum 2008). These interventions, termed ‘psychosocial’, and ‘psychosocial interventions’ became part of both humanitarian responses as well as long-term development programmes. By the mid-1990s, a small but specific field of ‘psychosocial’ interventions had established itself in Sri Lanka to respond to experiences of violence, displacement, and loss.

### **1.1 Rationale, Research Questions, and Objectives**

The evolution of the MHPSS field in Sri Lanka from the late 1980s to the present day has generated a small but substantive body of published and grey literature on MHPSS problems and interventions. However, there have been limited efforts to synthesise and communicate the knowledge generated in order to inform practice, policy, and further research. Some notable exceptions are in the areas of: domestic violence (Kodikara and Piyadasa 2012); gender-based violence (Sri Lanka Medical Association 2011); and suicide (Rajapakse et al. 2013). In addition, a recent review (Sritharan and Sritharan 2014) examines the findings of articles on mental health in Sri Lanka published since 2009. While needs assessments, and monitoring and evaluation practices are part of many non-governmental organisations (NGOs) providing MHPSS services, reports from these exercises are generated for donors. Rarely are knowledge and insights from such reports systematically collated and shared to inform decision-making beyond the work of a specific service organisation. Hence, it was thought that a review of the grey literature from NGOs and also the state Ministries who have been involved in MHPSS service provision would be important and useful. A review and appraisal of the range of MHPSS services that exist as well as the systems and structures that support and/or undermine MHPSS service provision in Sri Lanka were thought to be both timely and critical for several reasons. It has been five years since the armed hostilities of Sri Lanka’s civil war ended in 2009, and ten years since the tsunami in December 2004. Moreover, Sri Lanka’s landmark 2005–2015 National Mental Health Policy is due for revision in 2016.

The overall objective of the systematic review of literature was to identify and evaluate key findings from published research studies, as well as grey literature that include needs assessments and evaluations conducted across Sri Lanka during the past 10 years in order to explore factors that have strengthened and undermined MHPSS service provision. Initially, the specific objectives of the study were to:



- Explore facets that strengthen or undermine MHPSS service provision,
- Examine how existing MHPSS systems and structures have built and/or undermined the capacity and sustainability of service providers.

The following research questions informed the design of the systematic literature review:

- What is the extent and scope of the psychosocial field in Sri Lanka?  
What range of services are provided under the rubric of ‘Mental Health and Psychosocial Support’ (MHPSS) in Sri Lanka?  
What specific sectors do MHPSS services cover?  
What key target groups do MHPSS services serve?
- What factors, including systems and structures, are identified as strengthening and/or undermining the capacity and sustainability of MHPSS service provision in Sri Lanka?

## **1.2 Overview of Review**

The review of the literature did produce some answers to the initial research questions posed. However, the discussion on systems and structures that strengthen and undermine MHPSS services is framed by a theoretical debate about the importance of an integrated approach to mental health care and psychosocial support in Sri Lanka. An ‘integrated approach’ is used in literature to mean several different things: (i) Incorporating community-based medical approaches into the ‘traditional’ hospital-based medical services that have been predominant in Sri Lanka; (ii) Incorporating a psychosocial framework and approach in addressing mental health problems amongst individuals and communities; and (iii) Moving to a pluralistic model of MHPSS services by acknowledging the role of ‘local healing practices’ in the care and treatment of mental health problems and the provision of psychosocial support. The review examines these different interpretations to highlight some of the tensions and contradictions as well as challenges to service provision that arise from these multiple perspectives in the sector.

The conceptual debates inform the way in which mental health problems are framed in Sri Lanka. Following the section on ‘Methodology’, the review begins with section three of this chapter and provides an overview of mental health problems in Sri Lanka. Section four focuses on the history and development of the MHPSS sector and summarises the development of policies in keeping with the development of the MHPSS sector. Section five presents the scope of MHPSS services in Sri Lanka, while section six examines in detail the three main understandings of an ‘integrated’ approach to MHPSS services. The seventh section analyses the ideological commitment to incorporating local healing practices in providing MHPSS. Section eight answers more directly the second research question on the systems and structures that strengthen and undermine the provision of MHPSS services in Sri Lanka.

## 2. Methodology

A total of **245** documents have been included in this review.

Foucault (1969/2012) in *Archaeology of Knowledge* distinguishes between two types of knowledge: (i) *Connaissance*—which he defined as a particular body of knowledge on a particular discipline such as biology or economics; and (ii) *Savoir*—which Foucault discussed as the generalised and abstract knowledge in public discourse and everyday practices. Wikramasinghe (2014) argues that “the literature review is a feature of *Connaissance*, since the researcher is called upon to discover/construct formal knowledge from formal knowledge” (p.169). The gap between *Connaissance* and *Savoir* (or formal and informal knowledge) is distinctly felt in the MHPSS sector in Sri Lanka, especially in the context of conceptualising needs and designing interventions. There is a sense that much of the ‘insider knowledge’ is not fully captured in the formal corpus of academic literature, but ‘hidden’ in organisations that have worked in the MHPSS sector. The knowledge remains in the realm of ‘*Savoir*’ for several reasons. On the one hand, needs assessments and evaluations of services conducted in the context of a complex emergency were possibly not documented formally or systematically. In a context where human resources were scarce, responding to people’s distress took precedence over documentation. Organisations relied on their first-hand experience of the situation on the ground and the knowledge of their key resource persons to conceptualise interventions. When we visited MHPSS organisations to collect documents for this review, resource persons were informally interviewed about the history of their organisations, and it was clear that ‘institutional memory’ lies with people; however, these memories have rarely been formally documented. Wettasinghe and Jayasooriya’s (2013) study of two long-term MHPSS programmes discusses how *Shanthibham* and the Family Rehabilitation Centre (FRC) provided MHPSS services to trauma survivors in a politically charged environment. It records some of the ways in which counsellors have intervened in highly effective practical ways to respond to complex mental health needs. *Savoir* knowledge is consistently used when conceptualising and implementing MHPSS interventions, and funding is granted because many of these organisations have a long history of working in the MHPSS sector and some of the personnel are accepted both locally and internationally as ‘experts’ in the field. Transforming informal knowledge to formal knowledge requires a different set of skills: writing skills—often *English language* writing skills; familiarity with converting field experiences into an analytical framework; and recording them in the styles and format of a ‘report’. Many service providers had not developed these skills or prioritised them. On the other hand, ‘informal knowledge’ lies hidden due to the intense competition for funding. Organisations are often reluctant to make public their internal documents as this can lead to ‘knowledge theft’ whereby other service providers can use the knowledge in these documents to vie for funding. Nevertheless, the researchers attempted to include some of the informal knowledge in the review by requesting for ‘grey’ literature from organisations and ministries working in the MHPSS sector.

Given the context of the MHPSS sector in Sri Lanka outlined above, a *modified* systematic literature review was adopted as the methodology for reviewing the literature on MHPSS services in Sri Lanka. A systematic literature review has been defined as “a replicable,

scientific, and transparent process [...] that aims to minimise bias through exhaustive literature searches of published and unpublished studies, and by providing an audit trail of the reviewer’s decisions, procedures, and conclusions” (Tranfield et al. 2003:209 as quoted in Bryman 2008:85). A systematic literature review is adopted as a methodology when existing reviews of the literature reflect the biases of the researcher and do not cover the full extent of the existing literature available in the identified area of research. In the fields of medicine and public health, systematic literature reviews are regarded as complementing evidence-based empirical studies, and are conducted with the objective of providing advice to clinicians and practitioners through an overview of all available literature (Bryman 2008:85). More recently, the systematic review approach is being adopted mainly by those in the field of social policy. The methodology is best suited when researchers are seeking answers to the question: ‘What works? What doesn’t work?’

Drawing from Bryman’s definition, modifications were made to the objective and process of the systematic review; however, the purpose remained the same. In writing up the Systematic Literature Review, the authors found that adding to knowledge could not be separated from generating understanding of the issues. With regards to process, while explicit inclusion and exclusion criteria were used, the search for literature was limited to specific databases, organisations, and state institutions (see: ‘Categories of Documents’). The review first used an already existing database that had been established by MHPSS.net in 2014, and then surveyed the following databases: JSTOR, the Lancet, and Google Scholar. MHPSS.net had approximately 120 documents already identified; the goal was to add an additional 100-150 documents to the database.

## 2.1 Inclusion and Exclusion Criteria

Search Terms were defined and grouped to specifically elicit documents relevant to MHPSS services Documentary Data Key Words: ‘Sri Lanka’ AND

1. Mental Health	2. Wellbeing	3. Psychosocial	4. Wellbeing Assessment
5. Mental Health Workers	6. Mental Health Services	7. Mental Health Directorate	8. Medical Officers of Mental Health MOMH
9. Community-based Mental Health Services	10. Community Psychosocial Services	11. Self-help and Psychosocial	12. Consumer Action Groups + Mental Health
13. Counselling	14. Self-help and Counselling	15. Psychological Counselling	16. Coping Strategies
17. Traditional Healing Practices	18. Spiritual Healing	19. Religious Healing	20. Ritual Healing
21. Healing Ritual			

The following MHPSS services were included in the search terms even when the terms ‘Mental Health’, ‘Psychosocial’, and ‘Wellbeing’ were not included:

‘Sri Lanka’ AND

1. Psychiatric services,
2. Counselling,
3. Substance abuse (alcohol and drug rehabilitation),
4. Suicide prevention and care,
5. Gender-based Violence (GBV),
6. Child development – parent-child relationships; services for mental and physical abilities; support services for family.

## 2.2 Categories of Documents

This systematic review of literature on MHPSS services in Sri Lanka attempted to cover the following categories of documents:

- Articles published in international (peer reviewed) journals; books and book chapters published by recognised academic presses; articles published online in recognised e-journals and networks;

*Grey literature:*

The Fourth International Conference on Grey Literature in Washington, DC, in October 1999 defined grey literature as: “That which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial (including academic presses) publishers” ([www.greylit.org](http://www.greylit.org), accessed 27 May 2016).

- Documents published and circulated locally by recognised institutions and networks within Sri Lanka;
- Documents publicly available on state services in the following Ministries: Education, Health, Social Services, and Women and Children;
- Organisational documents from key institutions engaged in MHPSS service provision.

Selection of state services in the identified Ministries was based on the definition of what constitutes a psychosocial intervention (*cf.* PADHI 2008; White 2014):

- Explicit concern for improving the wellbeing of people’s lives,
- A holistic and person-centred approach,
- Multi-dimensional understanding of needs and services, i.e., going beyond the economic to a broader understanding of what makes life good,
- Positive perspective – an orientation towards people’s strengths and resources, rather than what is lacking. Not an exclusive focus on problems, issues, and vulnerabilities,
- Personal focus on quality of life – what people get out of life, rather than an assessment of what they have,
- Focus on experience and enjoyment – people’s subjective perceptions, not just objective achievements.

### **3. Mental Health in Sri Lanka – An Overview**

#### **3.1 Mental Health Problems – a Nation in ‘Crisis’?**

Literature on mental health problems in Sri Lanka, in the past decade, from 2005 to 2015, has focused extensively on the devastations caused by the protracted armed conflict in the north and east in Sri Lanka and the tsunami of 26<sup>th</sup> December 2004. It is conventional knowledge that large scale human and natural disasters exact heavy tolls on people’s wellbeing through the death of loved ones, displacement from home and the suffering resulting from the loss of livelihoods, disruption to the normal routine of daily life, interruptions to education, and the loss of a sense of security due to extended periods of uncertainty. For example, Somasundaram et al. (1993) have noted that incidence of schizophrenia among the Tamil community was likely to be higher than the country’s prevalence of 1%, which bordered on the higher level of global prevalence ranging between 0.5% to 1% (WHO n.d.). Insights into the context of mental health issues being higher among the Tamil community can be drawn from Somasundaram and Sivayokan’s (2013) discussion on the psychosocial impact of war on communities in the north. They observe that war experiences such as exposure to violence; innumerable stresses of being uprooted from familiar social environments; loss of loved ones and loss of social connectedness and social structures have resulted in weakened mental health manifested through collective and individual trauma, the sense of disconnect, mistrust, hopelessness, powerlessness, despondency, low self-esteem and a heightened sense of insecurity etc. (summarising Somasundaram 1993; Somasundaram and Sivayokan 1994; and van der Veen 2007). Similarly, the tsunami of 2004 has often been traced to higher incidence of mental health problems in the affected areas. For instance, Hollifield et al. (2008) recorded that in southern Sri Lanka, close to two years after the tsunami, the prevalence of clinically significant Post Traumatic Stress Disorder (PTSD) was 21% and depression and anxiety were 16% and 30% respectively. Catani et al. (2010) discussing the impact of traumatic events on wellbeing of children in Sri Lanka, states that “three event types – tsunami and disaster, war, [as well as] family violence – significantly contributed to poorer child adaptation” (p.1176).

High rates of suicide had placed Sri Lanka on the mental health map even prior to the conflict and tsunami (Knipe et al. 2014; Marecek and Senadheera 2012; Sirisena 2015). Sri Lanka, with a suicide rate of 31 per 100,000, is among the ten countries with the highest rates of suicide in the world (WHO n.d.:28). The WHO (2012) states that on an average, eleven people commit suicide or attempt self-harm in Sri Lanka every day. Sirisena (2015), summarising the data, notes that “in the century between 1880 and 1980, the rate of suicides in Sri Lanka increased from 2.3% of the total number of deaths to 20.1%. The rate increased by 450% in the thirty years from 1950 and 1980, and surged again in mid 1990s when Sri Lanka topped the world list of highest number of suicides carried out in a country per year” (p.3 summarising Caldararo 2006 and De Alwis 2012).

Demographic patterns of suicide indicate significant gender variation with suicide among men (44.6%) being over twice as higher than among women (16.8%). Furthermore, completed suicides and self-harm were higher in the northeast, especially among displaced

communities in Vavuniya (WHO 2004:28). The disruption of the ‘traditional’ following rapid social transformation after independence in 1948 and later by economic liberalisation is often attributed to increasing rates of suicide and self harm (Knipe et al. 2014; Sirisena 2015).

The above statistics form a grim picture of mental health in Sri Lanka. Significantly, it indicates incongruence, even a conundrum, with the relatively high ranking Sri Lanka has achieved in the Human Development Index (HDI). For instance, in 2005, despite post-tsunami challenges and the on-going war in the north and east, Sri Lanka was categorised as a country with medium human development and achieved a global rank of 93<sup>rd</sup> among 177 countries (Human Development Report 2005).

### **3.2 Attitude Towards Mental Health Problems – the Politics of Stigma**

The literature consistently highlights the stigma related to mental health problems as a crucial aspect that impacts negatively on treatment seeking, stabilising/recovery and social integration of people with mental illnesses. Ranaweera Banda (2007) draws attention to the widespread, socially constructed negative attitude towards mental health that results in people with mental illnesses being marginalised in society. He discusses the economic burden of mental illnesses on families, mainly due to constraints faced by people with mental health problems and their primary care givers to engage in economic activities, and emphasises that this burden is aggravated by being “stigmatised in their communities as not worthy of any social relationships” (Ranaweera Banda 2007:86). The high prevalence of poverty among people with mental health problems underlines the vicious cycle of exclusion and poverty (Kuruppu 2007 quoting World Health Report 2001). As Pathmarani and Dassanayake (2007) have emphasised, social exclusion deprives people with mental illnesses of their rights to be treated with respect and to participate in mainstream socio economic processes. Tribe’s (2007, quoting Ranawake 2003) observation that mental illness reduces marriage prospects of not only the affected person but also of the immediate family members, clearly illustrates the extent of social stigma generally associated with mental health problems (*cf.* Samarasekare et al. 2012).

Fear of stigma perpetuates a tendency to hide mental health problems of family members. Williams and Mendis (2011) state that stigma of mental illnesses “is the single most important factor that impedes access to mental health care, even when a person is seriously contemplating suicide” (p.55). Three main reasons for social marginalisation of people with mental health problems were identified at a stakeholders’ workshop conducted by Volunteer Services Organisation (VSO) in 2004. These were 1) Societies’ ignorance of mental health issues, myths and false beliefs and poor awareness of the rights of people with mental health problems; 2) Poor access to mental health services resulting in lack of treatment and rehabilitation; and 3) Economic barriers, which increase their social disadvantages (VSO, n.d.). Literature underlines that the compound effect of such factors frequently lead to relapses of mental illnesses, even after treatment and stabilisation (Ranaweera Banda 2007; Samarasekare et al. 2012).

The gravity of stigma and social exclusion experienced by people with mental health problems and their care givers was evident in a study on Organisations of Mental Health Service Users and Carers (BasicNeeds n.d.; Samarasekare et al. 2012). These organisations also known as Consumer Action Forums (CAF) (Samarajeewa et al. 2007), are generally initiated by mental health professionals and psychiatry social workers linked to mental health service centres/hospitals and NGOs to “build capacity of mental health service users and carers for improved rehabilitation care and continuous treatment”. However, the study revealed that mental health service users and their families joined these forums with the foremost expectation of participating in these collective initiatives so as to “fight the stigma and to improve their and their families’ social integration” (BasicNeeds n.d.:6). This wide disparity between their objectives and those of the mental health service providers; indicates that for people affected with mental health problems, support to deal with stigma and social exclusion could be a greater priority than even access to treatment.

### **Political Framing - the Politicisation of Mental Health in Sri Lanka**

The literature illustrates that the socio-political context associated with an individual’s or collective’s weakened mental health defines the nature of recognition the ensuing mental health issue receives. Literature on the two main disasters of the last decade, i.e. war and the tsunami, offers space to examine whether stigmatising of mental health problems varied with each context.

Overall, 3% of the country’s population is estimated to suffer from some form of mental illness (WHO 2008). Mental health problems also tend to be viewed as those found in ‘normal’ times and those related to adverse effects such as violent conflict (WHO n.d.). Literature indicates that stigmatising of mental health problems tends to vary with the contextual lenses through which mental health problems and crises affecting people are viewed. Three different contexts emerge in the literature of the last decade. These are, mental health issues linked to the protracted war in the north and east, mental health problems as an outcome of the tsunami in 2004, and mental health issues arising from individual bio-medical conditions or socio-economic stresses in people’s lives. Although, as discussed above, people with mental health problems are generally stigmatised, the magnitude of destruction by the tsunami and the high profile the disaster received nationally and globally brought forth greater acceptance towards psychological distress and ensuing mental health issues (Somasundaram 2008).

In comparison to the tsunami, the war in the north and the east, due to the politicised nature of the disaster and the violence during the war, received less public and policy recognition outside these two provinces and, therefore, less external support to address mental health issues. Mental health professionals, NGOs and community leaders etc., in the north and east, pooled resources, and used existing space within state health services and other facilities to address the mental health issues of people who had been exposed to many years of devastating experiences such as displacement; loss of family members, homes and property; injuries and living in fear (Samarasinghe 2014). During the war, notions of heroism upheld by both the Liberation Tigers of Tamil Eelam (LTTE) and the state forces restricted space to

openly discuss people's suffering related to war and to reach out to those who needed mental health services (Somasundaram 2014). In the post-war context, high security concerns and continued surveillance impeded expansion of psychosocial services especially at community level (Somasundaram 2014; Richards 2012). Spaces for therapeutic interventions such as counselling and healing activities, through which people can express psychological distress of their war experiences, became indirectly depicted as security-sensitive (Somasundaram 2014; Samarasinghe 2014). Overall, literature underlines that people of the north and east affected with issues of mental health faced a different type of marginalisation; that of being denied adequate spaces to systematically facilitate healing processes through broad-based individual, family or community based interventions (Somasundaram 2014, Samarasinghe 2014). This was dramatically different from state policy readiness and the wide space made available after the tsunami for even unregistered, visiting overseas teams to conduct varied psychosocial activities at ground level.

Analysis of the reviewed literature indicates that while mental health problems generally carry a considerable degree of social stigma, mental health problems related to the tsunami and the war were largely attributed to the devastations caused by these disasters. In comparison mental health problems of people, outside these contexts, are viewed by society, in general, as resulting from an individual's problematic personal or family conditions. Tribe (2007:24) describes this as attributing mental illness to 'bad blood' in the family or to one's 'karma' which carry notions of blame. Therefore, mental illnesses that are not linked to a socially accepted or politically acknowledged crisis are likely to be more severely stigmatised.

### **Theoretical Framing – the 'Trauma' vs. 'Resilience' Debate**

Discourse on mental health problems and services often focus on the merits and challenges of two key premises, i.e. the clinical model that frames mental health issues as an illness and an individual's problem, and the social model that recognises the diverse factors which impact on a person's or a collectives' mental wellbeing. While the predominant mention of mental health issues, in literature, uses medically diagnostic terminology, literature also illustrates a parallel defining of mental health problems through a psychosocial lens, which recognises the multi-dimensional stresses that erode people's wellbeing.

Somasundaram (2014) reiterates that although communities facing armed conflict in the north had their own coping strategies, frequent exposure to distressing events weakened their resilience, resulting in behavioural problems, social issues and poor wellbeing. Nevertheless, as studies have illustrated, the affected communities often interpreted their mental health problems through socio-economic markers. For instance, Samarasinghe (2014) points out that "Research in Sri Lanka has revealed that most people living in conflict affected areas seldom understood their suffering in psychological terms [but] tended to recognise material and social conditions of their lives had a bearing on their psychological wellbeing" (p.372). Furthermore, some symptoms of mental health issues, which are common among communities living amidst war, emerge as being accepted as normal behaviour: Somasundaram (2007:7) has noted that characteristic PTSD symptoms such as startle reactions to familiar loud noises - banging doors - were accepted as normal behaviour by communities in the north. This reduced their



interest to seek medical treatment for such conditions. Galappatti (2014:357) underlines a need to “look beyond purely psychological disorders” and adopting perspectives that relate to both “inner psychological and external social worlds” to understand and respond to the complexities of mental health issues. This premise has broadened the scope of mental health services to be more inclusive and broad-based so as to encompass social and economic support and engage diverse stakeholders in MHPSS service provision (Fernando, 2007). However, Williams and Mendis (2011) caution against “medicalisation of social issues” when treating mental health problems and view it as “state health services taking on a mandate beyond its scope” (p.55).

Literature signifies that the theoretical premises associated with mental health problems could also diversely influence the level of stigma to which people with mental health issues are subjected. Simultaneously, discourse on mental wellbeing and disasters, whether human-made or natural, indicate that socio-political framing of the disaster has a concurrent impact on the recognition of certain mental health issues and the marginalisation of others.

#### **4. History and Development of MHPSS Services in Sri Lanka**

The history and development of MHPSS services in Sri Lanka can be examined using two main frameworks: the co-existence of two main paradigms for understanding illness and healing; and the political transitions in Sri Lanka from the early 1980s onwards from war affected, to tsunami devastated, to post-war. MHPSS service provision in the country has developed through seemingly dichotomous avenues, which can be broadly categorised as the traditional/Ayurveda versus Western allopathic treatment or the clinical versus social models. However, as this chapter highlights and reiterates, such a dichotomy exists only in the realm of theory, and boundaries are often blurred in practice. On the one hand the tendency of people with mental health problems in Sri Lanka, as is the case in many parts of the world, is to simultaneously engage with different types of treatment and modes of healing. (This is the case for sickness and ill-health in general too.) On the other hand, MHPSS issues are often complex multi-dimensional crises and often cannot be addressed using a single ‘type’ of MHPSS service. Hence, this has enabled (and led to) greater space for pluralistic approaches within the field of MHPSS. Simultaneously, the history of the MHPSS sector has been influenced by three key phases in the country’s political history: active conflict, post-tsunami, and post-war. Rather than forming two distinct frameworks, the literature review will illustrate how critical international debates in mental health in general, as well as specific debates about the provision of mental health services in situations of complex emergencies have determined the history and development of the MHPSS sector in Sri Lanka.

##### **4.1 Key Approaches to Mental Health – Plurality**

Recognition of mental health as a subdivision of health services has a long history in Sri Lanka. Indigenous medicine, based on Ayurveda, has identified mental illnesses as one of the nine branches of treatment (Fernando and Weerackody 2009, quoting Kusumaratne 2005). Systematising Ayurveda and indigenous medical practice happened from the 1950s, especially with standardising of training in Ayurveda and establishment of educational institutions to meet these standards. Currently two universities provide training in Ayurveda.

These are the Institute of Indigenous Medicine attached to the University of Colombo and the Gampaha Wickramarachchi Ayurvedic Medical College affiliated to the University of Kelaniya (Fernando and Weerackody 2009, quoting Higuchi 2002). Apart from the registered practitioners of indigenous medicine, many others practice Ayurveda or other forms of indigenous treatment and due to the scattered and unregulated nature of practice, as Fernando and Weerackody (2009) note, it is difficult to assess people's use of indigenous treatment for mental health problems.

Psychiatry in allopathic or western medicine became dominant in the treatment of mental illnesses with its inclusion into the state health services in the colonial period. Weerackody and Fernando (2011) discuss the shift from healing of mental health issues at temples, churches and mosques to institution based allopathic care, under British colonial rule. The first institutional care, established in 1847 was a small hospital located in Borella, in the city of Colombo. The mental health hospital in Angoda, known then as the Angoda asylum, with increased facilities for residential care, was established in 1926 and became the centralised institution dealing with mental illnesses. For many years the Angoda hospital functioned as an asylum, where people identified with or perceived to have mental illnesses were brought for admission by their family or friends, and often were abandoned there (Fernando and Weerackody 2011: 13). In 2007, the hospital was re-named as the National Institute of Mental Health (NIMH) (Fernando and Weerackody 2011). With this, NIMH was developed as a post graduate training centre in addition to providing tertiary care to people with mental health problems (Gunawardhana 2015). By 2015, NIMH has broadened its scope to provide specialised mental health services within the hospital for learning disability, gender based violence, peri-natal care, and psycho-geriatric care (Gunawardhana 2015).

Literature indicates that the significant spread of psychiatric treatment through state health services to areas outside Colombo took place slowly. Out-patient units in state hospitals in some of the main towns began to be established only from 1966 onwards (Weerackody and Fernando 2011). Psychiatric treatment until early 2000 was largely based on centralised institutionalised care, with the three main psychiatric hospitals being located in the Colombo district (WHO 2004), and a higher presence of the few mental health professionals concentrating in Colombo and other main cities such as Galle and Kandy (WHO 2012). Expansion of mental health services outside the main towns also lagged behind due to the inadequacy of mental health professionals in ratio with the population. By 2004, Sri Lanka had only around 25 specialist psychiatrists for a population of over 20 million, and had no formal psychology services (Siriwardhana 2011, quoting Sumathipala and Siribaddana 2005). Fernando N (2007) points out that mental health services moved beyond the premise of centralised tertiary care to secondary care at base and district hospitals only in 2000, when a group of medical officers were trained to work as Medical Officers of Mental Health (MOMHs) in selected peripheral and district hospitals.

Inclusion of mental health in primary health care emerged in the 1980s with its recognition as one of the 17 key components considered under primary health care (Siriwardhana et al. 2011 quoting Jayasekera 2001). However, strengthening the primary health care systems to

systematically provide mental health services emerges as a continued gap. Siriwardhana et al. (2011:7, quoting WHO 2005) notes that institutionalised care of mental health problems lacked linkages with public health, primary health care and multi-disciplinary perspectives. This is despite the state health service mechanisms having extensive outreach to communities through a widely spread network of Medical Officers of Health (MOH) offices equipped with primary health care mechanisms. While the western, bio-medical treatment of mental health problems was primarily facilitated through the state health service mechanism, psychosocial services were initially explored and initiated largely by non-state actors.

## **4.2 Emergence of Psychosocial Services**

Psychosocial work in Sri Lanka began in the early 1980s in response to the inadequacy of medicalised approaches to deal with mental health problems that required addressing social, political and economic complexities which cause psychological distress to people, individually or collectively (CHA 2005). Early interventions based on approaches that promoted psychosocial wellbeing included psychosocial research by academia and community or individual client based interventions, such as counselling, by mainly non-state agencies (Galappatti 2014). Initial psychosocial interventions in the north and east concentrated heavily on meeting needs of the people affected by armed conflict (Somasundaram 2008) and mainly worked through approaches such as individual and group counselling and community collective interventions. Early interventions also included collaborations between state health services and NGOs. Since the 1980s, a few NGOs worked with the state health service sector to provide community based mental health care. For instance, interventions by Nest (<http://www.nestsrilanka.com>) and BasicNeeds (Weerackody and Fernando 2011).

The state sector's systematic inclusion of psychosocial wellbeing and MHPSS focus is visible primarily in the efforts to strengthen the school education sector with psychosocial support, with early interventions happening in the north: for instance in 2001, with the support of German Federal Enterprise for International Cooperation (GIZ), a psychosocial support programme was initiated for school children in Vavuniya, which had the highest number of communities displaced by the war (Somasundaram 2014). The first systematic, six-month training programme for teacher counsellors was initiated, in the north, in 2002, with the support of GIZ (formerly GTZ), Ministry of Education in the North-East Province and Shantiham. Long term training for teacher counsellors expanded notably after the tsunami.

During the war and even prior to the tsunami of 2004, some mental health professionals in the north and east, significantly enriched the understanding of MHPSS by incorporating more pluralistic, innovative approaches such as 'family friendly', 'community based' and less stigmatising practices into the treatment of patients at the mental health units of the district hospitals (Ganesan 2011). These also extended to cover promotion of psychosocial wellbeing through community based activities and engagement with traditional healers, with the aim of upholding a positive image of mental health service users (Somasundaram 2014; Ganesan 2011). Such initiatives worked with the understanding that suffering is both individual and collective and needs to be built on communities' interpretations of their wellbeing (Ganesan 2011; Somasundaram 2014). As such, several psychosocial interventions made an effort to

actively engage communities in the decision making processes and respond to their priorities in wellbeing. For instance, Somasundaram (2007:20) underlines the value of “affirmation and re-establishing of community processes, traditional practices, rituals, resources and relationships” when engaging with the communities to provide MHPSS services. Oxfam (2012) observes that when given the necessary space, communities were keen to have a decision making role in interventions that affected their lives. Literature also highlights the challenges and dilemmas that MHPSS service providers, especially those working on time-bound, donor funded projects faced when attempting to do this. For example, LEADS (2005), acknowledges the validity of the bottom-up approach while simultaneously drawing attention to the tension between participatory approaches that give communities a bigger decision making role and maintaining time efficiency of interventions, especially in post-crises contexts.

### **Institutionalising Broad-based MHPSS Service Provision**

The overwhelming response of humanitarian organisations following the tsunami of 2004 to promote recovery and rebuilding, and the availability of generous donor support (WHO 2012), despite significant coordination issues (Galappatti 2012), paved the way to ‘increased political commitment’ to enhance the outreach of the state’s mental health services (WHO, 2012). As a result, state mental health services expanded significantly and also facilitated structures that accommodated some space for community based interventions. The initial changes included training and appointment of Community Support Officers (CSOs), sponsored through WHO funds, to provide frontline support to people with mental health problems and link them with necessary services (WHO 2012). Infrastructure and systems within the formal health services too expanded significantly increasing decentralising of mental health services: For instance, functional acute inpatient units for mental health patients, within general hospitals were established in 20 health districts; which was a twofold increase from pre-tsunami status. Fully functional rehabilitation units for intermediate-stay for mental health patients increased from 5 units to 16. Mental health professionals at secondary and primary health care mechanisms increased significantly resulting in all the districts having access to at least one doctor with a diploma in psychiatry: primary and secondary health services were further strengthened with the appointment of 131 MOMH and the training of 46 psychiatric nurses by 2011 (WHO 2012).

The protracted war in the north and east and the tsunami in December 2004 highlighted the importance of holistic and integrated services that help address the complex needs of affected communities (Somasundaram 2008, 2014; WHO n.d.; Galappatti 2005a, 2005b). MHPSS responses to distresses and trauma caused by the war, during times of escalated war that heightened security concerns and restricted mobility, were largely driven by committed individuals, in their professional capacity as mental health professionals, academics, psychosocial practitioners, teachers and NGO workers etc. They used their knowledge and skills and the available limited resources to deal with the need for psychological, therapeutic and psychosocial support for affected communities. These interventions were defined by the need to actively engage the communities in shaping the healing processes (Somasundaram 2014). This also helped develop accountable and innovative initiatives

that were responsive to the limitation of resources as illustrated in the experience of The Mangrove coordination mechanism in the aftermath of the tsunami (Galappatti 2005a). These interventions generated valuable experiences, knowledge, skills, promising practices and lessons which underlined the potential to broaden the scope and enhance the quality of MHPSS in Sri Lanka.

Initiatives were also undertaken by several MHPSS service providers to share these experiences, locally and globally. For instance, *Interventions*, a journal discussing experiences of MHPSS practitioners working in challenging situations, was initiated in Sri Lanka (Galappatti 2014). Minas (2012) noted the dearth, globally, of literature focusing primarily on analysis of mental health services and mental health system development (as opposed to treatment, which is extensively discussed in literature) and has highlighted the need for “A journal focusing on mental health system development which has the capacity of networking good practices in service organisations, giving voice to successful experiences including those from low and middle income countries...” *Interventions*, initially circulated within Sri Lanka and now shared globally, and the Mental Health and Psychosocial Network ([www.MHPSS.net](http://www.MHPSS.net)), co-hosted in Sri Lanka, contributes towards addressing this need (Galappatti 2014).

A gap in the system of MHPSS service provision that is often discussed in literature, is the lack of coordination of MHPSS interventions, especially during crises, as was visible in post-tsunami humanitarian responses (CHA, 2005; Galappatti 2005b). Characteristic features of poor coordination across psychosocial interventions included “excessive competition among humanitarian agencies; excessive influence of donor constructed agendas; security issues and travel difficulties; and non-independence of the coordinating agency” (CHA, 2005:22). These as well as the state’s poor inclination to recognise, acknowledge and incorporate local lessons of MHPSS service provision has undermined the potential growth of the MHPSS sector in the country (Galappatti 2005b; Somasundaram 2014). Thus, analysis of the reviewed literature underlines a paradox in Sri Lanka’s MHPSS sector i.e. diverse and insightful knowledge and skills of effective MHPSS interventions being developed and used in specific locations/districts, especially in post-emergency contexts, as Samarasinghe (2014:363) noted, leading to “bringing an increased sophistication and coherence to Sri Lankan MHPSS work”. In parallel, there is a slowness to learn from these location-specific experiences, resulting in duplication of processes and re-inventing of the wheel (Somasundaram 2014) and a tendency for many psychosocial interventions to revolve around a few familiar options aimed at popular target groups. For instance, a workshop organised by CHA in 2005 identified that there was “a surplus of programmes for vulnerable children while few programmes support men” (CHA, 2005:25). The workshop urged humanitarian organisations to look beyond “reductive efforts” and adopt multi-disciplinary approaches that include “livelihood support, promotion of social justice, drama and expressive activities, life skills development and peer social support etc” (ibid.) to address complex psychosocial issues of vulnerable communities.

The exploratory and innovative initiatives visible in several MHPSS interventions, particularly in response to devastations caused by disasters, signify in-depth understanding

of people's wellbeing related issues and efforts by discerning MHPSS service providers to facilitate healing processes that recognise communities' strengths, capacities and their right to participate in facilitating services to address their MHPSS issues. However, state policies related to mental health do not seem to have kept pace with the advancement of the MHPSS sector, in Sri Lanka in the past decade.

### **4.3 Policy Status**

The Mental Disease Ordinance of 1873 is the first legislation pertaining to mental health services. This was amended in 1956 (WHO 2009, Gunawardhana 2015). Although mental health related service provision, in general, has moved forward from a solely disease based premise, the non-revision of the ordinance for nearly sixty years indicates the possible lack of priority given to mental health within the general health services of the state. The first Mental Health Policy of Sri Lanka was developed in 2005 (WHO 2005) within the largely MHPSS supportive policy environment in the aftermath of the tsunami of 2004. The policy was developed through a consultative process with contributions by psychosocial practitioners, academia, mental health professionals, legislators etc. (WHO, 2009). The relatively broad-based process facilitated space for exploration of effective MHPSS practices enabling the inclusion of community based and more decentralised mental health service provision (WHO 2008). Furthermore, the mental health policy of 2005 underlines a crucial need to update legislation related to mental health services and the directions it should follow.

In 2008, two sectoral plans were developed for mental health services in Sri Lanka. These were the World Bank funded Health Sector Strategic Plan for Mental Health, and an action plan funded by WHO for 2008-2009 (WHO 2009). These aimed at improved understanding of the demand for mental health services by conducting a national survey on mental health; enhancing quality of service through further training for MOMH; and engaging with a wider range of stakeholders through the establishment of community support centres and facilitating National Mental Health Advisory Council meetings (WHO 2009).

State budgetary allocations have a strong influence on translating policy into practice and the growth of the MHPSS sector. Research and studies have attempted to analyse the state's financial allocations to mental health based services (Kitsiri and Reid 2009; WHO 2009). However, such analysis is hindered by financial allocations for mental health services being integrated into the budget of general health services, except for the expenditure of the National Institute of Mental Health (NIMH) in Angoda, Colombo (WHO 2009, Kitsiri and Reid, 2009).

Health care in general, in Sri Lanka, is funded by two sources: these are the direct funds from the central government and the local allocations which are facilitated through provincial councils (Jenkins et al. 2012). Kitsiri and Reid (2009) have pointed out the significance of using separate budget lines for mental health services at institutional, regional and national level. Greater clarity on the budget allocation for mental health services within the state

health service would contribute to understanding and addressing gaps in resource allocation at different levels of mental health service provision.

#### **4.4 Post-War MHPSS Interventions**

Samarasinghe's (2014) study of MHPSS services soon after the end of the active conflict was conducted at a time when psychosocial interventions were regarded as a threat to national security, which resulted in many non-governmental organisations adopting innovative ways of providing MHPSS services. The study of specific MHPSS programmes focused on four locations: Mannar, Kurunegala, Anuradhapura, and Jaffna (p.369). Samarasinghe argues that:

“The post-war contextual change of the ground situation has not necessarily led to the re-conceptualisation of psychosocial interventions either by the state or by service providers. However, service providers have had to face the change in context either directly or indirectly when providing psychosocial interventions to clients and *through this* grapple with the need for a methodological change.” (pp.370-371 *emphasis added*).

At one level, the interventions were modelled on what had existed along the way: counselling services focusing on the psychological state of the affected individual with the inclusion of the family or group they belonged to and follow-up field visits (p.371). At another, the effort to help people overcome the impact of trauma as a result of the war or any other form of violence had resulted in a greater focus on empowerment, where “counselling [...] accompanied by medical services, legal assistance, financial aid, or even healing services [were] conducted with the cooperation of religious institutions” (p.371). ‘Empowerment’ is interpreted here as a focus on ‘wellbeing’ where psychological assistance is combined with the social, cultural, and political dimensions. Samarasinghe points out the holistic approach meant that organisations strived to network and coordinate with a range of service providers including the state as well as civil society organisations (ibid). In the state sector, a critical shift has taken place where large numbers of personnel are being trained in counselling using short-term training programmes that once again opens up the debate about the efficacy of counselling as a stand-alone service in addressing people’s MHPSS needs. What is being implicitly stated here is that while the holistic psychosocial approach adopted by organisations does not seem very different from the model of intervention during the war, the post-war context enabled greater coordination with a state that seemed more willing to invest services for the people in the Northern and Eastern Provinces. These included institutions such as hospitals, the police, the prisons, and various officers of the local government authority including the *Grama Niladhari*, Women Development Officers (WDOs), social workers, and mediation board officers (pp.371-372).

### **5. MHPSS Services in Sri Lanka**

Despite inadequate policy support, MHPSS services have expanded into many areas of support and involve a wide range of service providers, including the state health sectors.

Nevertheless, a lacuna in policy is reflected in the absence of effective coordinating mechanisms and quality assurance mechanisms that are required to ensure accountability of varied MHPSS interventions.

A wide spectrum of MHPSS interventions are practiced in Sri Lanka, some more common than others. These range from individual psychosocial care to multi-disciplinary support within collective interventions to respond to crisis and disaster situations. Among the MHPSS interventions are counselling, befriending, play activities for children and youth, protection, rehabilitation and reintegration, raising awareness, networking and coordination, addressing practical needs that impact on psychosocial wellbeing, capacity building and initiatives to improve quality of services, facilitating support groups and conducting specialised mental health related interventions (CHA, 2013), family tracing and reunification and supporting children's education through Accelerated Learning Programmes (UNICEF 2012); life skills programmes (VSO 2013); psychiatric care, facilitating traditional healing (rituals and religious practices etc.), and use of expressive methods such as psychosocial drama (Somasundaram 2014).

As discussed earlier, providing MHPSS services during the war and in the post war context in the north and east, and in response to the tsunami have highlighted the need for effective integrated services. Many service providers met this need mainly by focusing on one or two key psychosocial services and making referrals to relevant service providers for economic support, legal protection, educational support etc, to meet other needs (Samarasinghe 2014; Creech 2012). In the post war context of the north and east, psychosocial interventions that facilitated space to talk about war experiences or provide collective community support were difficult to practice, given the continued security surveillance. These, often, combined with services that addressed tangible, practical needs such as livelihood assistance (Somasundaram 2014).

Key stakeholders including service providers of MHPSS include mental health practitioners of various disciplines (psychiatry, psychology, social work, counselling and community work); religious organisations; community organisations and representatives of the community; people who are/have been patients i.e. users of mental health services; care givers of patients or ex-patients; indigenous healers working in the community, non-governmental agencies working in psychosocial care or welfare and international organisations, especially WHO (Weerackody and Fernando 2011, p.43)

## **5.1 Key Approaches in MHPSS Services in Sri Lanka**

Statutory health care services, from MOH to hospital based care chiefly adopt the bio-medical approach although a shift towards community based care giving is advocated in the Mental Health policy (2005). Mental health professionals in the north and east have made concerted efforts to include community care into hospital-based allopathic care for mental health problems. For example, at Kalmunai, the state hospital operates a unit run on a model of community care (Weerackody and Fernando 2011b). Predominance of western



models of psychological care are also seen in befriending and counselling as practiced in many parts of the country (Galappatti 2014). Similarly, capacity building and training of teachers on Psychosocial Support and specifically counselling largely follow western models (GIZ, 2012). Mental health professionals in some locations, for instance in the north and east, have attempted to integrate western models of psychological/psychosocial support, with local practices of healing. For instance, in the north, even prior to the tsunami, mental health professionals, the Ministry of Education, GIZ and Shanthiham collaborated to develop a training curriculum that is sensitive to the socio-cultural context of the area and which also accommodated communities' idioms of suffering and wellbeing. This aimed at improving the capacity of teachers trained in counselling to better relate to communities' expressions and understanding of their war related experiences (Somasundaram 2014).

MHPSS interventions that were designed with a broader understanding of the psychosocial needs of people in post-crises situations aimed to address pressing familial or practical needs. These included interventions such as providing information on essential services and facilitating complaint and advocacy mechanisms in refugee camps, re-uniting siblings separated after loss of parents and supporting people through tracing of missing family members (Galappatti 2014:359). Empathetic understanding of survivors' distress, sometimes, helped service providers to identify specific but crucial support. For instance, in the immediate aftermath of the tsunami, in Batticaloa, The Mangrove, ICRC, Shade and a few other organisations set up a mechanism to help family members go through a process of identifying their deceased relatives from police photographs, which was a highly distressing experience for surviving family members (Galappatti 2014).

### **Humanitarian Response to Integrating MHPSS Approaches in 'Development' Work**

While some practical needs were disaster context specific, others such as livelihood assistance and protection required intermediate or longer term interventions and supportive monitoring that did not undermine affected people's psychosocial wellbeing. The challenges of combining psychosocial care with livelihood support that entails provision of loans is discussed in depth by Samarasinghe and Salih (2004) and Salih and Galappatti (2006). Both reports discuss the conflicting priorities of ensuring productive use of loans, with timely repayment while providing empathy and psychological support, which includes maintaining confidentiality. The authors highlighted the need to maintain these two services as separate processes.

### **Focus on Human Rights Approaches**

The CHA (2005) mentions the presence of human rights perspectives in multi-disciplinary MHPSS service provision from the 1990s onwards. This increased interest in the provision of legal and human rights protection support to some interventions. However, the reviewed literature, while recognising the protection issues people — especially in war affected areas — faced, lacks substantial discussion on the practicalities of incorporating legal/human rights approaches into MHPSS service provision.

In the post-war context, NGOs are striving to focus on women's rights to address the issue of violence against women in the home as well as in the public arena. Samarasinghe (2014) records psychosocial interventions that have introduced a rights perspective into counselling by incorporating 'awareness': women are given information about the Prevention of Domestic Violence Act (2005) and advised on which authorities they can approach for assistance; and men who come for couples therapy are educated on the rights of women (p.377). Samarasinghe records that NGOs believe that rights awareness acts as a deterrent because men are apprehensive of answering to the authorities. NGOs have also been involved in raising awareness about the Prevention of Domestic Violence Act with police officers who are then better equipped to handle complaints, as well as with counsellors who, without the knowledge of rights, tend to advise women on managing violence (p.377-378).

### **Theoretical Framing Based Response to MHPSS Interventions**

The literature suggests that MHPSS emergency responses to disasters varied with the differing levels of state and public recognition given to the tsunami and the war. Given the wide publicity generated on the devastation caused by the tsunami, "over 400 agencies poured into Sri Lanka to support post tsunami relief and recovery, overwhelming existing coordination structures" (CHA 2005:9) Furthermore, CHA (2005:9) reports that most of these agencies and professionals used bio-medical approaches which "created a resurgence of the idea that trauma was the problem and counselling was the solution." As Galappatti (2005a: 65-69) notes, this resulted in service providers unfamiliar with the context "tripping over one another" trying to provide MHPSS services, especially counselling, to address perceived mental health problems of those affected.

In parallel, organisations, health professionals and practitioners experienced in providing MHPSS services to local communities especially in the north and east, responded to the post tsunami MHPSS needs by addressing basic needs of shelter, food, safety and family tracing which helped deal with their immediate needs and could contribute to improve the sense of wellbeing of the majority of affected communities (Galappatti 2005:65-69). This aimed more at strengthening the resilience of the affected communities and discussing MHPSS emergency responses of the tsunami and the war Galappatti (2014:356) observes that the different premises on which these two types of interventions were built gave rise to debate between "trauma and resilience camps."

In comparison to the tsunami, as noted earlier, the state's acceptance of the psychosocial issues of the war was poor resulting in available international and local NGOs addressing psychosocial issues through projects/programmes and showing a greater interest to facilitate integrated programmes (Somasundaram 2014). During and after the war, working within an environment of high surveillance, MHPSS service providers in the north and east continued to negotiate with authorities to facilitate space for psychosocial interventions at ground level and engage with the communities to enhance relevance and outreach of MHPSS services. Furthermore, mental health professionals in the war affected areas found it unfeasible "to treat large numbers of people affected with minor mental health problems due to the disasters with western psychiatric treatment" (Somasundaram, 2007:7). A more

appropriate option, therefore, was to work with communities, incorporating communities' understanding of suffering and wellbeing. Interventions included provision of basic psycho education and psychosocial training to communities and ground level service providers such as teachers, primary health care workers, priests, *grama niladharis*, and traditional healers, which enabled them to identify people requiring professional care and make the necessary referrals (Somasundaram 2014:293). Anecdotal evidence by MHPSS service providers such as Shanthiham and Family Rehabilitation Centre (FRC) illustrate how neighbours or relatives referred people affected with mental health problems to MHPSS services, how they informed counsellors of people who needed but feared to access MHPSS support, and how community volunteers and community groups engaged in village level action committees or Village Mental Health Committees to enhance outreach of MHPSS services (Wettasinghe and Jayasuriya, 2013). Another significant collaborative initiative by mental health professionals, writers, youth groups etc. was the use of expressive methods such as street dramas, on psychosocial or social themes, which provided much needed platforms to talk about and publicly acknowledge the suffering of the war (Somasundaram 2014:345).

## **5.2 Models for Service Delivery**

A wide range of MHPSS services are practiced by diverse stakeholders. Some of these indicate a high degree of responsiveness in the design, while some others have been sensitive to immediate pressing needs of people. The few examples discussed below indicate a potential for growth, within the institutions these are located in, or growth in terms of outreach to people with MHPSS issues.

### **Developing Capacity of Teachers as First Respondents: Counsellor Teacher Training**

Engagement of teachers as first respondents to children dealing with crises and psychosocial stress is widely discussed in literature, especially in relation to the tsunami and the war in the north and east (*cf.* Wickrama and Kaspar 2007). Training teacher counsellors to respond to disaster related issues of children initially took place in the north through a process that started in the late 1990s. This was in response to the disruption of school education due to war. Somasundaram (2014, quoting BECAre of GTZ, 2003) discusses that by 1995 over 230 schools in the north and east were displaced while another 173 had closed. Although emergency education measures were in place and schools were held in any available space, sometimes even outdoors, the stresses of providing and gaining education were many. For instance, children with behavioural problems arising from psychological issues were often punished by parents and teachers, and girl children who had lost their families were often used as housemaids, depriving them of school education (Somasundaram 2014:317). Training teachers in basic mental health and psychosocial skills was recognised as a useful mechanism to reach large numbers of students who need psychosocial support. The initial training of counsellor teachers in the north focused on adapting the western counselling model to suit the local culture and context of the war affected communities. It also aimed to promote collaboration through multi-disciplinary networking to help address diverse needs of affected children (Somasundaram 2014). Later interventions such as the teacher support programme in the Northern and Eastern Provinces recognised the psychosocial stresses of

teachers who have also faced war related experiences, and aimed to strengthen their coping to deal with these while supporting their students (GIZ, 2011)

Developing capacities of teachers as first respondents to children affected by disaster rapidly gained ground in the aftermath of the tsunami where many agencies provided counselling or psychosocial training for teachers. For instance, GTZ, working with the Ministry of Education supported the establishment of a Guidance and Counselling unit within the National Institute of Education (NIE) and had appointed 400 counsellor teachers and 1400 guidance teachers by 2008. Selected teachers were given psychosocial skills development training (GTZ, 2008). UNICEF, also working with the Ministry of Education and the NIE, established Psychosocial Care Units and Psychosocial Resource Centres in all nine provinces and selected teachers were trained as counsellors to provide support to children through these centres (UNICEF, 2013:65)

Literature points out several challenges encountered in engaging teachers as first respondents to distressed school children. For example, a baseline survey report by the Ministry of Education and GIZ (2010) identified that half of the 200 schools surveyed did not have access to counselling and psychosocial care services. The study also found that the inclination to participate in longer term training was generally low among the teachers. While 83% of the counsellor teachers surveyed had not undergone longer term training, 68% had participated in training programmes which lasted a duration of only 1 – 3 days (Ministry of Education and GIZ, 2010). Richards (2012) highlights that teachers released for guidance and counselling training were sometimes given other responsibilities such as class room teaching or being in charge of the library, which constrained the space they had to spend with children who needed counselling support. GTZ (2008) discusses location specific variations in the interest to promote counsellor teacher training. Unlike in the north and east, which displayed a keenness to implement the counsellor teacher training programme, there was resistance to it by some school principals and teachers in the other parts of the country. Overall, as Earnest and Finger (2006) point out, these interventions are being implemented in a context where “education has failed conspicuously to promote nation building by fostering mutual understanding and tolerance and respect for the rich cultural diversity of Sri Lankan society and in this process has made little contribution to ensuring social cohesion and stability” (p.3). Hence, especially in a post-war milieu, psychosocial care for children who have experienced trauma due to the ethnic conflict can only be meaningful if the education system ultimately addresses the underlying causes of ethnic tensions.

### **Promoting Self-Help Advocacy Forums**

A significant strategy adopted by MHPSS service providers is developing capacities of MHPSS service users to form self-help groups for mutual support, increased social interaction and for advocacy to meet their needs. These exist at district or national level. WHO (2009) noted the role of state and non-state MHPSS service providers in supporting these mental health service user organisations. The Alzheimer Foundation at national level, Bamdoo in the Batticaloa district (WHO 2009) and the Consumer Action Forum of the Southern Province (Samarajeewa et al., 2007) are some examples. A study conducted

on these mental health service user organisations noted the support of mental health professionals and MHPSS service units as their strength, which also could simultaneously become their weakness due to ensuing dependencies on these health professionals and institutions (BasicNeeds, n.d.)

### **Working with Groups with Higher Vulnerabilities**

Priority consideration of children as a highly vulnerable category is commonly visible in many MHPSS interventions. Of these, psychosocial care and legal assistance for neglected, unaccompanied and abused children require multi-layered interventions ranging from counselling and therapeutic interventions to legal assistance (LEADS 2011, 2012). State support mechanisms include provision of a hotline for easy access to child protection authorities to inform of incidents or risks to child protection, legal assistance where necessary, counselling and related support to deal with psychological distress, facilitating public awareness and a policy environment favourable to child wellbeing and protection (NCPA 2008, 2009, 2011). Among non-state interventions are counselling and other therapeutic care such as play groups, support for families to develop their capacity to look after children, and skills development for children, community and school-based awareness raising on child protection and abuse, and developing capacities of law enforcement authorities such as the police to be more responsive to the protection and care of children (LEADS 2005, 2010, 2014). Post-crises interventions focusing on children also included support to trace and reintegrate with families, including the reintegration of ex-combatant children and youth (UNICEF 2012, LEADS 2011). While most organisations that work with children emphasise child participation, Daniel (2009) questions the reality of child participation that disregards social power dynamics that limits opportunities for children to voice their views which leaves space for adult manipulation of children, in the name of participation, to represent issues/programmes prioritised by adults.

Other categories of service recipients, with higher levels of vulnerabilities include women in adverse life situations and survivors of torture and trauma. Psychosocial support for women, especially women heading households, includes programmes, for widows in the war affected areas: these aimed at enhancing economic stability and developing their skills, capacities and collective strength to challenge social marginalisation of widows (Somasundaram 2014). Support programmes for women facing domestic/intimate partner violence included counselling, legal support and livelihood assistance etc. (Kodikara 2014). FRC and Shantiham, facilitate psychosocial support, combining medical care, counselling and livelihood support, for trauma survivors in the north and east (Rasmussen and Carew, 2013). Both these interventions have complexities that require in-depth analysis of the socio-cultural or socio-political contexts. For instance, Kodikara (2014) discusses the conflicting priorities between empowering women which requires more of an activist orientation and counselling that requires empathetic understanding and support.

### **Interventions Aimed at Minimising Stigma**

A few NGOs and some state hospitals have aimed to reduce the level of stigma mental health service users face by making service delivery more inclusive. For instance, in Batticaloa and Kalmunai, the Mental Health Units (MHU) of the hospitals adopted more

family-friendly policies and facilitated greater flexibility of mobility to mental health patients (Ganesan 2011; Gunasekara 2008), thereby encouraging mental health patients' continued close interaction with families and providing space for mental health patients to mix in society with confidence and engage in local healing practices, if they so wished. In another non-discriminatory approach, FRC followed a practice of non-labelling children with mental illnesses when organising play groups/play activities for them (Tribe, 2004). Similarly, the community psychiatry clinic, supported by the Colombo Municipal Council, was intentionally located on premises that also accommodated maternity and child services and social activities. This helped people with mental health problems to discreetly access psychiatric care without being stigmatised (Ranasinghe, Mendis and Hanwella, 2010). Another example is BasicNeeds' strategy of combining occupational therapy and livelihood support, which helped mental health service users, stabilised after medical treatment, to engage in productive work and earn an income. The strategy aimed at strengthening mental health users' self-esteem; enhancing their status in the family and society; and, thereby, promoting their social integration (Kuruppu 2007).

## 6. An Integrated Approach to MHPSS

The literature stresses the importance of an integrated approach to mental health and psychosocial care in Sri Lanka. An 'integrated approach' is used in the literature to mean several different things:

- Incorporating community-based medical approaches into the 'traditional' hospital-based medical services that have been predominant in Sri Lanka;
- Incorporating a psychosocial framework and approach in addressing mental health problems amongst individuals and communities;
- Moving to a pluralistic model of MHPSS services by acknowledging the role of 'local healing practices' in the care and treatment of mental health problems and the provision of psychosocial support.

### 6.1 Critique of the Bio-medical Model

Fundamental to the critique of the bio-medical model is the assumption it makes that biology is universal in its conceptualisation of both human physiology (the human body), and in understanding personhood (socio-cultural understanding of what constitutes 'a person' or 'the individual'). Medical anthropologists have argued that to understand the body, it must be situated as a product of specific social, cultural, and historical contexts (*cf.* Lock 1993; Sax 2015; Tribe 2007). Moreover, assumptions about the relationship between the person and society as well as between the mind and body inform the way medical health care is planned and delivered (*cf.* Lock and Gordon 1988; Scheper-Hughes and Lock 1987; Sax 2015; Tribe 2007). Tribe (2013) makes the link between the bio-medical model and Western philosophy's understanding of personhood as recorded from the observations of a Buddhist monk: "the location of the individual at the centre of western morality and cosmology makes it difficult for many to accept that this is, in fact, specific to western culture, and not simply a view of the world as it really [is]" (p. 27). Sax (2015) in his exposition of what constitutes 'indigenous

medicine' in Sri Lanka (and beyond) argues that “*how* a patient is integrated into her society is of great importance for the outcome of her treatment, and that individual behaviour and biology is strongly linked to local cultural contexts and values” (Sax 2015, *emphasis in original*).

Weerackody and Fernando (2011b) in their overview of the mental health sector in Sri Lanka strongly advocate taking into consideration the socio-cultural conceptions of personhood if mental health services are to be effective. They assert that in Sri Lanka, “spiritual aspects of people, religion, family relationships and feelings of being connected with one another are as important as the biological aspects of the individual. So the bio-medical illness model (derived in western culture) on its own is of limited value” (p.13). They argue that moving beyond what is perceived to be a ‘universal’ model of human physiology to a social approach is important because it influences people’s understanding of health and illness and their health-seeking behaviour. Furthermore, incorporating a socio-cultural approach to health is critical because

“in the social approach to illness, problems that people suffer from are analysed and explored according to their social impact. Illnesses can be diagnosed and given the same names as in the bio-medical approach, but their genesis and causation are not seen primarily as biological changes in an individual, but as a mixture of their own reactions to problems and expressions of distress they may feel—expressions that vary a great deal depending on how they perceive themselves as persons and their basic beliefs about the human condition—what life means and the purpose of living” (Weerackody and Fernando 2011b:14).

As discussed in the introduction, an integrated approach to health care in the country should take into consideration the socio-cultural aspects of health-seeking behaviour in Sri Lanka in general, and, more specifically, the coping mechanisms used in times of disaster such as in times of conflict and in the aftermath of the tsunami for the effective implementation of MHPSS services. Hollifield et al. (2008) in their study of coping mechanisms within two years of the tsunami found that “respondents coped with symptoms and distress by utilising a number of culturally relevant resources, the most common being their own strength, family and friends, the use of a Western-style hospital and their own religious practice (p.43).

The plural approach to health and wellbeing prevalent amongst various groups in Sri Lanka is recognised widely in the literature. For example, Weerackody and Fernando (2011b) note that

“the situation in Sri Lanka today is that people look to a variety of different sources of help when they encounter mental health problems. Primarily, people look to family, friends and community for support. But outside this they turn to practitioners of both western (allopathic) medicine trained in (western) psychiatry, indigenous medical practitioners (IMPs) drawing on Ayurvedic, Siddha or Unani practices and various ritual healers, religious institutions, priests and a variety of counsellors and community workers” (p.12)

## 6.2 Social and Community Support

The importance of understanding the role kinship and family play in fostering wellbeing and promoting healing of people is stressed in the literature, as is the role of community support. Despite the fact that the ‘official’ model for mental health care provided by the state is an ‘institutional’ one, Gambheera and Williams (2011) disagree that mental health services in Sri Lanka have been defined by an institutional model of care. They argue that by virtue of having inadequate resources to provide institutionalised care for all those with mental health problems, as evidenced by the low ratio of psychiatric beds to the population, many mental health patients have been cared for by their families and the community. Therefore, they assert that a paradigm shift from institutional to community care is unnecessary (Linsley et al. 2001 cited in Gambheera and Williams 2011). Rather, they argue that a community-based health system should *strengthen* the existing family and community support structures (Gambheera and Williams 2011:19).

Somasundaram (2007) points out that the impact of conflict and natural disaster not only at the level of the individual, but also on family and community are multifarious. He argues that “just as the mental health effects on the individual psyche can result in non-pathological distress as well as a variety of psychiatric disorders; massive and widespread trauma and loss can impact on family and social processes causing changes at the family, community and societal levels” (p.7). Drawing from his ethnographic study of communities in the conflict-affected north, Somasundaram observes that the protracted ethnic conflict “has had a profound impact on Tamil village traditions, structures and institutions that had been the foundations and framework for their daily life causing fundamental, irrevocable change in these processes” (p.7). In addition, the disproportionate number of deaths of women during the tsunami has led to a high prevalence of male widows, which has also contributed to changes in family structures in the north and east. Moreover, Somasundaram notes that the conflict has deeply affected family cohesion by disrupting traditional hierarchical relationships, such as children losing respect for elders. Furthermore, Somasundaram also observes that the high prevalence of depression has also fundamentally affected kinship relations.

Somasundaram’s interpretation of a community-based programme is one where “damaged family units and social structures, networks, resources and relationships” are rebuilt, which will “encourage re-establishment of helpful traditional healing rituals and practices; group meetings and functions, in short to start the community working again.” Such an approach, he argues, is far more “judicious” than “treat[ing] the large numbers affected with minor mental health problems due to the disasters with western psychiatric treatment (p.7). Somasundaram’s view is supported by Siriwardhana and Wickramage (2014) who, in their review of the literature on the impact of conflict on health in Sri Lanka, find that “post-disaster mental health interventions that extend beyond the provision of treatments for psychiatric morbidities and seek to strengthen social support have especially proven to be appropriate for many ethnic minority groups” (*cf.* Norris and Stevens 2007; Somasundaram 2013).

The next section summarises all of the examples from the literature that document successful community-based MHPSS interventions. It must be noted, however, that while



the immediate advantages and positive effects of these interventions are presented by the writers, what is missing is an evaluation of the long-term impacts and outcomes. The displacement of communities and the dispersion and breakdown of families due to death, disappearances, and migration are consequences of war that have fundamentally changed the very structure of kinship and family in the war-affected regions of Sri Lanka. Such structural changes to social institutions cannot be addressed in the short-term. Restoring displaced communities to their original lands and homes are interventions that must be addressed at the level of the state and continues to be a politically contentious issue.

### **6.3 Community-based Mental Health Care**

A fundamental transformation of the MHPSS sector in Sri Lanka is envisaged as a moving away from institutionalised care—which is widely acknowledged as an antiquated approach to mental health—to a community-based health care model (*cf.* Siriwardhana and Wickramage 2014).

Some of the literature argues that the approach to mental health in Sri Lanka is strongly oriented towards a psychiatric bio-medical model, aimed at curing mental illness rather than promoting positive mental health and psychosocial wellbeing (Miller and Rajapaksa 2007). Despite the international debate in the 1990s in the field of mental health and psychosocial support on the ‘Trauma’ (biomedical) approach versus the ‘Resilience’ (or community-based or social) approaches to interventions in situations of conflict and disaster finding resonance in Sri Lanka and resulting in a moving away from exclusive bio-medical services to the introduction of psychosocial support especially in conflict affected areas, the health sector in Sri Lanka had, apparently, remained firmly rooted in a curative, disease model of mental health in the first few years following the tsunami. In an independent evaluation report of the UNFPA’s funded programme, Miller and Rajapaksa (2007) found that a majority of the staff in the Directorate of Mental Health (Ministry of Health) had limited understanding of prevention and wellness promotion strategies and concepts. Miller and Rajapaksa note that there was “considerable confusion regarding the meaning of ‘psychosocial’ among the Deputy Provincial Directors of Health Services (DPDHs) and MOHs with whom we spoke, and observed that the term was frequently used to refer to activities aimed at destigmatising mental illness, raising awareness regarding mental illness, and providing respite to caregivers of mentally ill persons” rather than the promotion of wellbeing and prevention of mental health and psychosocial problems (Miller and Rajapaksa 2007:24).

The existing institutions in any case cannot cope with the demand for services as there are only, according to one study, 2031 psychiatric hospital beds and only around 48 specialist psychiatrists for a population of over 20 million (Siriwardhana and Wickramage 2014). According to a WHO Report (n.d.) the long-stay patients have little access to psychosocial rehabilitation or specialist nursing care, and the only provision of statutory community care is by a team of only 6-8 psychiatric social workers and only one active consultant community psychiatrist (p.29-30).

In contrast to the bio-medical approach that seems to have dominated the Ministry of Health's approach to mental health until recently. Somasundaram (2014) records that in northern Sri Lanka—one of the main battlegrounds of the ethnic conflict—"a public health approach in combination with MHPSS intervention strategies" was adopted, which constituted a 'community-based approach' (p.291). The principle of the approach was to "empower the community to look after their own problems" in order to develop a sense of agency and efficacy at an individual level and engender a sense of trust at the collective level (p.291-292). The response seems to have been an intuitive yet carefully planned intervention designed by experts from within the community to strengthen the resilience of a war-affected community in a context where there was not only a severe dearth or even absence of services, but also the disintegration of community bonds and social cohesion as a consequence of the conflict. This is evidenced in the way the Transcultural Psychosocial Organisation (TPO) protocol, supported by the WHO, was adapted as part of the community-based approach (p.291).

### **Models for Community-Based Mental Health Care and Psychosocial Support**

The literature records a number of 'successful' models of community-based mental health care. They are:

- The approach adopted in the Northern Province from the 1990s onwards (Somasundaram 2014),
- Community Psychiatric Service established in Colombo 15 (Ranasinghe et al. 2010),
- Mental Health Ward in the district of Kalmunai (Gunasekera 2008a; WHO 2008; Weerackody and Fernando 2011b),
- Anti-Smoking campaign in the district of Hambantota (Jayasinghe 2008),
- Other Community oriented interventions (Betancourt et al. 2013; Rajah et al. 2008; Ranasinghe et al. 2010).

#### *Community-based MHPSS Services in the Northern Province*

Somasundaram (2014) records the most extensive example of a successful community-based model for MHPSS services in the Northern Province of Sri Lanka, which was mentioned in the previous section as an intervention model that diverged from the bio-medical and institution-based mental health care model that characterised the mental health services in the rest of Sri Lanka. Several key factors seem to have contributed to the success of the model: (i) the commitment of local mental health professionals to respond to the mental health crisis as a consequence of the war; (ii) recognising very early on that in the absence of state support, local resources must be utilised and developed; (iii) the long-term support of international NGOs in funding local initiatives and training MHPSS personnel; and (iv) a willingness to work with both government and militant organisations, as well as local organisations.

Somasundaram (2014) documents the model as comprising three main components: psycho-education, training, and introducing psychosocial support through various methods and strategies in the community. The dissemination of "basic information about what has happened, what to do and what not to do, and where help can be obtained" was achieved

through the media, the distribution of pamphlets, and a series of public lectures and seminars conducted in schools and in the University of Jaffna, as well as to groups of state and NGO workers and the general public (p.292). Psycho-education was also enabled through the commemoration of World Mental Health Day through cultural celebrations and the organisation of various art, storytelling, and writing competitions (p.192).

The training component of the community-based approach in the North is recorded as a systematic and well thought-through programme comprising theoretical knowledge and practical skills and offered to a wide-range of MHPSS personnel at the local community level (Somasundaram 2014:292-299). These included “teachers, primary health workers, priests, village headmen (GSs), traditional healers, youths and elders (p.192). Rather than *ad hoc* or one-off trainings, teaching and training in basic mental health care was incorporated into the curricula of the family health workers, medical students, and nurses. The training was enhanced through the availability of Tamil language texts—both translations of international training manuals as well as locally produced texts by mental health professionals working in Jaffna (p.293). Shanthiham—a local NGO established to provide MHPSS services to the community—is documented as a central player in the training of MHPSS service providers. Somasundaram (2014) documents how Shanthiham was the training hub of the north where annually batches of counsellors were trained for a period of six months after which their practice was supported with regular supervision. Although trained by an NGO, these counsellors were placed in the state hospitals in the Northern Province as well as in community centres and NGOs (p.293). Twenty-five more counsellors were trained following the Tsunami, and Somasundaram underscores the success of the training programmes as well as the dedication of these counsellors by recording how, with the exception of two people, they continue to work as counsellors in the north of Sri Lanka (p.293).

The success of the community-based training programme is also evidenced by the development of a set of local trainers to teach new counsellors and provide supervision support (pp. 293-296). Somasundaram asserts that their experience in the same field helped them provide meaningful support to new recruits. The training programme was enhanced by adapting a number of resources to fit the particular context of the Tamil population living in the Northern Province. These included adopting the TPO protocol for the ‘Training of Trainers’ as well as adapting a WHO and UNHCR manual—*Mental Health of Refugees* (1996)—for the Tamil community (*cf. Mental Health in Tamil Communities* by Somasundaram and Sivayokan 2001). Drawing from Bernal et al. (1995) and Bronfenbrenner (1979); Somasundaram (2014) documents the process by which the training manuals were developed to be “ecologically valid and culturally sensitive to be practically useful in a community setting [and to] capture the environment and experiential world of the target community [and] fit their cultural and psychosocial situation” (p.294).

The formal incorporation of psychosocial support as part of the services provided under the rubric of ‘mental health’ reflects the shift globally to a resilience model in responding to mental health crises in the context of war and natural disaster. This meant designing a training programme for ‘psychosocial workers’ that spanned a period of nine-months. The

training included social theory that drew from the disciplines of psychology, anthropology, and sociology; hospital-based training in the psychiatric units as well as centres for those with disabilities, elders, and orphanages; and field-based training that focused on identifying and strengthening local resources mainly traditional healers, as well as conducting a variety of discussion groups within the community about psychosocial issues and needs (p.295-304).

#### *Community-based Psychiatric Clinic in Colombo 15*

Ranasinghe et al. (2010) model for community based psychiatric service was established in the Colombo municipal postal zone 15—a predominantly ‘poor’ area—after it was discovered that in the year 2009, seventy-five patients were admitted to the mental health ward of the National Institute of Mental Health (NIMH) and many of the patients had had three admissions within that year due to frequent relapses (p.4). The authors discovered that “the main reason for relapse was defaulting of treatment which was due to the reluctance of patients to attend the outpatient clinic at the country’s main hospital” (p.4). The stigma associated with attending a psychiatric clinic was addressed by establishing the clinic at a venue that also housed a maternity and child services clinic. Ranasinghe et al. believe that by linking psychiatric care “with other ‘acceptable’ services such as family planning, immunisation and child care and also with religious and social service organisations”, the stigma was significantly reduced while simultaneously reducing the time and transportation costs—a significant issue for many of the urban poor (p.4). Moreover, the more anonymous general health setting made it less intimidating for mental health patients who were more willing to attend their regular clinics. The involvement of the family also became easier because patients could bring relatives along without causing significant disruption to their scheduled commitments. The community-based location also prompted Family Health Workers (FHW), whose formal ‘Duty List’ did not include mental health, to identify mental health problems in the community and refer them to the clinic. Furthermore, if the patient was not able or willing to come to the clinic, the relatives were able to take the Community Psychiatric Nurse (CPN) to their home to review the patient or administer a depot injection (p.4-5).

Ranasinghe et al. (2011) recognise the need to expand services in order to address social problems and employment needs in the community as a way of improving the efficacy of the service. They point out that “substance use and domestic violence are major problems in the area where the clinic is located; therefore, special programmes and services need to be developed, liaising with organisations dealing with these issues. Culturally appropriate vocational training and job placement services are a need because employment is highly valued by patients and families” (p.4).

#### *Kalmunai Mental Health Ward*

The mental health ward established in the Kalmunai district is a model of care that incorporates institutional care with community support. In Gunasekara’s (2008a) study it was found that maintaining family links when people with acute mental health conditions had to stay in hospital was important to both patients and families. Provision was made for relatives to stay overnight with patients. Gunasekara records that, in contrast to the

patients in the older mental health institutions, the incorporation of family and community has meant that “in general, patients stay no longer than two weeks in the Acute Ward of the hospital [and only] during the most difficult stages of their mental illness” (p.2). The success of the Kalmunai community-based model has also been due to the collaboration with communities for referrals. The study found that “Community Service Organisations (CSOs) work very closely with communities on the identifying and referring of possible new cases of people in need of mental health assistance” (Gunasekara 2008a:3). The WHO supports this finding in their study of psychiatric social workers whose home visits “helped family members to better understand persons suffering from mental disorders and helped them to rebuild their personal social connections.” (WHO 2004:41).

#### *Anti-Smoking Campaign in the District of Hambantota*

Jayasinghe (2008) in his description of a substance abuse campaign in Hambantota records a community-based intervention that was simple but effective. He records that “those present realised that the implementation of simple programmes such as these, assisted people in finding solutions to their problems, rather than the preparation of large scale reports” (p.7).

#### *Other Community-oriented Interventions*

Another successful programme that incorporates a community-oriented approach is recorded by Betancourt et al. (2013) in their literature review of peer-reviewed psychosocial and mental health interventions designed to address mental health needs of conflict-affected children. They discuss a community-based rehabilitation programme for children with disabilities that adopts a “consensus strategy [...] intended to promote teamwork between families, organisations, and communities to ensure that people with disabilities can maximise their physical and mental capacities and contribute to community life” (ibid, p.81). In addition to recognising the importance of family and community collaboration and support, such an intervention, according to Betancourt et al. (2013),

“was used to bring together warring Sinhalese military and Tamil groups in educational workshops on child developmental disabilities such as polio, blindness, and stroke. These programmes exposed both groups to the commonalities of the disability experience and promoted mutual assistance between them. Such community-level interventions aimed at raising awareness, building empathy, and combating stigma about mental and cognitive disabilities have significant potential to benefit war-affected children, families, and communities, and merit much more effort in programme evaluation” (p.81).

Rajah et al. (2008) note that in Sri Lanka, as well as in India, successful models of community-based rehabilitation and mental health development models involved community-based collaborative work, proactive outreach, use of local resources, and training of personnel working with those affected (p.8). As discussed by Ranasinghe et al. (2010), these services must be enhanced by addressing livelihood needs. Rajah et al. (2008) also argue that in tandem to addressing immediate practical needs, advocacy for the recognition of rights must also be initiated at the community level.

A WHO report (2012) advocates for piloting community mental health psychosocial models in different settings to ascertain how a community-based approach could minimise the disease burden in the community. The WHO believes that in piloting various models the problem of stigma associated with mental health illnesses can be addressed as well as strategies “to improve the country’s capability to develop evidence-based strategies, programmes and interventions for the prevention and management of mental illnesses and related issues, including suicidal behaviour” (WHO 2012:23).

In the conclusion of their study of a model of community-based mental health care, Ranasinghe et al. (2010) propose a seventh criterion in addition to those described by Caplan: that services provided should be ‘culturally appropriate’. They argue that “state mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving population [...] Providing culturally competent mental health services requires that the patient’s culture be understood, accepted and respected by providers during all phases of the therapeutic process” (pp.4-5).

#### **6.4 A Psychosocial Framework**

Responding to conflict as a mental health emergency due to widespread trauma amongst affected populations was widely critiqued in the 1990s (Ager 1999; Bracken 1998; Galappatti 1999; Summerfield 1996; 1999). Proponents of ‘the psychosocial approach’ have argued that responding only to the psychological dimension of individual suffering through psychological support such as counselling is grossly inadequate because the social consequences of death, displacement, and the disruption in the daily lives of people through the loss of livelihoods, education, community support etc. has a significant impact on their mental health and wellbeing (Ager 1997; Honwana 1999; Jareg 1996; Lawrence 1998; McCallin 1999). The international debate in the field of post-emergency mental health and psychosocial support between the ‘Trauma’ (biomedical) approach versus the ‘Resilience’ (or community-based or social) approaches to interventions in situations of conflict and disaster gained momentum in Sri Lanka and resulted in a significant shift in MHPSS service provision—a moving away from psychological support to a psychosocial framework in the provision of mental health care in early years of the new millennium and more specifically in the aftermath of the December 2004 tsunami (Galappatti 2014). It must be noted here that psychological support prior to this shift was not limited to individual therapeutic interventions, but had psychosocial elements to it such as legal aid and credit schemes, and in the case of children, encouraging pro-social behaviour through cooperative games and providing nutrition (Galappatti 2014:354-355). However, as Galappatti notes, the psychological and psychosocial components were “compartmentalised” because service providers did not “see at the time [how] the different problems [...] were actually interrelated, and that [the] attempts to assist them could have been more meaningfully integrated” (p.355).

Galappatti (2014) outlines the several different ways and models through which the psychosocial approach became incorporated into mental health services as well as humanitarian and development interventions in Sri Lanka. Drawing from experiences and insights in the field, Galappatti argues that recognising how the “the psychosocial

consequences of conflict were mediated and shaped by the social and structural conditions of people's lives" led to a shift within NGOs providing mental health services to survivors to move beyond therapeutic services and engage more decisively in the social aspects of the lives of survivors (p.357). At the same time, proponents of the psychosocial approach strongly advocated that mainstream humanitarian and development interventions integrate "approaches conducive to enhancing psychosocial wellbeing" (p.357). As Abeyasekera (2014) observes "a *psychosocial* approach that would focus on the constant interplay between the *inner world* and *external environment* of individuals seemed to be particularly appropriate in the context of conflict and disaster" (p.38). Galappatti provides a salient example that demonstrates why such an approach is not merely idealistic. Drawing from field experiences with women affected by conflict in the Northern and Eastern Provinces as well the South, Galappatti argues that the murder of one's husband for example, "might not only cause a woman grief, a sense of powerlessness and existential doubts, but also new challenges in terms of material and economic survival, increased vulnerability to sexual violence or exploitation and changes in social identity and relationships with her children, relatives, and neighbours" (p.357).

The shift to thinking more broadly and holistically about mental health ran parallel to a similar discussion in the field of international development on promoting wellbeing and improving people's quality of life (Abeyasekera 2014). There was a growing consensus that traditional economic development indicators like GDP and GNP provided only a partial idea of what constituted 'development'. Rather, a multi-disciplinary approach that takes into consideration human and social indicators that measured the quality of life and the wellbeing of individuals and communities was promoted as a far more reliable and appropriate measure of the overall objectives development programmes were trying to achieve (Abeyasekera 2014; White 2014).

While the principle of the psychosocial approach was clear—a 'person-centred' approach through the integration of the psychological and the social dimensions of people's lives—how 'psychosocial' was translated to describing interventions caused much confusion, because 'regular' development programmes like health services, micro-credit, and skills training were now being classified as 'psychosocial' (Abeyasekera 2014). Amarasuriya (2009) argues that it is not the type of intervention that differentiates a psychosocial programme. As Abeyasekera (2014) points out, "it was the *principles and values* underlying the design of a programme and the *way* it was implemented that determined the 'psychosocial-ness' or 'psychosocial sensitivity' of an intervention. The *Psychosocial Assessment of Development and Humanitarian Interventions* (PADHI) framework (2009) developed at the University of Colombo argued that the principle of 'social justice' should be at the core of any development intervention that aims to enhance the wellbeing of individuals, families, and communities (Abeyasekera and Amarasuriya 2009). This means taking into consideration not only what constitutes wellbeing, but also what mediates wellbeing—power and identity—as well as the systems and structures that have the potential to support or undermine people's experience of wellbeing (Abeyasekera et al. 2009).

Somasundaram (2014) interprets 'psychosocial' to mean recognising the "potential *within* the community to resolve their own psychosocial issues", where 'psychosocial interventions'

meant the training of “selected members in the community with skills such as befriending and communication to identify and resolve psychosocial problems within their capacity or refer them to mental health professionals” (p.312 *emphasis added*). ‘Psychosocial workers’ would be able to “respond constructively during times of crisis in a family, conflict within groups, illness or death” and figure out ways to reconstruct community structures that supported the wellbeing of individuals and families and maintained social cohesion through practices such as story-telling by elders and encouraging rituals and cultural events (pp.312-313).

Sritharan and Sritharan (2014) in their overview of research and resources in post-conflict Sri Lanka stress the importance of asking why and how some communities do better than others in coping with war and other traumatic events. They advocate for a resilience model in designing MHPSS services wherein researchers explore more thoroughly individual and community resilience in less affected areas and amongst older children and adults to understand what they are and how they are influenced by “religious beliefs, cultural values, emotional levels, and social skills” (p. 153).

This is evident even in the state sector, where the blurring of the distinction between reproductive health, gender based violence and psychosocial issues were found in some of the reproductive health initiatives funded by the UNFPA (Miller and Rajapaksa 2007: 8; 26-27). According to Miller and Rajapakse, a successful psychosocial approach is one that combines the promotion of wellbeing with the upholding of human rights. They found evidence of such programmes in some of the centres they visited in the Southern Province: “centres that promoted the psychosocial wellbeing of women and girls, as well as boys and men.” They assert that “by reducing violence, promoting positive parenting, reducing women’s stress, increasing family income and literacy, and enhancing social support, it seems likely that holistic centres such as these will also have a substantial positive impact on reproductive health as well” (p.23).

## **6.5 Pluralistic Approach – Incorporating ‘Traditional’ and ‘Cultural’ Healing Practices**

The need for an integrated approach to MHPSS care based on a pluralistic model is recommended because peoples’ health-seeking behaviour is pluralistic in nature (Tribe 2007). Budosan’s study (2011) among health professionals including primary health care doctors, for example, found that while there was a significant gap between mental health needs and services a substantive proportion of mental health care issues were being dealt with the assistance of traditional healers (p.129). While the lack of services cannot be attributed to people seeking care from traditional healers, the lack of resources of the state’s health sector calls for “the collaboration of medical and mental health professionals with appropriate traditional resources, such as faith healers, pastoral care, and clergy” (D’Souza and Singh 2005 p.68). D’Souza and Singh assert that such collaboration is an “important and necessary engagement” due to the lack of resources, but also an opportunity to imbue meaning to the process of healing and facilitating general community support (ibid).



A pluralistic model, by its very definition, will not look the same in every location. One of the main reasons for this is the way in which the MHPSS sector in Sri Lanka developed historically with various NGOs—local and international—setting up services in different parts of the country, namely in the conflict—affected north and east. This has meant that a uniform model of service provision does not exist throughout the island. Weerackody and Fernando (2013) observe that “in building mental health services there are many stakeholders in a Sri Lankan context, depending on location of care. In some locations “people attending out-patient clinics at government hospitals may have psychiatrists working with psychiatric social workers and clinical psychologists” (p.41). Therefore, they assert that in Sri Lanka a community-based mental health service would have a complex structure. “Stakeholders for delivering community-based mental health care in Sri Lanka should be drawn from many different sources. The exact combination would vary from place to place and according to availability.” (p. 41-42).

Underlying the call for a systematic approach within a plural model is a fear that any one of the frameworks—the biomedical or the so-called ‘traditional’—can be harmful if implemented without consideration of its limitations. Weerackody and Fernando (2013) argue that “allopathic (western) psychiatric treatment could damage people if (for example) excessively large doses of medication are prescribed or Electroplexy (ECT) is given too often. Similarly, ...spiritual therapies by religious agencies may lose sight of their own failure to help, and may actually do harm by sticking dogmatically to beliefs (in say prayer or rituals) while ignoring needs of people suffering disabilities that could be better helped by traditional medical means” (p.41).

## **7. Local Practices versus Western Psychiatric Imposition**

There seems to be an ideological commitment to and also an intuitive understanding that ‘traditional healing practices’ including cultural ways of coping must be acknowledged and supported by MHPSS services. The literature does not clearly delineate the difference between ‘local healing practices’, ‘religious rituals’, and ‘cultural ways of coping’. Rodrigo and Wimalasingham (2006), describe more coherently the various ways in which concepts such as ‘local’ and ‘cultural’ can be understood in relation to MHPSS care. At one level is the extended family structure of Sri Lankan families; they argue that family and community support can be enhanced by providing support to carers in the family and also by introducing livelihood options for sufferers who often burden the family. At another level, people with mental health illnesses seek relief from ‘traditional’ healing methods that draw on religion and cultural practices of prayer, devotion to deities, yoga and meditation. Rodrigo and Wimalasingham also refer to collective rituals especially religious festivals and ceremonies that provide solace in times of grief. While there are certainly overlaps between these concepts, it is perhaps important to note the differences between:

- medical systems (e.g., Allopathy, Ayurveda, Unani and so on);
- cultural and religious rituals that are prescribed when a person needs healing (e.g., exorcisms);

- cultural and religious rites and ceremonies that commemorate distressing life events like death; (e.g. funerals and alms-giving); and
- cyclical religious and cultural rites and festivals that mark important moments in community life (e.g. church feasts, the rites of first harvest).

Ekanayake et al. (2013) found that those who talked of 'loss of faith' appeared to suffer more long-term emotional distress, while religious practices contributed to relaxation and emotional wellbeing of those who engaged in them (p.73). Sundram et al. (2008) argue that rituals and ceremonies associated with grieving are "culturally mediated protective factors" and records how after the December 2004 tsunami "funerals and anniversaries were very powerful ways to help in grieving and finding comfort" (p.11). The effectiveness of MHPSS services during this time, according to Sundram et al., is described in the way "affected schools were encouraged to have regular ceremonies to commemorate those who died [and] support was sought for communities to build memorial structures at sites of mass burials where public gatherings, meetings and religious ceremonies were arranged for communal expression of feeling, reviewing, and coming to terms with the collective trauma" (p.11). They argue that not only in allowing cultural expressions of grief, but supporting collective expression through memorialising, MHPSS services enabled individuals and communities to "socially define and interpret the community's experiences, as well as [re-establish] social relationships and planning for the future" (p.11). Prietler (2012), however, adds an important note of caution about how mourning practices, when observed on purely ethnic and religious terms, can contribute to further rage and hatred. She records a case study of a collaboration between international and local 'outsiders' who developed new interventions for mourning that were informed by tradition and faith, but promoted communal harmony (p.246).

The Working Group (WG) on Mental Health and Psychosocial Support, in their report on factors that promote or hinder the long term sustainability of emergency mental health and psychosocial interventions in crisis and conflict, stress the importance of not "dismantl[ing] effective local models in order to replace them with often untested 'standardised' programmes" (Patel et al. 2011:4). The recommendations refer to a case example from Sri Lanka where such an effective local model for dealing with violence against women was replaced with gender based violence (GBV) initiatives by NGOs, international agencies, and the central government that have, in effect, undermined pre-existing structures on gender-based violence (ibid). With the exception of this one concrete case example, the review did not find any documentation (or institutional memory) identifying local models or specific traditional healing practices and how they worked. If we continue to stress the importance of acknowledging the role of local practices and advocating for their integration into a pluralistic model of MHPSS care, then it is critical these practices are identified and research conducted on what specific elements of these practices made them effective in healing people with mental health issues as well those seeking psychosocial support. Often times, the disruptions created by the introduction of new methods and models of health care (or any other service) are those arising out of the process of transition where the community

adjusts itself or gets used to the existence of something new. The disorder created in the time of transition only means that people everywhere take time to adjust to change and are usually comfortable with the status-quo, however ineffective it may have been.

The study of an area severely affected by the tsunami to estimate the prevalence of symptoms 20 months after the tsunami and also coping mechanisms conducted by Hollifield et al. (2008) found that drawing on “their own strength” and visits to the hospital combined with social support and religious practices were the most helpful ways of coping with somatic and psychiatric symptoms associated with PTSD, depression, and anxiety. The authors note that since their data is cross-sectional “it is *possible* that those with more anxiety are rightly seeking culturally appropriate coping activities that *may be* helping over time” and conclude that their findings on coping mechanisms “indicate a need for services that augment current coping practices” (p.43, *emphasis mine*). However, they indicate the need for a longitudinal study “to evaluate the utility of these particular coping activities on symptoms and impairment (Hollifield et al. 2008:43).

The criticism against Western psychiatric care in situations of protracted conflict and disaster are twofold: on the one hand they are not sustainable in contexts where services cannot be offered in the long-term largely due to the lack of resources; and on the other hand, the impracticability of psychiatric care in treating a large population of affected people. Such services are also untenable due to, according to D’Souza and Singh (2005), “the very limited psychological mindedness of these cultures [where] psychiatric morbidity usually remains unrecognised and not treated.” They observe that the situation is compounded by “the influx of well-intended non-governmental organisations [...] bent on offering trauma-focussed interventions [which are mostly] one off psychological debriefing and some benzodiazepines.” They argue that an “approach of promoting PTSD case finding and trauma focussed treatment, in the absence of a system wide public health approach considering pre-existing human and community resources, might be not appropriate” (p.68).

However, rather than a sweeping dismissal of ‘Western’ imposition and a call for ‘local’ practices, a more nuanced, evidence-based discussion must be present to understand how they can strengthen existing MHPSS services. Somasundaram (2007), for example, does not dismiss the effectiveness of ‘Western’ psychiatric care; in fact he acknowledges the efficacy of psychopharmacotherapy and state-of-the-art cognitive behavioural therapy (CBT) in the treatment of what he terms “conventional psychotic illnesses” like Schizophrenia and Bipolar disorders, as well as those with manifest dysfunction as a result of the impact of conflict. He notes that “a small minority with more severe dysfunction does benefit from psychiatric treatment which could also include cultural techniques like yogic relaxation methods (p.7). However, Somasundaram makes the point that it is impractical “to treat the large numbers affected with minor mental health problems due to the disasters with western psychiatric treatment.” One of the main reasons is the lack of human resources. He points out that “in northern Sri Lanka, CBT was not possible as there were no clinical psychologists. Even the recommended psychopharmacological agents in the west, (serotonin-specific reuptake inhibitors (SSRI’s),

were not available” (p.7). However, Somasundaram does not advocate abolishing ‘Western’ psychiatric care altogether. He asserts that:

“Indeed, community mental health programmes that do not include the possibility of addressing the problems of those with severe mental disorders would fail in the eyes of the community and cause a breakdown in the smooth functioning of the setting where they were” (p.7).

Somasundaram’s reference to combining psychiatric treatment with “yogic relaxation methods” draws our attention to the aversion to relying solely on ‘Western’ psychiatry or the bio-medical approach even in cases of “conventional psychotic illnesses”. Weerackody and Fernando (2011b) notes that “a social perspective of illness” entails “work[ing] with the persons and those people that they are in close contact with, in order to help them to see a way out of the difficulties. Where necessary medications may have a part to play, but always combined with other interventions such as psychotherapy (talking therapies), indigenous modes of obtaining help (such as spiritual healing), and making changes in the social settings they live in” (p.14).

As noted before, the ideological commitment and intuitive belief in combining cultural coping practices and traditional healing with a range of what is popularly termed as ‘Western’ modes of care has meant that the response in times of conflict and disaster have drawn from various modalities of mental health care and psychosocial support. Sundram et al. (2008) note the multi-disciplinary nature of the psychosocial support that was provided in the aftermath of the tsunami. The responses consisted of “psycho-education, crisis intervention, psychological first aid, behavioural-cognitive strategies, traditional healing, rituals, relaxation techniques, pharmacotherapy, group and family work, expressive methods, rehabilitation, networking and community approaches” (p.10-11). The multi-faceted nature of the response is further illustrated by the wide range of service providers from within and outside the community who were trained to care for those affected. They included: community workers such as camp and relief workers, teachers, primary health staff and government officers, and later Community Support Officers (CSOs) (p.11). Whether such a multi-disciplinary approach was effective is not discussed by the authors nor in the wider literature. However, it must be noted that the literature does not question the plurality of the response but rather describes how the need to coordinate the multifarious MHPSS relief efforts “spontaneously” sprang up from within the community through the setting up of coordinating bodies like The Mangrove in the east and the Mental Health Task Force in the north (Sundram et al. 2008:10).

## **8. Systems and Structures that Strengthen and Undermine the Mental Health Sector in Sri Lanka**

Taken as a whole, the decisive victory of the Sri Lankan government over the LTTE in May 2009 that ended the active conflict of three decades in the Northern and Eastern Provinces of Sri Lanka, is a watershed moment in the nation’s history that had the potential

of transforming the mental health sector in Sri Lanka. As Samarasinghe (2014) points out, the positive changes are substantive: many inaccessible areas have been opened up; the development of infrastructure from roads and bridges to schools and hospitals has meant greater mobility and access to services; and land that has been unoccupied for decades is being restored gradually to communities (p.365). However, given the politically charged nature of ethnic conflicts, the post-war challenges of addressing long-term suffering due to the loss of life, displacement, the violation of human rights, and living in an atmosphere of fear and suspicion without the guarantee of even basic safety and security are, without doubt, tremendous. Samarasinghe argues that a meaningful transition from war to peace can only happen in an environment of reconciliation where the “uncomfortable issues of torture, trauma, disability and the resulting depression and psychological distress of the hundreds of affected people [are] considered” (p.365). In fact, Samarasinghe quantifies the number of people directly affected not in the ‘hundreds’ but as at least one million (p.366). The road to reconciliation will also require the state to address complex issues: resettlement of people in their homes of origins when those ‘homes’ have been destroyed or are now occupied by others; the continuing existence of refugee camps in the Trincomalee district; the reaching out to the Sinhalese communities in ‘border villages’ who fled their homes after continuous attacks from the rebels; and the tense post-war atmosphere exacerbated by armed robberies and killings (p.366). Finally, Samarasinghe argues that a reconciliation process will also require the state to initiate a mechanism through which the stories of those affected are ‘listened to’ if not addressed through a transitional justice process.

## 8.1 Call for Systematic and Coordinated Approaches

The literature stresses on the need for a more systematic approach to mental health care and psychosocial support services in Sri Lanka. The rationale for systematicity, coordination, and regulation are similar. The service user is conceptualised as a person who is unable to choose and thereafter access the appropriate services in a timely manner for several reasons. Firstly, there is inadequate knowledge of mental health issues. Once a mental health issue is suspected or identified, then the service user may not have the adequate information regarding available services. In the Northern and Eastern Provinces where MHPSS services were established by the NGO sector and grew exponentially after the tsunami of December 2004, a question of isolated service providers whose quality cannot be determined arises (*cf.* Rangaswamy and Ramachandran 2013). The lack of coordination compounds the issue as the service seeker is not given the opportunity to go through the various steps of appropriate care and may have to resort to the services he/she is aware of (*cf.* Krishnakumar et al. 2008).

One of the primary causes for the lack of systematic and coordinated service delivery is the existence of several bodies of knowledge that service seekers draw from for the purpose of healing. The biomedical body is the dominant system in Sri Lanka. But many also resort to ‘local healing practices’. Local or indigenous knowledge systems are not monolithic. They consist of Ayurvedha, ‘traditional’ or *paramparika* system (which is also not a single system but are cures and remedies that are handed down within the family), Unani, cultural rituals, and religious practices—once again not originating from a single body of ‘knowledge’.

Sax (2015) argues that:

“Whether the object of our attention is biomedicine or traditional healing, it is important to beware of what Bourdieu calls the ‘synoptic illusion’—that is, the fact that formal representations tend to engender a false notion of systematicity [...]when we read a modern medical textbook or a conservative historiography of medicine, we tend to think that modern medical science is systematic, internally coherent, and contextually independent—a kind of therapeutic ‘mirror of nature,’ whereas, in reality, it is a hodgepodge of practices, theories, and assumptions that are not always mutually compatible—a kind of Rube Goldberg machine that sometimes gets the job done, but usually in a rather haphazard and indirect fashion” (p.8).

It is critical then, to understand how the literature imagines a successful MHPSS sector and, more importantly, what reasons are given for the need for systematic, coordinated, and regulated services. Is there an inherent ontological bias about the nature of bio-medical services as being ordered, systematic, regulated, and scientific in contrast to indigenous knowledge that is the anti-thesis of these characteristics because they are based on cultural beliefs, faith, tradition and so forth?

Closely related to this debate about systematicity is the discussion around the need for culturally appropriate or culturally adapted tools for diagnosis, needs assessments, and monitoring and evaluation (Elbert 2009; Jayawickreme et al. 2012; Lukumar et al. 2008; Marsden and Strang 2006; Miller et al. 2009).

## **8.2 Persistent Challenges in the MHPSS Sector in Sri Lanka**

Among the recurrent themes featured in the literature as enabling effective MHPSS interventions are:

- the skills, capacities and commitment of many MHPSS professionals who have worked innovatively, managing limited resources and diverse challenges to address MHPSS needs, especially in crises situations;
- the recognition and space facilitated through some MHPSS interventions for community participation in MHPSS service provision and the pluralistic approach adopted in several state and non-state service approaches that recognise the diverse realities of people’s lives.

The expansion of the state mental health service mechanism, albeit gaps, emerges as a positive change.

Several factors that undermine responsive MHPSS service provision also emerged in the literature review. These include:

- disproportionate funding and resources for mental health and concentration of resources mostly in and around Colombo, despite efforts to decentralise MHPSS services through the state sector;

- slow recognition of location specific MHPSS interventions that could inform and strengthen the designing and implementation of MHPSS service provision in the country;
- absence of political commitment to look beyond socio-political context and recognise MHPSS issues and options, especially related to conflict;
- poor recognition of less prevalent but equally distress-causing psychosocial issues;
- lack of mental health professionals to provide equitable MHPSS services across the country; and
- issues in the flow of financial resources that cause shortages in psychotropic drugs issues through the state mechanism.

Despite the positive transformation, the mental health sector in Sri Lanka continues to experience challenges at the structural and systemic level (*cf.* Banda 2007; Jenkins et al. 2012; Ranasinghe et al. 2010; Rodrigo and Wimalasingham 2006; Siva 2010). Challenges of:

- Human resources and capacity building,
- Funding and issues in budgeting,
- The centralisation of MHPSS leading to a gap in the distribution of services,
- Inpatient care and access to drugs,
- Coordination,
- Legislation.

For an in-depth discussion on psychosocial support within the National Colleges of Education in Sri Lanka, refer Dhammapala (2013).

### **Human Resources and Capacity Building**

Although Sri Lanka prides itself on having a free national health service since achieving independence, the shortage of mental health specialists is the primary reason for inadequate MHPSS services in the country. With a population of 19 million, Sri Lanka has only 48 consultant psychiatrists most of whom work in the Western Province—the location of the capital city (Jenkins et al. 2012, Ranasinghe et al. 2010). The United Kingdom has 11 psychiatrists per 100,000 people, the United States 13.7 and Singapore 2.3, in contrast to 0.2 in Sri Lanka, - the same as in India (Ranasinghe et al. 2010:4). According to the World Health Organisation (WHO), Sri Lanka requires 251 psychiatrists to fulfil her mental health needs (Ranasinghe et al. 2010:4). While state universities, fully funded by the Sri Lankan state through its free education system, have trained a substantial number of psychiatrists (88 from 2002 to 2009), many have migrated to higher income countries following postgraduate training (Ranasinghe et al. 2010:4). Gunarwardhana (2015) points out that by 2015 the number of certified psychiatrists had increased to 85 but overseas migration of psychiatrists trained in the country is a continued concern (p.5). Ranasinghe et al. (2010), nevertheless, acknowledge the dedication of those psychiatrists remaining in the country and the number of psychiatrists returning to the country after training [that has] enabled Sri Lanka to have a psychiatrist providing care in 22 of her 25 districts (p.4). However, the enormity of the

problem is evidenced by the fact that according to a WHO report (n.d.), as of June 2003 there were only two Tamil psychiatrists who were providing community mental health care in and near the districts of the two largest cities in the Northeast—Batticaloa and Jaffna (p.29).

The lack of human resources is compounded by the dearth of other mental health professionals: “the lack of specialised psychiatric nurses – although there are around 800 nurses attached to psychiatric units with some experience in psychiatry; the existence of only three psychologists attached to the university units; 57 occupational therapists; and 20 psychosocial workers (PSWs) and 60 assistant PSWs” (Jenkins et al. 2012:16).

### **Funding and Budgeting**

The lack of financial resources is one of the main challenges the MHPSS sector faces, especially in the context where conflict and natural disaster have drained state resources (Jenkins et al. 2012). However, rather than a lack of funding it is the way in which resources are allocated that has impacted the MHPSS sector in the period under review. An analysis of the 2006–07 WHO budgets “revealed that the funds allocated between communicable and non-communicable diseases are disproportionate, with 87% of the budget allocated to infectious diseases, 12% allocated to non-communicable diseases, and only 1% to injuries and violence” (Jenkins et al. 2012:23). Kitsiri and Reid (2006) note that the “only item of mental health service that [has] direct fund allocation [at] present from the national health budget, is [for] the three large traditional mental hospitals in the western province” (p.27). Furthermore, they note that “the absence of an actively used separate budget line/ heading for mental health services at national, regional and institutional levels makes the quantification of this fund allocation, and utilisation rates extremely difficult” (p.8). Hence, they argue that “the total allocation for mental health remains to be quantified leaving room for many challenges in financing mental health of the country and making it a policy priority [that] eventually would be reflected in the disparity between the growing burden of diseases and treatment gaps” (p.8).

### **Centralisation - Urban-Rural Divide in Distribution of Services**

The centralisation of services is one of the major issues facing the MHPSS sector in Sri Lanka. In addition to the three residential mental hospitals based in and around the capital city Colombo, mental health services are limited in the rest of the country, especially in rural areas. In fact, according to one study approximately 11 districts in the Central, Northern and Eastern Provinces have no mental health services available (Gunasekara 2008a:3). A WHO (2011) Report notes that the lack of human resources and supporting infrastructure leading to centralisation of MHPSS services have meant that only two of the seven districts in the north and east have the facilities for inpatient care for acute mental health problems. While a few outreach clinics exist that provide follow-up care for patients with severe mental disorders, these are located in Divisional Secretariats (DS) close to the urban centres of Jaffna and Batticaloa (WHO 2011:29). The WHO report argues that “without such facilities, chronic patients with schizophrenia do not receive the care they require. They are at risk of neglect or becoming long-term residents in the Colombo-based custodial



psychiatric hospitals, where treatment is inadequate and patients tend to deteriorate in the absence of psychosocial rehabilitation or family social support” (p.29-30).

### **Access to Inpatient Care and Drugs**

The centralisation of mental health services in urban areas that lead to an increase in the disease burden at a community level is not unique to Sri Lanka and is a characteristic of low and middle income countries increasing the treatment gap. (Saraceno et al. 2007). Furthermore, the scarcity of adequate and appropriate drugs for treatment are also major problems undermining the quality of care for mental health patients. (BasicNeeds Sri Lanka 2007; Ranasinghe et al. 2010).

### **Coordination**

The urban-centric provision of the Sri Lankan state’s mental health services and the severe lack of human resources resulted in the NGO sector taking leadership in establishing MHPSS services, mainly targeting “trauma-related mental and social problems”, in the Northern and Eastern Provinces during the time of the conflict (WHO 2011). This resulted in “different mental health stakeholders in the northeast advocat[ing] for different mental health activities. In the absence of a comprehensive mental health plan, new activities appear to develop in an uncoordinated fashion, with the implementation of lower order activities before higher order needs are met (WHO 2011:29).

In a context where MHPSS services have been historically provided by a wide range of non-state actors, especially in the conflict-affected north and east of the country, and the more recent expansion of state services after the tsunami, the literature under review stresses the importance of coordination, collaboration, networking, awareness-raising, and information exchange (Krishnakumar et al. 2008; Rangaswamy and Ramachandran 2013). A study surveying the MHPSS services in the districts of Puttalam (North-Western Province) and Anuradhapura (North Central Province) found that psychosocial support and the referral system are poor, with both service providers and community members being unsure how to access MHPSS services at the district level (Gunasekera 2008b). The study stresses the importance of collaboration between NGOs and the government if they are to provide an effective response to affected communities in these districts (p.3).

### **Legislation**

Sri Lanka’s legislation on mental health is archaic and dates back to the Lunacy Ordinance of 1873 introduced by the British colonial government. While the need for new laws is widely accepted and new laws have been drafted, these archaic laws continue to prevail with a few minor modifications introduced in 1956 (Weerasundera 2011:43). The law does not provide the impetus for better care, and instead continues to sanction involuntary treatment, involuntary admissions (Weerasundera 2011:44).

## **8.3 Research – Designing Evidence-based and Appropriate MHPSS Interventions**

The literature under review strongly criticises the lack of mental health research in Sri Lanka (*cf.* Jenkins et al. 2013; Konradsen and Munk-Jorgensen 2007; Siriwardhana et al. 2011;

Waidyanatha 2002). Jenkins et al. (2013) point out that “there is a dearth of systematic epidemiology in the country. A sub-national mental health survey was commissioned by the Ministry of Health in 2007 with the assistance of the World Bank, Health Sector Development Project, but has not been published” (p.16). According to Konradsen and Munk-Jorgensen (2007) universities in Sri Lanka are not research focused and therefore there are very few opportunities for academics and professionals to conduct mental health research on a full-time basis. However, literature reviewed from the latter part of the decade indicates a positive change. For instance, Gunawardhana (2015) makes note of two research instruments developed by universities: one is the Peradeniya Depression Scale developed by the University of Peradeniya and the other, a research instrument for neuropsychological testing in the elderly, being developed in Karapitiya by the University of Ruhuna (p.5).

The research culture in Sri Lanka, according to Siriwardhana et al. (2011), is influenced by ‘envy’ which fosters “subtle, long-lasting and unpredictable” effects which have had a significant impact on hindering research efforts in the country (p.81). In addition, the out-dated pedagogy of the university has also contributed to the dearth of research on mental health. Therefore, he notes that “research is not a popular career option for mental health professionals; many are often unhappy and seek ways of leaving the country, contributing to the brain drain” (p.81). Siriwardhana et al. (2011) argues that the dearth of research in Sri Lanka can only be addressed by improving critical skills of mental health professionals such as team work, networking and collaboration, negotiating, and supervising and training others. Ultimately, according to Siriwardhana et al., “increasing resource allocation or capacity building alone will not improve the research capacity in a developing country. A radical reform of the agendas of the scientific community and of policy makers to create an environment conducive to research is needed” (p.82).

Such a research environment is not unique to Sri Lanka. Siriwardhana et al. (2011) note that studies done on research outputs in Asia have found that research is largely conducted in private institutions. In keeping with this trend, Siriwardhana et al. note that “at the Institute of Fundamental Studies, Kandy, Sri Lanka, the research output in terms of per capita publications in journals quoted in the Science Citation Index in recent years has been nearly ten-fold higher than that of universities and other research and design institutions in Sri Lanka” (Samaraweera et al. 2008 and Waidyanatha 2002 cited in Siriwardhana et al. 2011). However, “a survey done among Sri Lankan researchers has revealed that some of the out-dated practices in government research institutions have made researchers in Sri Lanka 100–200 times slower than their foreign counterparts, despite the fact that they are on a par with their foreign counterparts in terms of competence” (Nanayakkara 2004 cited in Siriwardhana et al. 2011).

Siriwardhana et al. (2011) lauds the establishing of the Institute for Research and Development (IRD) whose aim was providing “a ‘bureaucracy-less’ environment to carry out research, to influence policy by concentrating on high quality policy relevant research, working with people standing to benefit from research and establishing strategic partnerships with individuals and institutions having similar aims” (p.79-81). The studies of De Mel et

al. (2013) and Catani et al. (2008), for example, that seek to establish the underlying causes of mental health and psychosocial problems are critical for designing appropriate services, especially in a context where there is substantive criticism levelled against services being externally designed, or transplanted from other contexts and, therefore, inappropriate in the Sri Lankan context. The question is: how can such research be incorporated into design, as there is often a gap between academics who conduct research and organisations that provide services. Two possible solutions would be the establishment of an ethics committee that makes it imperative for researchers to present their findings to service providers and collaborate with service providers when conducting research.

## 8.4 MHPSS Services in Need of Improvement

### Domestic Violence

The prevalence of domestic violence and substance abuse, especially alcoholism, is widely recorded as a severe problem affecting the wellbeing of individuals, families, and communities (*cf.* Kodikara 2012, 2014; Perera et al. 2011; Ranasinghe et al. 2010). Kodikara (2014) argues that cultural attitudes that hold women accountable for violence and the perpetuation of traditional gender roles contribute to the dismissal of domestic violence and the deepening of gender inequality (p.31-35). These attitudes are mirrored by the legislature, which opposed the Domestic Violence Bill “on the ground that domestic violence is not a matter for judicial intervention [and] appealed to family values, children’s welfare, Buddhist culture, the Catholic tradition, the western/NGO origins of the bill as well as local cultural narratives that trivialise and dismiss domestic violence” (Kodikara 2012, p. 9). Ranasinghe et al. (2014), in recording their experiences of establishing a community-based mental health clinic in the postal region of Colombo 15, note the high prevalence of domestic violence and substance abuse in the area. They recommend the development of special programmes and services that liaise with organisations dealing with these issues if the clinic is to be more effective (p.4). Perera et al. (2011) in their review of research evidence on the prevalence of gender-based violence assert that the health sector plays a critical role in identifying violence against women and supporting the survivor; and state that healthcare providers must be sensitised to play this role. They recommend that MHPSS services in the form of psychological counselling must be made available to both the victim and the abuser (p.34). Such an intervention, they acknowledge, would need a cadre of trained social workers, psychologists, and psychiatrists “to handle the emotional and psychological problems of both the victims and aggressors” (p.34). Perera et al. also strongly recommend that, in addition to revising the medical curriculum to challenge existing cultural beliefs and attitudes about violence against women, universities must offer “individual and group counselling services to medical students to help them overcome the severe consequences of exposure to violence in their families of origin” (p.34). This need was addressed to some extent, by 2015, with the inclusion of two modules on gender based violence and domestic violence, into the training manual for MOMHs on “Management of Mental Health Problems: A guide for the doctor in the community”, published through collaborative efforts of the Sri Lanka College of Psychiatrists, The Asia Foundation and USAID.

## **Child Abuse**

Shanmugam and Emmanuel (2010) record that a significant number of adolescent girls in Batticaloa have experienced sexual abuse—at least one in every 30. Service provision is limited because

“Credible and accurate estimates of the nature and extent of sexual violence and abuse of children in Sri Lanka do not currently exist, making it difficult for service providers to assess the scale of the issue, plan targeted responses and advocate for essential services. A major factor in the information gap is the lack of a robust, cost-efficient and ethical methodology to collect information on the incidence of sexual abuse of children” (p.5).

In the case of services available for children who have suffered abuse, Colombage et al. (2005) note that there are major flaws in the current system, notably the lack of a proper system of medical care, the absence of proper monitoring or follow up of victimised children, and delays in finding foster homes (pp.16-17). Moreover, they note that there have been serious challenges in implementing ‘case conferences’ for victims (p.16). A lack of infrastructure for follow-up and family support has led to frequent re-admissions and a heightened risk of rejection (WHO 2004). A later study by Emmanuel et al., in 2015, identified that the moral standpoint prevalent in health services discourages under-aged pregnant girls from accessing health services for the fear of being reprimanded.

## **Other Significant MHPSS Service Needs**

The reviewed literature also indicates lesser attention given to psychosocial distress and psychosocial needs of some groups. The low frequency of these MHPSS issues and service requirements point to possibly fewer psychosocial support interventions to address these needs. For instance, Williams (2011) discusses psychological morbidity of people who have recovered from snakebites. Although 50% of people who have undergone significant levels of envenoming typically show depressive symptoms between one to four years after the experience, Williams (2011) points to a lack of recognition of this mental health issue.

Another example of less discussed, but significant conditions of psychological distress is of people suffering from chronic filarial lymphodema also known as elephantiasis: The swollen lower limbs lead to social rejection, sometimes from their own family; withdrawal; and gradual social exclusion resulting in anger, bitterness and depression (Wijesinghe 2007). Similarly, Armstrong et al. (2014) draw attention to the plight of people dealing with spinal cord injuries and calls for multi-disciplinary interventions that include psychological support to facilitate rehabilitation of stabilised patients. The authors discuss an intervention carried out in collaboration with the Vanni Rehabilitation Organisation for the Differently-abled (VAROD) as a demonstration of the potential to help improve the mental health of people affected by spinal cord injuries through collaborative psychosocial responses.

On a different note, nevertheless bringing to attention a much neglected psychosocial issue, Kandiah and Senanayake (2007) discuss the need for greater sensitivity towards women

drug users and for counselling and other psychosocial support programmes to help them deal with their drug addiction. The article focuses on the heightened social stigma these women face as drug users and the socio-economic contexts that often trap them in situations of domestic violence and economic burdens. Kandiah and Senanayake (2007) explore the existing rehabilitation programmes, which are mostly residential, and underline their inaccessibility for women drug users with family and child care giving responsibilities.

Although war related experiences figure extensively in the reviewed literature, there was marginal focus on the psychological distresses of personnel in the armed forces. Gunawardene et al. (2007:145) highlight the mental health problems of soldiers who have undergone amputation of limbs. According to their study 36% of the amputee soldiers studied recorded psychological distress. Being less than 30 years of age was identified as an aggravating factor and the study also indicated possible high consumption of alcohol and substance abuse

Disproportionate focus given to MHPSS issues of different geographical locations across the country are indicated in WHO (2008) observations which highlight the inadequate and less developed mental health services in geographical areas such as Nuwara Eliya, Puttalam and Kegalle.

MHPSS services for the following groups are not discussed widely in the literature reviewed. However, the needs of these groups are discussed as having distinct MHPSS needs that should be considered in service provision in Sri Lanka.

- Adolescents and Youth (*cf.* Dawson et al. 2012; Emmanuel et al. 2011; Fernando et al. 2010; Thalagala 2004; Miller et al. 2009; Ministry of Youth Affairs and Skills Development 2014; National Youth Policy Sri Lanka 2008; National Survey on Emerging Issues among Adolescents in Sri Lanka);
- People with disabilities (*cf.* Peiris-John, R. et al. 2013 *Disability studies in Sri Lanka: priorities for action*);
- Substance abuse, especially alcohol and tobacco (Jayasinghe 2008);
- The military and combatants (Gunawardene et al.2007; Hanwella et al. 2014; Hanwella et al. 2012; Jayatunga 2005; Kanagaratnam 2005). ;
- Migrant Workers (Hettige et al.2012);
- Snake-bite victims (Williams 2011).

## 9. Conclusion

### 9.1 The Expansion of and Improvement of Services after the Tsunami

The December 2004 tsunami enabled significant changes in the provision of MHPSS services in the country. Coordinating bodies like The Mangrove in the east, and the Mental Health Task Force in the north were local initiatives that spontaneously sprang up in

response to the influx of both local and international services following the tsunami disaster. Somasundaram (2007) notes that despite challenges of placing psychosocial and mental health concerns on the agenda and “the general stigma associated with mental health”, these bodies were successful in influencing policy making, rehabilitation and international aid programmes at the national, regional and district levels and managed “to make some contribution towards prevention and alleviation of the effects of individual and collective trauma” (p. 23). In fact, according to Somasundaram (2008), the tsunami enabled “for the first time [a] wide acceptance of psychosocial problems, the so-called ‘tsunami wisdom’, and there were considerable efforts to address psychosocial and mental health needs by the state, militants, NGO and INGO sectors” (p.10).

In fact, the “post-tsunami atmosphere” combined with the influx of international aid into Sri Lanka enabled some significant changes. The WHO was able to finally advocate successfully for a National Mental Health Policy and Plan (WHO 2005). It was during this time that significant reforms such as the decentralisation of mental health services and building up of the peripheral mental health services and infrastructure was made possible. National councils and committees on disaster management, planning and preparedness at various district levels were also constituted at this time. In addition, UNICEF introduced counselling and psychosocial capacity within the school system by working collaboratively with the Ministry of Education (Somasundaram 2008:11).

The response by UNICEF in dealing with children affected by the tsunami drew on a psychosocial rather than a ‘trauma’ approach that focused on returning children to school. An Emergency Education Desk was set up at the Centre for National Operations and a Task Force was established to support the return of children to school by the end of January 2005. Schools were not only cleaned and repaired but new buildings were designed with child-friendly facilities which prioritised girls’ needs with the following criteria (Oxfam 2006): locating schools within walking distance; ensuring primary-aged children had a school to attend; designing dynamic learning spaces; involving children in the locating, planning, and management of schools; and supporting teachers to build links with the community.

As noted in the introduction, following the tsunami, efforts have been made to decentralise mental health services. With the publication of the mental health plan in 2005, a few services have been introduced within the statutory sector. Although progress has been slow, the numbers of psychiatrists serving in in-patient units across the country and medical officers trained in psychiatry manning less populous locations have increased in the period under review. Weerasundera (2011) notes that “services are moving towards reasonable, if not comprehensive coverage of even remote regions” (p.43). Weerackody and Fernando (2011b) record the number of outpatient clinics and rehabilitation units that have been set up in many parts of the country as well in the peripheral hospitals (p.15).

Even though efforts are being made to change the staffing structure—a vertical programme from national to sub-district level— there are difficulties in integrating mental health into

primary health (Siriwardhana et al. 2013). Jenkins et al. (2012) argue that “neither the current nor the planned availability of MOMHs is adequate for MOMHs to be the front line health workers for mental health, and to see, assess and manage all those with a mental disorder” (p.16). They recommend that “it makes logistical sense that they should be viewed as the first level of specialist care, taking referrals from primary care, with more complex referrals being passed to district psychiatrists” (p.16).

Although in the past, capacity building of mental health professionals has been mostly limited to the medical postgraduate qualification system, following the tsunami, the state has taken steps “to train doctors as medical officers of mental health, a mid-career non-psychiatric category, tasked with easing the burden of the limited number of specialist psychiatrists working in the country” (Siriwardhana et al. 2011, p.78). Gambheera and Williams (2011) record the improvements to the medical health education in the universities that included eight weeks or more of full time exposure to different aspects of psychiatry and mental health where students are assessed “extensively on par with the other final year specialties.” They point out that

“most medical schools also have a behavioural sciences strand from the first year of medical training which focuses on holistic care, imparting empathy and sensitive communication with all patients and their carers. In addition to imparting essential knowledge, these measures also contribute to a positive attitude towards psychiatry among most medical graduates qualifying in this new stream with hopeful minimisation of stigma within the profession” (p.18).

In addition, efforts have been made to train family health workers (i.e. primary care staff). However, a majority of the primary care staff have not achieved the competency levels required to identify mental problems, manage common mental disorders, do referrals, and provide follow-up mental health care for those with severe problems (Budosan 2011; Ranasinghe et al. 2010; WHO 2011).

The state’s acceptance of the psychosocial impact of the tsunami contrasts, argues Somasundaram (2007), with its lack of acknowledgement of the mental health repercussions of the protracted ethnic conflict. The state’s lack of state accountability resulted in INGOs and NGOs stepping in to fill the lacuna. “Unfortunately”, argues Somasundaram, “many of these internationally supported programmes and structures tended to collapse when the funding stopped or INGO’s pulled out. The local partners and government [are] not able to maintain the momentum. This raises the question of long term sustainability.” While in the aftermath of the tsunami, state supported MHPSS services have become more widespread, “the national discrimination, inequity in distribution of resources and programmes, and exclusion of the north and east continue to be insurmountable hurdles” in addressing the mental health concerns of these two regions (Somasundaram 2007).

## 9.2 Post-War Challenges

According to Samarasinghe (2014), two critical issues in the post-war context undermine the long-term effectiveness of MHPSS services to facilitate healing: one is the inability to openly and directly address victims of torture due to the political implications of identifying victims and perpetrators; and secondly the prevalence of high-levels of poverty that severely undermine the healing process of people living in those areas directly affected by the conflict (p.373). In addition, the post-war milieu has led to the emergence of several socio-economic problems that state and non-state organisations must take into account in planning MHPSS services. The cessation of hostilities has meant that people are no longer concerned about survival and are making long-term plans for the future such as the education of their children and investment in assets. To meet these economic needs, provision must be made for sustainable livelihoods (p.374). The absence of the LTTE's authoritarian regime has led to the emergence of old and new problems. Many of them are gendered and, therefore, have serious implications on women's lives: caste-based issues including discrimination and practices such as dowry and censure of inter-caste marriages; increasing incidents of domestic violence as well as incidents of rape; moral censure of women; the social and economic issues of widows who have been abandoned or cannot prove legal marriage; and the rehabilitation and reintegration of ex-combatants especially women (p.374-379). In the Sinhala areas, the presence of soldiers in the home and the substantive number of disabled soldiers are creating tensions in families and have also led to increasing incidents of domestic violence (p.375).

The MHPSS sector faces many challenges in providing adequate and meaningful services to people who have suffered for more than three decades. Samarasinghe (2014) records the high number of torture victims who are seeking counselling because they had been afraid to approach services during the time of the conflict (pp.384-385). In addition, prisons and courts are also referring victims of torture to service providers who face human resource challenges when catering to the increased numbers as well logistical difficulties in providing group counselling for victims from different cultural backgrounds, such as not having a common language with which to conduct the group therapy sessions (p.385). Government restrictions on international funding and the state's suspicion of the international humanitarian community immediately following the end of the war led to the drastic reduction of funds for MHPSS services (p.385). Although the state has expanded its MHPSS services, its narrow view of MHPSS services as mainly 'counselling' has meant less emphasis on psychosocial interventions (ibid). The tense political situation after the violent end to the war also restricted service providers from helping people in the war-affected areas because of the threat of arrests and detention (p.386).

Samarasinghe points out how development interventions under the aegis of President Rajapaksa had focused on infrastructure development with less emphasis on concrete measures and mechanisms for reconciliation and peace building (p.389). The 'Lessons Learnt and Reconciliation Commission (LLRC)', however, provided "many from the [directly affected areas] a space to air their grievances" and Samarasinghe argues that the emphasis on redress and justice means that "reconciliatory steps have to be taken



at the community level if lasting peace is to be ensured” (p.391). What is critical here is what Samarasinghe’s research study highlights: the important role the MHPSS service providers, who intervene using an explicit or implicit psychosocial framework, have to play in reconciliation. The organisations who participated in the study have all taken steps to introduce a reconciliatory element to their programmes. This has meant bringing together people with similar traumatic experiences, but from different ethno-religious backgrounds in order to establish common ground between them. For example, the organisation in Mannar actively involved Tamil women in rebuilding houses for Muslim women (p.391). Organisations have encouraged Sinhala and Tamil communities to interpret the conflict not as an ethnic one but as a “dispute between two armed groups” (pp.391-392) while other organisations have encouraged people “to think of themselves as Sri Lankans” (p.391). The flexibility of the psychosocial framework in accommodating issues of justice, reconciliation, and peace in meaningful ways points to the critical role the MHPSS sector will have to continue to play in Sri Lanka.

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Counselling Assistants, Ministry of Women and Child Affairs  
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# Sustainability of Mental Health and Psychosocial Support Services after Disaster and Conflict in Sri Lanka: A Desk Review of the Literature

By Ananda Galappatti and Sabrina Cader

## Introduction

This chapter presents a desk review of the current literature on the sustainability of mental health and psychosocial support (MHPSS) services established in response to disaster and conflict in Sri Lanka. Despite a growing concern with this issue, there has been no global overview in relation to publications on this topic since the report “Transitioning Mental Health & Psychosocial Support: From Short-Term Emergency to Sustainable Post-Disaster Development” produced by Patel et al. (2011) for a Harvard Humanitarian Initiative Working Group on MHPSS. This desk review has sought to update this overview with more recent studies, and also widen the literature search to cover broader bodies of literature. This chapter reports on the findings in relation to interventions responding to humanitarian emergencies in Sri Lanka.

## Methodology

The study team planned to systematically review the available global literature in relation to sustainability and transitions in mental health and psychosocial support. This was to involve a search of key international academic databases, online websites and the internal collections of articles accumulated by The Good Practice Group and The Asia Foundation, using all possible combinations of specified search terms. The identified material was subjected to an initial screening to ensure that the content was relevant to the review topic. Selected publications were then subject to an independent review before selection for inclusion in the desk review. Relevant content was finally subjected to thematic analysis to generate an overview of key issues arising from the literature. For this chapter, a selection was made from the global literature of those publications with an explicit reference to sustainability issues in Sri Lanka, and the content of these 42 publications was utilised in the preparation of this review. Any content in these publications that was unrelated to Sri Lanka (i.e. was relevant to another specific context) has been excluded.

## Search strategies

Three sets of key terms that constituted the search criteria for inclusion in the review were as follows:

1. “Mental health” OR “psychosocial” OR “psychological”  
AND
2. “Conflict” OR “disaster” OR “war” OR “emergencies” OR “fragile state”  
AND
3. “Sustainability/Sustainable” OR “Transition” OR “Integration/Integrating” OR “Systems”.

All possible variations of these terms (which amounted to 60 search permutations in total) were entered into databases, search engines, and other tools.

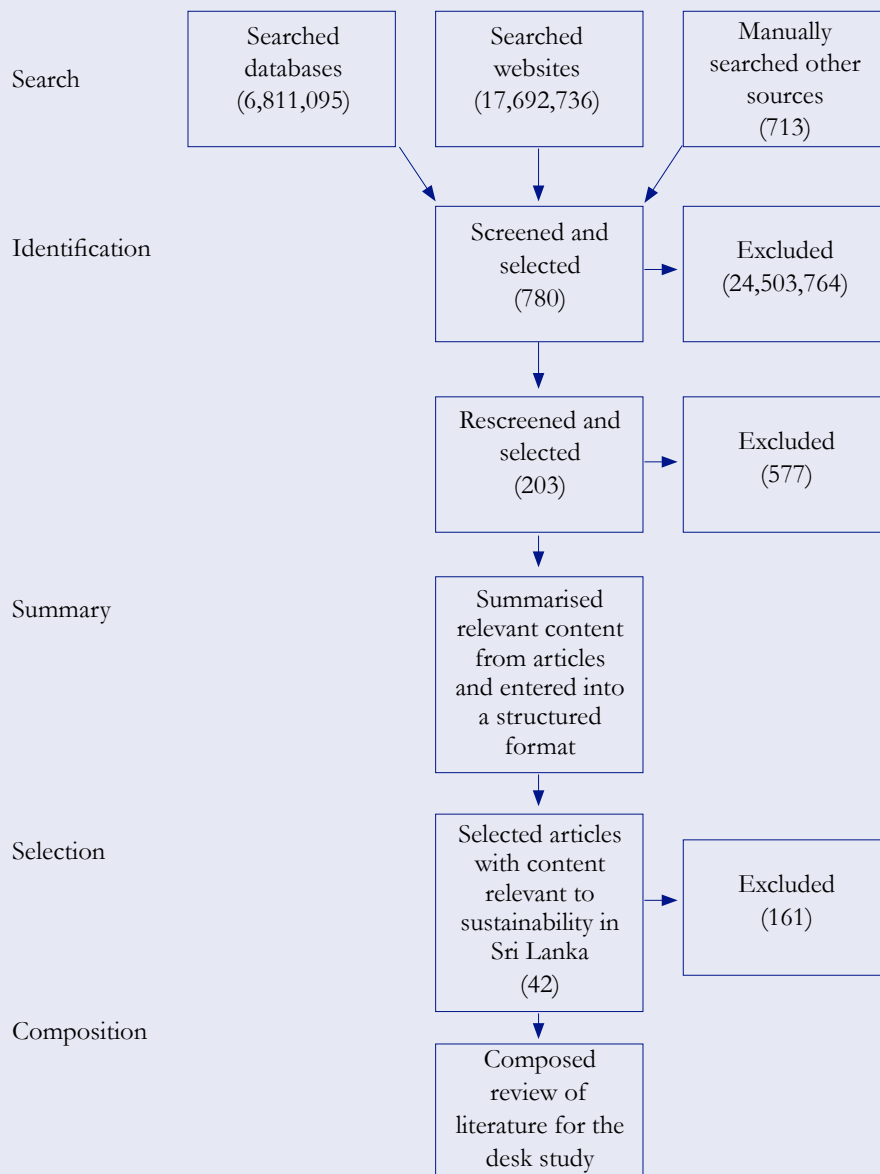
The academic databases that were searched in the above manner were PubMed, PsycINFO, PILOTS and JSTOR. In some instances (especially in the cases of PsycINFO and JSTOR), the searches yielded vast numbers of results (often in the order of many tens of thousands of articles) that were not filtered appropriately by the search engine. Due to time constraints and limited human resources, it was decided to pragmatically limit the search of academic databases to an initial screening of the first 1000 search results only.

Online sites that were searched using the same search strategy included Google Scholar, FMO repository, Intervention Journal and MHPSS.net. As Google Scholar too returned poorly filtered and unmanageable numbers of articles for each search permutation, the pragmatic limit to screening were the first 1000 results for each of the 60 permutations.

The archive of MHPSS related publications on Sri Lanka maintained by The Good Practice Group and the database materials collected for the concurrent literature review (Abeyasekera and Wettasinghe 2016) commissioned by The Asia Foundation were both searched manually by scanning through the individual documents and reviewing whether or not they fit the inclusion criteria.

In addition to the key terms that were used to refine the search, the literature selected had to be either an article, report, editorial or essay. Book reviews, popular magazine articles and webpages were specifically excluded from the review. Further, only documents written in the English language were selected for inclusion. For this chapter, only documents explicitly referencing Sri Lanka were selected for review.

Figure 1: Process Overview



## Findings

The content dealing with the issue of sustainability that was included in the desk review can roughly be categorised as falling into the following three categories:

1. Making a case for the need for sustainability,
2. General statements or views on what factors promote or limit sustainability,
3. Reporting on factors that have impacted on sustainability in a specific context.

## The Case for Sustainability

### Assertion of Need to Sustain Services

In their review of interventions for children affected by war, including a number of studies conducted in Sri Lanka, Betancourt et al. (2013) highlighted the importance of sustainability, claiming that “Humanitarian organisations supporting psychosocial and mental health programmes in conflict and war-affected countries need to systematically integrate a longer-term perspective into their work.” They argued that while, “Budgetary support, technical assistance, and incentives from the international community can deliver immediate and emergency psychosocial support and mental health care, political will is needed to galvanise the actual reforms that would build and strengthen systems at the local level. Overall, a dramatic paradigm shift must occur from the deployment of short-term “Band-Aids” to lasting investments, staffing, and technical support.”

Making the case for sustained services, Betancourt et al. (2013) highlight, “the potential of approaches that begin with broad-based stabilising interventions for all war affected children but that move toward increasingly specialised treatments for those children who do not respond to general treatment approaches (i.e. a stepped-care model)”. They argue that, “An additional promising element of interventions to maintain improvements over time is that they provide an ongoing opportunity to build capacity and strengthen systems. Depending on how emergency interventions are delivered, these programmes can help to build or augment sustainable systems of care and establish mechanisms for training, supervision, and sustained employment of mental health workers serving war-affected youth. When systems used are *ad hoc* and incapable of being sustained beyond the emergency period, an opportunity is lost.”

Commers et al. (2014) invoke the notion of sustainability as a key goal of MHPSS responses by highlighting the importance of, “conforming to the widely accepted criteria that interventions be both culturally appropriate and sustainable”.

Ashraff (2005) reports in the WHO Health Bulletin in the immediate aftermath of the Indian Ocean tsunami on assertions by several mental health technical specialists of the need for long-term and sustainable services to be established, rather than an emphasis on short-term emergency response or a narrow focus on specific disorders like PTSD.

D’Souza and Singh (2005), also writing soon after the tsunami disaster, recognise, “the temptation to implement short-term measures to alleviate suffering,” but urge that this, “must be accompanied by a long-term plan to rebuild essential mental health services at the primary, secondary and tertiary levels,” stating that, “this will mean not only empowerment of the people, but preparing the population for future disasters and emergencies”.

Describing the short-term psychosocial response after the 2004 Indian Ocean tsunami disaster, Carballo (2006) writes that, “It should also be borne in mind that although hundreds of relief agencies came to work on psychosocial issues, few have stayed on; a reminder that humanitarian relief is often seen as short-term by the agencies and the



donors involved, when in fact many of the problems are of a longer nature. That most of the agencies have already gone is also a reminder that recovery strategies are ultimately the task of local communities and health and social authorities. External groups cannot always be relied on to stay for long periods. Strengthening the capacity of local communities thus needs to be given far more priority than it has in the past, and there needs to be far greater acknowledgement of the role they can and do play in developing and sustaining psychosocial as well as other health actions”.

Also writing about the humanitarian response to the 2004 tsunami, D’Souza and Singh (2005) acknowledge “there is a temptation to implement short-term measures to alleviate suffering,” but argue that “This, however, must be accompanied by a long-term plan to rebuild essential mental health services at the primary, secondary and tertiary levels.”

Danvers et al. (2006) assert that, “the needs of those affected by the tsunami must be balanced and integrated with those of the rest of the population.” They also express the hope that the “unprecedented attention given to mental health by the Sri Lankan government, media and public” “will provide an opportunity for Sri Lanka to reinforce and restructure mental health services for the benefit of the whole population.”

Amaratunga and O’Sullivan (2006) identify the changing nature of psychosocial issues throughout the disaster cycle, across the phases of preparedness, response and recovery, and argue for the need to engage continuously with these.

Minas (2012) states that “Failure to sustain long-term gains from even well-designed and implemented community mental health system development projects is a source of serious concern and is all too common.”

### **Need to Know About Sustainability of Benefits**

Betancourt et al. (2013) point to the fact that although the, “Inter-agency Standing Committee guidelines prescribe sustained care for individuals with mental health issues,” little is known about the lasting benefits of interventions for individuals with mental health issues. To illustrate the importance of this, they cite one case where intervention effects of a school-based group intervention based on Cognitive Behaviour Therapy (CBT) were no longer maintained just 2 months post-intervention in the absence of continuing care.

Reporting on the effectiveness of a post-tsunami mental health training programme for primary health care staff in Hambantota District, Budosan and Jones (2009) also highlighted the need for research to evaluate the sustainability of the effects of this intervention, pointing to risk that improvements in services may be compromised by limited resources in developing country contexts. Budosan et al. (2007) posit that, “one of the problems post-disaster is that external agencies intent on training will overload the same unfortunate worker with numerous trainings (e.g. HIV, malaria, trauma) with the result that time is taken out of his/her work, while at the same time no thought is given to how he/she will sustain or deliver

on all his/her new sets of skills, or how multiple new skills can be integrated. A second problem is the failure to provide follow-up and supervision after short courses, so that trainees are left floundering when seeing actual cases.”

## **Assertions of What is Needed for Sustainability**

### **Universal vs. Targeted Coverage**

Writing about services for children living in conflict-affected communities, Armstrong et al. (2004) take the view that psychosocial interventions that use, “approaches that do not single out particular children but instead look at processes that may contribute to the wellbeing of [community] children in general,” are likely to be more socially acceptable and have greater sustainability.

In a review on ‘psychosocial adjustment and social reintegration of children associated with armed forces and armed groups’, Betancourt et al. (2008) argued against stand-alone services for this group of vulnerable youth, and instead advocated that there be, “investments in locally viable and sustainable systems of psychosocial and mental health interventions for all war-affected youth with particular expertise to respond to highly traumatised groups”. They also call for operational research to understand how services function in terms of providing viable, sustainable and effective systems of psychosocial and mental health care, suggesting that, “qualitative and quantitative research with beneficiaries and providers from front line staff to higher level leadership can illuminate critical issues in the implementation of mental health care in low resource settings.”

### **Use of Locally Available and Relevant Resources, Healing Systems and Conceptual Frameworks**

Armstrong et al. (2004) also, “recommend use of local concepts and understandings of trauma and mental health whenever possible rather than importing categories and notions from outside the cultural context since this makes use of local resources and systems of healing more feasible, thereby increasing sustainability”.

Reviewing interventions for children associated with armed groups, Betancourt et al. (2008) also assert that, “service systems should be developed to capitalise on indigenous supportive responses and capacities”. They highlight the need for training of local staff, ensuring mechanisms for sustainable funding and supervision to ensure that these services, “do not vanish once the period of humanitarian emergency subsides.” Betancourt and colleagues also advocate for the development of service systems through close collaboration and leadership from local governmental and non-governmental actors, “to build technical capacity, collaboration and referral networks and the political will to develop and sustain systems of care”. They caution that, “without attention to long-term sustainability issues and how trained local staff might be supported and provided with high-quality supervision, even the most well-intentioned outside effort may be misguided”. Betancourt et al. take the view that, “partnership between international NGOs and local NGOs and CBOs at the grassroots level,” is critical to build the local capacity to sustain

services beyond the limited timeframe of work by international agencies. They suggest that close collaboration between local government, international donors, international agencies and civil society is required to develop context and culturally-relevant and sustainable systems of care.

Somasundaram (2006) has suggested that to ensure sustainability, “Efforts should be directed at capacity building, so that local people become skilled in giving psychosocial help. In these training and skill building activities, importance needs to be given to local resources, particularly from the traditional sectors. Helpful traditional familiar methods may need to be identified and encouraged rather than importing western methods that may not be effective in the local cultural context. Practitioners already experienced in these methods may need to be found, encouraged, and coaxed to take part in psychosocial programmes.”

Fernando and Weerackody (2009) argue in relation to post-tsunami mental health development processes that, “Mental health services in low and middle income non-western settings should be ‘home-grown’, suited to the cultural context and needs of the communities themselves, and not based on models imposed from outside. Also, they should be sustainable and supported by the communities they serve.” The model they propose for programme development is of a, “mutually beneficial learning partnership”, between communities, agencies and researchers, that results in devising, “a sustainable and effective system of community care linked to the health and social care systems in the district. [The] exact nature [of this] will depend on the priorities and approaches identified by the community, combined with assessments of feasibility, and consideration of models suggested by agencies and universities”, evolving through a process of community development.

### **Sustainability of Intervention Benefits may Require Changes Across a Number of Domains.**

The review by Betancourt et al. (2013) also makes the point that since “the gains made to psychosocial wellbeing in a short, school-based interventions programme may not be sustainable without additional changes in familial, peer, and community supports, further integration of these interventions within family and community-based models is well warranted, as are strategies to reduce poverty and social/political conflict and to improve employment opportunities and educational access.”

Budosan and Jones (2009) take the view that, “mental health investments in primary care are important but are unlikely to be sustained unless they are preceded and/or accompanied by the development of community mental health services.”

Jones et al. (2009) argue for the need for external agencies responding to humanitarian crises to collaborate with existing health services and authorities to facilitate sustainable care, illustrating this with the example of how agencies in post-tsunami Sri Lanka, “substantially contributed to the development and continuous implementation of a national mental health strategy in the country”.

Saxena et al. (2006) put forward the view from WHO that, “the only sustainable way to respond to the psychiatric needs of large populations affected by disasters is to develop mental health services as a component of the health services.” They identify the use of a community mental health model, mobilisation of resources to sustain services, and research on sustainability as key elements to ensure continuing provision of appropriate services.

Minas (2012) takes the position that, “effective mental health system development is not possible without sustained and distributed leadership.”

### **Evidence and Accounts of what has Influenced Sustainability**

Patel et al. (2011) share several examples from Sri Lanka to illustrate factors that promoted or hindered sustainability of MHPSS services during the transition after emergency response. One positive account was how the existence of a draft provincial mental health plan and practices that had not been previously capitalised on because of a lack of resources and political will, could be used to formulate a national mental health policy when the tsunami disaster led to an influx of funds, overwhelming stakeholder support for MHPSS and opportunities for external agencies to partner with the national government. A cautionary example was also given of how gender-based violence initiatives by NGOs, international agencies and central government have undermined existing effective local models by seeking to replace them with untested ‘standardised’ programmes or drawing local human resources away from more sustainable local structures. This was contrasted with approaches by an international agency that conducted, “a rigorous, independent and confidential stakeholder analysis before designing [a] programme for support to mental health.” In another example, the lack of accreditation for staff trained for emergency response was shown to have severe negative consequences for sustaining their services despite 8 years of work in a local hospital, as they were disadvantaged in relation to, “new less capable novices,” who had recognised credentials. Patel et al. argue that, “Simply measuring its short-term impact (for example, through measuring the immediate improvement in patient outcomes) or whether it was sustained long-term is insufficient”. They assert that, “a sustained service that is neither fully accessible nor acceptable to the local population is of little use,” and give the example of, “a drop-in centre for women affected by GBV to “hangout” in post-tsunami Sri Lanka which was largely unused due to its remote location and the culturally unfamiliar framing of the intervention.” Patel et al. report that, “even in situations where donors wish to provide funding for MHPSS relief, large amounts of funds could instead work to undermine existing, effective service providers who understand the local context, or could introduce interventions that are not proven to do more good than harm.” They give the example of Sri Lanka, where pre-tsunami funding cycles for interventions averaged over three years for programmes, but by contrast, “post-tsunami funding more often saw much shorter funding cycles, even for only a few months. The tight timeframes often led to an over-supply of costly short-term or superficial interventions (i.e. children’s activity festivals), rather than the financing of long-term community mental health services.” They also report that, “the dramatic drop in external financing available after the post-tsunami boom, and the subsequent end of the armed conflict in 2009 has resulted in a shrinking of the field to below pre-tsunami levels,” and highlight that, “the harm in this case was

that a dependency on generously funded and externally staffed programmes has seriously impaired the capacity of local support structures to sustain required services.”

Drawing on examples from practice such as those given above, and on limited global publications on the topic, Patel et al. (2011) recommend the following key considerations to ensure sustainability: 1) Is there an existing strategy, framework, or policy in place? 2) How, and to what extent, should government be involved? 3) How do we sustain buy-in from the government? 3) Leverage existing human resources and understand management structures. 4) Facilitate long-term mentoring and apprenticeship. 5) Develop leadership and ensure professional support. 6) Accreditation may be essential. 7) Train everyone at every level and develop sustainable supervision structures. 8) Sustainability in development requires addressing the whole system. 9) Allow for different entry points for sustainable MHPSS Services. 10) Consultation from various community stakeholders is essential. 11) Plan for long-term sustainability from the outset, even with short-term interventions. 12) Do not forget to address neglected and vulnerable groups. 13) It is necessary to combine service delivery and research. 14) Funding for continuing monitoring and evaluation is essential. 15) One of the best measures of impact for a majority of MHPSS interventions is restoration of functioning at the individual or community level. 16) Success is determined by the sustainability, acceptability, access, and impact of the given intervention. 17) Consider the costs: “Emergency funding” should be for a minimum of 1–2 years. 18) Large amounts of short-term money can sometimes do more harm than good. 19) Innovate mechanisms for reserving or investing money for long-term use.

### **Financial Resources**

A review of interventions for war-affected children by Betancourt et al. (2013) highlighted the importance of cost-effectiveness in ensuring sustainability, illustrating this with examples of feasible interventions with groups in school and community settings, and even multiple-family groups in community programmes. Jordans and colleagues’ (2011; 2013) study of cost-effectiveness in multi-layered psychosocial care packages in Burundi, Indonesia, Sri Lanka and Sudan also highlighted the need for reduction of human resource costs, which they identified as being the largest contributor to overall cost. De Silva et al. (2014) highlight the fact that despite the effectiveness of the multi-layered interventions described by Jordans et al. (2010; 2011; 2013), except in the case of Burundi, the end of project funding resulted in the termination of the programmes in all countries, including Sri Lanka.

### **Limited Resourcing in Conflict Settings**

Writing about the situation in the conflict-affected Northern Province, Somasundaram and Jamunanantha (2001) state that, “sustaining long-term counselling and other programmes due to lack of funding from donors is another problem.” Somasunderam (2006) argues that in Sri Lanka the state had not accepted responsibility for the mental health consequences for the war, and “thus it has been left to international and local NGOs to provide limited and urgent help.” He claims that, “without the involvement of the state, the long-term sustainability of these programmes cannot be maintained. An important constraint is the lack of human resources. Trained individuals tend to leave the area of conflict.” Somasundaram

(2007) has reiterated and expanded on this perspective, writing that, “although there was wide acceptance of psychosocial problems due to the Tsunami and there were considerable efforts to address these by the state, militants, NGO and INGO sectors; the state is still to accept or take responsibility for the psychosocial problems arising from the war. As such it was left to INGO and local NGO’s to carry out psychosocial interventions and programmes. Unfortunately, many of these internationally supported programmes and structures tended to collapse when the funding stopped or INGO’s pulled out. The local partners and government were not able to maintain the momentum. This raises the question of long term sustainability”.

Nagai et al. (2007) also mention the limited human resources allocated by the health sector for mental health in the Northern Province of Sri Lanka, and highlight the sporadic nature of counselling services offered by NGOs with limited budgets.

Sivarajah (2012) in a report on psychosocial service providers in northern Sri Lanka highlights how innovative informal arrangements in service delivery - such as a multi-disciplinary team approach within government health services - face challenges to sustainability due to a lack of ‘official recognition by the Ministry of Health and a reliance on *ad-hoc* financial assistance from NGOs.

### **Leadership**

Describing work to support the development of mental health services in the Southern Province of Sri Lanka, Minas (2012) reports that, “a year after the completion of the project, the system developments that were accomplished are being sustained and extended by government support.” He argues that the most important amongst the lessons learned from this process was, “that leadership matters most and that effective mental health system development is possible even in unusually difficult environments”. Minas asserts that, “without skilled, sustained leadership at multiple levels—most importantly, from national and local governments—efforts to develop or strengthen mental health systems will fail”. He states that, “in order for such development to succeed, it is necessary to build partnerships that can be sustained over the long haul. The quality of the relationships will be much more important than the specific details of project design. These relationships, like any others, need to be based on such things as honesty, mutual respect, and trust, supplemented by a joint commitment to equity and to protecting the rights of people with mental illness. It is also helpful and even important to enjoy each other’s company—which makes it easier to continue working collaboratively when things might not be going so well.”

Ganesan’s (2011) account of his role as a government consultant psychiatrist developing and maintaining mental health services in conflict and post-disaster contexts highlights the empowerment of staff, strategic use of limited human resources for mental health and mobilisation of community resources, and fostering of networked services in the community as key strategies employed.

### **Working with Government**

Writing about the American Red Cross post-tsunami responses in Sri Lanka, Dayal (2006) describes how, “The Psychosocial Support Program (PSP) has established formal relations with the Ministry of Education and the Ministry of Social Services and Welfare. These relationships have led to participating in committees, conducting capacity building activities, planning joint activities, and preparing a crisis intervention professional programme of study,” and claims that, “these interactions with the Government of Sri Lanka will help ensure the programme’s long-term sustainability.”

### **Participatory Development and Ownerships**

Writing more generally about the approach taken by the American Red Cross in post-tsunami Sri Lanka, Prewitt Diaz (2006) states that, “the long-term development psychosocial support programme is predicated on participatory planning by community members. The process proposes a set of community activities that will lead to community ownership, the development of human resources, and the sustainability of a representative community planning mechanism.” He argues that, “the meaningful participation of project beneficiaries in the assessment, planning, and implementation stages is essential in generating appropriate activities, a sense of ownership, and increased likelihood of sustainability.” In a later publication on this approach, Prewitt Diaz (2008) asserts that, “The results are sustainable because community-based psychosocial activities become part of the recovery process,” and that, “for sustainable reconstruction efforts, the community is the principal entity that should make choices about what needs to be done for rebuilding life”.

### **Use of Local Frameworks and Resources / Integration with Existing Systems of Care**

A PhD study by Jayawickrama (2010) described the, “lack of usage of available cultural tools,” and lack of community ownership of projects as creating a barrier to sustainability for interventions examined in Sri Lanka. He argues that this was due to the, “projects [under review] lack[ing] community ownership where the community could bring their strengths, traditional knowledge systems and cultural tools” and in one case study from Batticaloa, identified the influence of an international partner in changing the nature of the project as undermining community ownership and sustainability.

Jordans et al. (2010) argue that, “integrated, non-vertical care systems...are likely more sustainable and cost-effective.” They also state that “working with traditional healing and religious practices, availing norms and coping is preferred for reasons of availability, sustainability and cultural sensitivity,” and that, “active community involvement taps into the responsibility of the community to support, reducing dependability on external service/resources.” Reporting on work to develop multi-level interventions for children in conflict settings, Jordans et al. (2010) caution that, “a care package approach, even with non-specialised paraprofessionals, may be difficult to sustain with limited financial resources,” and also suggests that, “sustainability of a system of care will depend in part on the level of integration with existing systems of care,” cautioning that a, “stand-alone care package risks fragmentation and competing parallel care systems

solely dependent on outside financial and technical inputs.” In addition, they argue that, “integration of a care package into existing community and government systems tends to reach more people, be more sustainable and carry fewer stigmas.” In a later publication on the same programme, Jordans et al. (2013) reported that, “one of the most challenging aspects of building a care system was to integrate the package within existing community structures and to make use of existing resources”, and identified both a strategy to work more closely with existing community structures (i.e. parent-teacher associations for work with schools) and a general recommendation for more work on, “developing and evaluating strategies to integrate the care package into existing governmental structures to ensure sustainability”.

Miller and Rajapakse’s (2007) evaluation of a technical assistance project in post-tsunami Sri Lanka raised questions about the sustainable impacts of manual development and primary health sector training activities in the absence of operational infrastructure (i.e. staff and community centres) and a field-level commitment to implement activities or approaches covered in the training. In contrast, training content and activities on adolescent life-skills for tsunami-affected students were reported to be sustainable due to successful integration with an existing programme in secondary schools.

Betancourt et al. (2008) state that despite increasing interest in, “lasting positive and productive opportunities for youth,” in post-conflict peace-building, there is a, “consistent failure of development agendas to invest in developing systems of care beyond primary health care and education (i.e. child protection, social welfare systems),” and that, “short-term humanitarian psychosocial and mental health interventions must be translated into sustainable investments in developing and sustaining a local system of child and family services that can endure beyond the immediate emergency phase”. They report that, “the lack of a specific political mandate, the enormity of problems on the ground, and inadequate support from dedicated but technically ill-equipped government leadership in the child protection and social welfare sectors has meant that the majority of high-risk youth are often left to fend for themselves”. Betancourt and colleagues assert that, “field experience has taught us that one of the greatest contributions ‘outside’ mental health specialists can make is to employ their significant skills as facilitators to help those who naturally play a role in the lives of children (teachers, religious leaders and community mentors) to get back to doing so in an effective and sustainable manner”. They argue that this requires a focus on, “improving outcomes and developing a system of care that can operate in a holistic, sustained and integrated way”, and call for, “investments in improved and locally-valid assessment and treatment planning along with improved clinical training, supervision, programme evaluation, management, professional development, and sustainable funding”.

In a review of disaster mental health psychosocial support in South and South-East Asia, Satapathy and Bhadra (2009) identified the sustaining of mental health and psychosocial support through integration into the primary health care system in Sri Lanka as a good example of the promotive and preventive measures taken by crisis-affected countries. However, they identified that rather than depending primarily on services provided by local



and international NGOs, “[Sri Lankan] Govt. disaster management protocol and institutional mechanisms [need] to include [psychosocial care] in their protocol of post-disaster regular service provisions,” as this is, “the most sustainable form of basic community based disaster psychosocial care.” Satapathy and Bhadra also noted more generally that, “inter-sectoral cooperation has [emerged] strongly [as a factor] for a sustainable community based disaster psychosocial and mental health service”.

Tribe (2004) describes how a cascade approach to training community members to carry out play activities for children affected by war in Sri Lanka, “rendered the programme sustainable,” and increased community ownership and adaptation of the intervention.

VSO (2013) reported that, “one of the main challenges to all of the trainings,” in their mental health programme implemented in Sri Lanka, was, “continuity and sustainability,” due to, “internal and external staff rotations and transfers [that] disrupt the dissemination of knowledge and skills between practitioners.”

Jenkins et al. (2012) report on a training of trainers initiative that involved a partnership of the World Psychiatric Association, the Ministry of Health, and the National Institute of Mental Health, using the Sri Lankan UK diaspora and the WHO Collaborating Centre, Institute of Psychiatry, King’s College London in order to ensure that the training was suitable for Sri Lanka, fitted into wider Sri Lankan initiatives, and had a chance of long-term sustainability. Despite this, they highlight a number of key challenges to this, including fears that trained Medical Officers for Mental Health move on from posts faster than their replacements can be trained, and that Ministry of Health funding for roll-out has been difficult to obtain because of financial constraints (and limited budgetary allocations) for mental health.

Commers et al. (2014) outline the general success of the Happy/Sad Letter Box (HSLB) Project, implemented in 68 schools in Sri Lanka’s Hambantota District, which succeeded in, “accommodating the full range of children’s daily stressors” and which was also, “sustainable”. More specifically, they make a case for sustainability with the finding that, “100% of students, 97.6% of teachers, 100% of teacher counsellors and 100% of principals believed that the HSLB Project could and should be continued.” However, they also report that actual behavioural evidence indicates otherwise, and note that, “by January 2006, boxes were being used noticeably less frequently than when first introduced.” Still, Commers et al. (2014) make an observation that the project, “enjoyed the support of principals and educational zone directors with the former declaring that they themselves saw it as a long term strategy. Hence, there seems to be little question that the intervention was both culturally appropriate and politically sustainable.”

### **Response to the 2004 Tsunami**

Reflecting on mental health training of primary health care workers in Sri Lanka, Pakistan and Jordan, Budosan (2011) argues that “More sustainable changes in their mental health care practices were achieved only as a result of several factors combined together: a)

professionally designed and implemented mental health training; b) motivation by all key players to develop community mental health services; c) political will by the government followed by formulation of a mental health policy promoting integration of mental health in primary care; d) good timing of the programme; and e) influx of funding and professional expertise.” He illustrates this by describing the role that training of health care staff played in catalysing the development of broader community mental health care services in Kalmunai, Sri Lanka.

Describing efforts to ensure sustainability of training provided to mental health service providers in Kalmunai and Ampara, Budosan et al. (2007) identified continuing external technical supports from psychiatrists in Kandy and from the UK as key factors, as well as formalisation of mental health service clinics and Medical Officer for Mental Health posts by the health authorities.

Mahoney et al. (2006) identified the modest pay rate of \$2 per day offered to the 500 Community Support Officers recruited to provide frontline support within the 14 tsunami-affected districts as a strategy to ensure sustainability and proportionality to the existing economy (whilst acknowledging this was considerably less than was being paid by many NGOs at the time).

Kohan et al. (2011) identified conditions that allowed Sri Lanka to use the response to the 2004 tsunami disaster as an opportunity to improve mental health services, highlighting the following: “mid-income [status], political willingness to implement a process of reform, minimal number of professionals, and a five-year plan developed as collaboration between the government and the WHO”.

Sundram et al. (2008) also recognise that following the 2004 tsunami disaster, there was, “wide acceptance of psychosocial problems, the so-called ‘Tsunami wisdom’, and there were considerable efforts to address psychosocial and mental health needs by the state, militants, NGO and INGO sectors. Using the conducive post-tsunami atmosphere and generous international aid, the WHO was able to push through considerable reform including a National Mental Health Policy and Plan, decentralisation of mental health services and building up of the peripheral mental health services and infrastructure”.

Krishnakumar et al. (2008) describe how efforts to sustain coordination of MHPSS responses in northern Sri Lanka, “ran out of steam” ten months after the 2004 tsunami disaster, and claimed that there were, “no mechanisms to sustain,” the local coordination structure.

### **The WHO Model of ‘Building Back Better’: Sri Lanka as a Case Example**

WHO (2013) takes the view that, “Emergencies present unique opportunities for better care of all people with mental health needs. During and immediately after emergencies, the media often rightly focus on the plight of surviving people, including their psychological responses to the stressors they face. In some countries, senior government leaders express

– for the first time – serious concern about their nation’s mental health. This is frequently followed by the willingness and financial ability of national and international agencies to support mental health and psychosocial assistance to affected people. In other words, in emergencies, attention and resources are turned towards the psychological welfare of affected people, while decision-makers become willing to consider options beyond the status quo. Collectively, these factors create the possibility of introducing and implementing more sustainable mental health services. But momentum needs to be generated at an early stage so that investments continue after an acute crisis.” In the report ‘Building Back Better’ (WHO, 2013), key promotive factors were identified through 10 case studies of post-emergency sustainability, including post-tsunami Sri Lanka:

1. Mental health reform was supported through planning for long-term sustainability from the outset. As demonstrated by several cases in this chapter, successful mental health reform commenced meaningfully in the midst of emergencies when an early commitment was made towards a longer-term perspective for mental health reform.
2. The broad mental health needs of the emergency-affected population were addressed. In many cases highlighted in this chapter, reforms were undertaken that addressed a wide range of mental health problems. No case established stand-alone (vertical) services for just one disorder (e.g. post-traumatic stress disorder) that ignored other mental disorders.
3. The government’s central role was respected. During and following some of the emergencies described in this chapter, government structures were adversely affected but humanitarian aid helped subsequently to strengthen them. Examples included seconding professional staff and temporarily assigning certain functions to non-governmental organisations (NGOs) under government oversight.
4. National professionals played a key role. Local professionals – even when they were too few in number – were powerful champions in promoting and shaping mental health reform. Helpful international experts and agencies involved themselves in mental health reform only to the extent that they were specifically invited to do so.
5. Coordination across agencies was crucial. Coordination of diverse mental health actors was typically crucial when working towards mental health reform. It helped facilitate consensus among diverse partners and then worked from an agreed framework. It also often helped partners complement – as opposed to duplicate – one another by taking different areas of responsibility.
6. Mental health reform involved review and revision of national policies and plans. Most cases featured here describe an overall process that involved policy reform. In the context of disaster, when political will for mental health care was high, the policy reform process was typically accelerated.
7. The mental health system was considered and strengthened as a whole. Many cases described processes that reviewed and assessed the mental health system as a whole, from community level to tertiary care level. Doing so provided an understanding of

the overall system and how it was affected by the emergency. Decentralisation of mental health resources towards community-based care was a key strategy.

8. Health workers were reorganised and trained. Opportunities frequently arose post-emergency to reorganise, train, and provide ongoing supervision to health workers so that they were better equipped to manage mental health problems. The majority of investments were made in people and services, rather than in buildings.
9. Demonstration projects offered proof of concept and attracted further support and funds for mental health reform. They also helped ensure momentum for longer-term funding. The latter was particularly true when the demonstration projects were explicitly linked to discussions and plans on broader mental health reform.
10. Advocacy helped maintain momentum for change. Almost all cases featured in this chapter described individuals or groups who became successful advocates of broader mental health reform. They helped maintain momentum for change. Advocacy was most successful when diverse groups of people were not only informed about the issues, but also asked to become part of the solution.

Epping-Jordan et al. (2015) reinforce and extend the WHO model highlighted above, noting in relation to Sri Lanka specific factors that contributed to ‘building back better’ after the 2004 tsunami: a) the recognition by Sri Lanka’s head of state of the need to address the acute psychological distress of survivors, international media interest and rapid resolution of other health issues enabled mental health to become a prominent part of the political agenda; b) a new national mental health policy adopted shortly after the disaster, guided reform emphasising comprehensive, decentralised, and community-based mental health care, and called for several new cadres of mental health workers to address the considerable challenge presented by the lack of trained mental health professionals, partners worked together to establish a one-year diploma course in psychiatry and to train Medical Officers of Mental Health, Medical Officers of Psychiatry, community mental health nurses, and community support officers; c) although mental health has lost prominence within the political agenda since the tsunami, national and international investments in mental health have continued, allowing Sri Lanka to continue to build on the early momentum and expand mental health service coverage beyond the tsunami-affected zones to most of the country.

## **Conclusion**

Despite serious limitations in the global literature on sustainability of mental health and psychosocial support services established in response to humanitarian emergencies, Sri Lanka was represented in approximately 20% of the publications identified through a thorough search of databases, websites and local archives. Whilst there was significant content on Sri Lanka, especially discussion of sustainability issues in relation to actual practice, rather than only assertions of theoretical practice, the detail and depth of this was often limited. Although many authors have clearly recognised the importance and challenges of sustainability, the type of operational research advocated by some to explore this in depth is not evident in the literature. The findings of this desk review further underlines the

relevance of the case studies in this volume that focus on sustainability in post-emergency transitions.

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Psychosocial worker, Family Rehabilitation Centre  
Source : Gemunu Amarasinghe 2016



## Mapping the Roles of Community-Level Government Service Providers Relevant to Mental Health and Psychosocial Support Services in Sri Lanka

By Ananda Galappatti, Nilanthi Gunawardena and Sharanya Ravikumar<sup>2</sup>

### Background to the Development of Mental Health and Psychosocial Support Services in Sri Lanka

Addressing the diverse and sometimes complex mental health and psychosocial issues affecting individuals, families and communities in the context of Sri Lanka's post-war transition requires multiple approaches to intervention and support provision. It is recognised that these efforts will likely involve diverse actors such as state sector service providers, non-government service providers, community stakeholders (i.e. faith institutions, traditional healers, community groups, families, etc.) and even private service providers.

Since the 1980s, there has been a gradual growth of services for mental health and psychosocial work in Sri Lanka (Galappatti 2014). In addition to clinical services by the state health services, there has been an expansion of community-based approaches to address a wide range of psychosocial problems since the 1990s. A significant proportion of these were related to southern political violence and the war in the north and east. But there has also been a growth in services due to mental health and psychosocial concerns being identified and responded to in the context of the broader Sri Lankan society—for instance in the areas of care and protection of children, sexual and gender based violence, serious mental disorders, disability and other forms of adversity such as social discrimination or injustices.

There was widespread acknowledgement of the need to develop professional services, to supplement more informal and traditional societal coping mechanisms, to help people deal with a wide range of mental health, interpersonal and social problems that were causing considerable suffering to individuals, families and communities. By the end of the 1990s, approaches had expanded beyond (often basic) psychological therapies or psychiatric treatments, to those that sought to address social and structural factors that produced mental health problems and psychosocial suffering.

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The past decade saw unprecedented expansion and development of mental health and psychosocial support (MHPSS) services in emergency contexts, primarily in the war-affected Northern and Eastern Provinces, and in the coastal regions devastated by the 2004 Indian Ocean tsunami. The post-tsunami period marked a boom in non-governmental MHPSS services, although there began a steep decline in the level of these with the resumption of full-scale war, and this has continued into the post-war-period. It remains to be seen if there will again be growth in the NGO MHPSS sector as a result of investment in transitional justice and reconciliation processes implemented by the current government.

By contrast, over the past decade (and especially since the 2004 tsunami), the growth of MHPSS services provided by the state has continued steadily through deployment of significant cadres in the fields of health, education and social care amongst others. Whilst government and non-government MHPSS services often complemented one another in the past, sometimes working closely together, the scaling back of the latter in recent years has seen an increasing burden fall on the remaining state service providers in the post-war era.

### **Existing Government MHPSS Services**

Recent efforts (Sivarajah 2013; CHA 2013; TAF 2015a 2015b; Kodikara and Piyadasa 2012) to map psychosocial services in the state and non-government sector have demonstrated both the existence of a variety of MHPSS service providers across the country. Although there is no comprehensive overview of all the MHPSS services now provided through the public sector, it is clear that there are significant human resources deployed to provide MHPSS services through central and provincial government structures. Figures presented in this section are approximate, since verified statistics are rarely available for personnel numbers, which may also fluctuate.

For instance, state health services have approximately 200 Medical Officers (MOMH/MO Psychiatry) and over 50 Consultant Psychiatrists supporting mental health care around the country, in addition to nursing staff and limited numbers of Psychiatric Social Workers, Occupational Therapists, and in a few provinces Community Support Officers (CSO)/ Psychiatric Social Assistants (PSA) working at community level. Almost every district now has a functioning acute mental health unit within a general or base hospital, as well as regular clinics in peripheral health facilities (WHO 2013). The Ministry of Social Welfare has over 100 Counselling Officers working through district or divisional secretariat offices, as well as significant numbers of social service officers (TAF 2015). The Ministry of Child Development and Women's Affairs has over 200 Counselling Assistants deployed at district and divisional level (TAF 2015), as well as National Child Protection Authority-affiliated psychosocial coordinators in nearly every district. Facilities for juvenile offenders and rehabilitation of girls and women survivors of violence also have personnel assigned to provide psychosocial care, while Women Development Officers, Child Rights Promotion Officers and Probation Officers are also often expected to provide psychosocial support. The Ministry of Education has now over 1400 graduates officially appointed as Guidance and Counselling teachers in schools across the country, with even more released to perform this function in schools with over 300 students. In addition, there are counsellors attached

to courts through the Ministry of Justice, as well as plans to train existing field officers of the Ministry of Foreign Employment to provide counselling at divisional level. This is not a comprehensive account of the government personnel with direct mandates to provide MHPSS service, but in addition to these cadres, there are also numerous government service providers whose remit to address key economic, legal, material or social issues can impact on key determinants of mental health and psychosocial wellbeing (whose effects may even eclipse those of explicitly therapeutic services).

### Current Limitations Impacting Access to State MHPSS Services

Considerable human resources have been made available by the state to improve access to MHPSS services. However, recent studies (Kodikara & Piyadasa 2012; Sivarajah 2013; TAF 2015a; TAF 2015b; Kodikara, 2014) and insights gained from implementation and training have highlighted some shortcomings in the current provision of MHPSS services. Access to MHPSS services is defined as that set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR) – General Comment 14 – and denotes availability, accessibility (i.e. affordable, physically accessible, no discrimination, information is accessible), acceptability and of good quality.

- Uneven geographic patterns of deployment, mismatches between resourcing and level of needs, and lack of logistical support for personnel to conduct community work leads to serious gaps in coverage.
- Often the intervention approaches used (predominantly one-to-one counselling or even small-group counselling) are not easily scalable – and there is a lack of systematic programmes for prevention and promotion of mental health and psychosocial wellbeing at a community level. There is a lack of strategic approaches to balancing the urgency of case-work with the need to do promotion and preventative work.
- There is a fragmentation of efforts, with personnel associated with each line-Ministry usually working in silos at community level rather than as part of a team. Where cooperation and collaboration exists, it is often *ad-hoc*, and is rarely supported by official circulars or formal mechanisms. The often-complex problems that they seek to address require multi-disciplinary and multi-sectoral responses both at individual case level, as well as at a community-level. There are also challenges to access resources and services offered by other departments and Ministries such as social security, livelihoods assistance or vocational training. Cooperation with non-government organisations (including CBOs) has been affected by the shrinking of these services.
- The challenge of coordination between services at both national and local levels is compounded by competitiveness, lack of effective mechanisms for inter-sectoral communication, lack of information about activities and needs on the ground, and the lack of strategic vision and effective leadership to solve these problems.
- Line-Ministries and Provincial Ministries are inadequately resourced to provide meaningful support and supervision to service providers in the field, and success often rests on the availability of resources and leadership at district-level.

- The failure to collect and use data systematically to design, plan and evaluate interventions also undermines the effectiveness of the services (Galappatti 2010; Sritharan & Sritharan 2014).
- Ongoing training and technical supervision of personnel in the field is limited and often non-existent. Pre-service training is often not practically oriented. The gap in skills and support required to deal with complex cases often results in personnel being overwhelmed and demotivated, which affects the quality of services.
- The lack of clear delineation of roles and referral arrangements between different types of personnel often mean that each cadre sees an extremely wide range of clients and problems – which they are often not adequately equipped to deal with in terms of skills and resources.

Whilst some existing services often appear to provide significant assistance to distressed or vulnerable adults and children, it is clear that the available human and material resources might be far more effectively deployed to provide access to mental health and psychosocial support, especially through better collaboration and cooperation between the various complementary service providers in the public sector. Linkages with service providers in the non-governmental sector and other community-level resources are also crucial. Recent research (see Ibrahim, 2016; Salih et al., 2016; Cassiere-Daniel, 2016; in this volume) into the sustainability of MHPSS services in the years after the tsunami and the war highlights the role that key non-governmental actors can play in supporting and complementing the public sector services, especially in relation to complex or sensitive cases.

## **Rationale for Mapping Process**

As highlighted above, one of the key barriers to better connections, coordination, collaboration and collective work amongst government service providers and between them and non-government or private service providers is the lack of information about the respective roles or functions played by the plethora of government service providers at community-level. When attempts to obtain this information from various actors at Divisional Secretariat level, District-level and National Ministries weren't successful, it was decided that identifying the many government personnel who provide direct services to the public and compiling a list of their duties and functions would be a valuable contribution towards the creation of tools, training and mechanisms for communication, cooperation and referral that would enhance access to public services that address, mitigate or prevent MHPSS problems. There was interest in the outcome of this activity from the Special Task Force on Psychosocial Wellbeing in Post-War Sri Lanka, at the Office of National Unity and Reconciliation (ONUR), which provided the authorisation to conduct the mapping exercise.

## **Objective**

The objective of the mapping process was to generate the following information:

- Titles of all community-level government personnel providing direct services to the public relevant to MHPSS;

- Official roles and functions of these personnel;
- Institutional affiliations of these personnel;
- Line managers or supervisors of these personnel.

## **Methodology**

There were two parallel approaches identified for the collection of information for the mapping process:

1. Data gathering at community-level through DS level survey and meetings,
2. Requests to National and Provincial Ministries for information about personnel and programmes.

## **Divisional-level Data Gathering**

The DS level data gathering was conducted in the Manmunai North and Koralaipattu North (Vakarai) divisions of Batticaloa District. Between 50 and 65 different government personnel participated in each ½ day consultation session where the following activities were carried out:

1. Survey in relation to role, duty-station, supervision, training, case load, referral and language skills,
2. Collection of Duty Lists and Job Descriptions,
3. Qualitative recommendations on ways of improving field level coordination and referral.

There was an enthusiastic reception of the mapping initiative by the District Secretary and Divisional Secretaries of the divisions participating in the mapping exercise, and there was an acknowledgement of the need to better integrate the work of personnel at community level. Personnel attending the sessions too were positive about the initiative and engaged actively in sharing their details and job descriptions/duty lists. The quality of data gathered through the survey was of variable quality – due to uneven completion of the questionnaire. As a result, only selected fields related to the core details required for producing a referral or mapping tool were extracted. The responses from personnel with the same designation were cross-checked against each other, and also against job descriptions/duty lists collected from DS consultation sessions and other sources (see below).

## **Requests to National and Provincial Ministries for Information**

Draft letters for information requests on field personnel and current programmes were prepared for submission to relevant National and Provincial Ministries. This information was to complement (and provide a fresh perspective) on the data collected at community level. However, given that ONUR was able to provide the research team with letters of introduction only for Divisional Secretariat level data collection, it was not possible to approach Ministries directly. Therefore, an alternative strategy was employed to supplement

the field data with information gathered via direct requests for job descriptions and duty lists made to the mapping team's contacts and colleagues working at Divisional Secretariat level in the Eastern and Southern provinces, at line-Ministries in Colombo, and researchers and trainers who have worked closely with particular groups of government personnel.

## Mapping Results

The dual approach to data gathering yielded positive results, although with over 90 different designations of government service providers identified as working at community-level, obtaining job descriptions and duty lists for all of these proved a remarkably challenging task. At the time of writing, approximately 50% of the job descriptions/duty lists had been obtained in Sinhala or Tamil, from which each officer/service provider's key tasks were extracted and translated into English. Details related to their usual duty station were also obtained from either these documents or the DS level survey. Unfortunately, given inconsistencies in the information contained in duty lists/job descriptions, as well as incomplete survey responses, there remain some gaps in the information gathered. It is also worth noting that most of the community-level service providers are formally appointed to work under the provincial government, and therefore it is possible that each province *may* have its own variant on the job descriptions/duty lists for each of these cadre positions. However, it is also likely that most provinces simply adopt the framework that has been developed by the central government when establishing the cadre positions nationwide.

Based on the mapping exercise, the following government officers (see Table 1.) were identified as being designated to engage in activities directly related to MHPSS services – either through explicitly therapeutic activities, psychosocial interventions, identification and referral, participation in case-management, or carrying out other tasks that aim to provide practical, social or psychological interventions related to prevention, promotion, care or treatment of mental health and psychosocial problems. It is not possible to verify if these service providers actually undertake the activities specified in their job descriptions/duty lists, or indeed to what degree of quality.

**Table 1.**  
**Government Officers Involved in Activities Directly Related to MHPSS Service Provision**

Early Childhood Development Officer (MCDWA)	District Child Protection Officer (NCPA)	Divisional Child Protection Officer (NCPA)	Child Rights Promotion Officer (MCDWA)
District Psychosocial Officer (NCPA)	Probation Officers (DPCC)	Child Rights Promotion Assistants (MCDWA)	Youth Services Officers
Women's Development Officer (MCDWA)	Relief Sisters (MCDWA)	Elder's Rights Promotion Officer	Sports Officer
Development Officers – Counselling/ Counselling Assistant (MCDWA)	Development Officer (Counselling) AKA Counselling Officer (MSW)	Court Counsellors (MoJ)	Mediation Board Members (MoJ)
Cultural Officer	Guidance and Counselling Teachers (MoE)	Guidance and Counselling In-Service Advisors (MoE)	Counselling Assistants (NDDCB)
Consultant Psychiatrists / Paediatricians (RDHS/MoH)	Medical Officers Mental Health (MOMH /MO Psychiatry) (RDHS/MoH)	Community Support Officers / Psychiatric Social Assistants (RDHS, North & East Provinces Only)	Psychiatric Social Workers (RDHS)
Nursing Officers (RDHS/MoH)	Public Health Midwives (RDHS/MoH)	Health Education Officers (RDHS/MoH)	Medical Officers Maternal and Child Health (MOMCH)
Mithuru Piyasa / GBV Desk Personnel (usually Nursing Officers) (RDHS/MoH)	Occupational Therapists (RDHS/MoH)	Social Services Officer (MSW)	Development Officer – Migration (MFE)
Development Officer – Disaster Relief	Coordinating Officer – Religious Affairs	Development Officer – Indigenous Medicine (MIM)	Development Officer – Foreign Employment (MFE)

Additional government personnel at district or sub-district level were identified as designated to provide services that were complementary to MHPSS service provision, and potentially addressing key determinants of mental health and psychosocial wellbeing (i.e. livelihoods, shelter, legal status, access to public services, etc.).

**Table 2.**  
**Other Officers Engaged in Complementary Services Relevant to MHPSS Service Provision**

Grama Niladharis (GN)	Community Development Officer	Divineguma Development Officers (formerly Samurdhi Officer)	Coordinating Officer – Persons Registration
Housing Officer	Land Officer	Development Assistant – Land)	Programme Assistant – Land
Development Assistant – Skills Development	Rural Development Officer	Development Officers – Rural Development	Development Officer – Traditional Industries
Development Officer – Export Development	Graduate Trainee - Economic Development	Graduate Trainee – Public Relations and Research and Communications	Development Assistant – Human Resources
Development Coordinator	Colonisation Officer	Social Development Assistant	Statistical Officer
Public Health Inspector (RDHS/MoH)	Development Officer	Development Officer – Agriculture	Sewing Instructor
Development Officer – Resettlement	Divineguma Manager	Science and Technology Officer	Coordinating Officer – Persons Registration
Additional Registrar – Grade III	Field Coordinator – Vidatha Centre	Technical Assistant	Investigative Officer – Land
Technical Officer	Graduate Trainee – Land Use Planning	Investigation Assistant – Land Acquisition	Grama Niladhari – Admin. Special Rank
Development Assistant – Admin	Cashew Development Officer	Development Officer – Planning	Development Officer – Regulations
Development Officer – Resettlement			

It is proposed that the information gathered be used to create a *referral and networking tool* for use in district-level training and implementation. The latter will provide an easy-to-use flow chart for referral to frontline providers across different sectors of the public services. It will be possible to later integrate other local resources (i.e. NGO, religious, community structures, etc) into this tool and referral system.

The mapping information collected can also be used as a basis for consolidation of available information on each type of service provider and further collection of information on field practice. In conjunction with this, the data can be used at field-level to design training and capacity building across silos, grouping participants appropriately for involvement in different levels and areas of capacity-building and supervision.

Despite the limitations of this mapping exercise, it has yielded, to date, the most complete listing of the designated roles of government personnel relevant to the provision of mental health and psychosocial support in Sri Lanka.



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Nursing Officer, National Institute of Mental Health  
Source : Gemunu Amarasinghe 2016

## Sustainability and Transitions in Coordination of Mental Health and Psychosocial Support Services in Sri Lanka, 2004-2014

By Marsha Cassiere-Daniel and Maleeka Salih<sup>3</sup>

### Introduction

Coordination of Mental Health and Psychosocial Support (MHPSS) Services actors in times of emergencies and during post emergency situations has been identified as a high priority in humanitarian settings, as exemplified by the prominence given to this in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC 2007). Despite recognition that poor coordination is the ‘Achilles heel’ of humanitarian response (Wessells 2008) and general commentary on this (Galappatti 2005; Wickramage 2006; Abramowitz and Kleinman 2008; Seale-Feldman and Upadhaya 2015), there have been relatively few accounts that have examined MHPSS coordination initiatives in detail or paid particular attention to challenges to their sustainability.

There have been a few examples of coordination mechanisms that support MHPSS service provision over the past decade in Sri Lanka. Located in Colombo, Jaffna, Vavuniya and Batticaloa, these coordination initiatives faced challenges at key junctures, which had impact on their function and sustainability. The purpose of this study was to gain insight into some of these challenges associated with sustaining services during and after transition periods, as well as to identify factors that exacerbate, protect against and mitigate them. This chapter specifically explores, in retrospect, the various transition points for the coordination networks in terms of their sustainability to carry out their key functions.

In identifying key challenges as well as factors that help or hinder sustainability of coordination networks the authors analysed and drew on the experiences of three coordination mechanisms in the north and east of Sri Lanka, based on a structured framework consisting of the six thematic areas of governance, management, human resources, finance, external resources and external context. Based on the framework, three key points of transition that have strongly impacted sustainability were identified –1) the operationalisation of coordination mechanisms in the immediate aftermath of the 2004 tsunami, 2) governance and power dynamics during escalated conflict between 2006 and 2009, and 3) the challenges related to sustaining of coordination bodies in a post 2009 conflict situation.

<sup>3</sup> The authors acknowledge the assistance of Shanthi Thambiah in data collection and Ashra Anwer in data coding. Ananda Galappatti is thanked for designing the study and providing input in the writing of the chapter.

This study found that sustainability of coordination depended on influential leadership and supportive government, strong networking among and between coordination networks and MHPSS institutions, conscious management of power, and strategic planning for sustainability. Most crucially, the sustainability of coordination networks strongly depended on whether MHPSS service providers valued the utility of a coordination network. In essence, it is hoped that, the findings of this case study will contribute towards informing future efforts to coordinate services for MHPSS in Sri Lanka.

## **Contextualising Coordination Mechanisms in Sri Lanka**

MHPSS coordination networks in the north and east of Sri Lanka emerged as a vital part of the humanitarian response in the immediate aftermath of the 2004 Asian tsunami (Galappatti 2005; Wickramage 2006; Krishnakumar et al., 2008) to address issues of duplication, fragmentation and uneven quality of services. However, discussions of the importance of coordination networks and attempts to materialise these networks had been underway in the MHPSS sector in the midst of Sri Lanka's civil war prior to the tsunami (Galappatti 2003; Galappatti n.d.). In fact, MHPSS coordination networks were functioning in Vavuniya and Colombo during this period. Therefore, the idea of a coordination network in managing responses to disaster and conflicts was not a new concept, however, the importance of the role of these coordination networks only surfaced in post tsunami Sri Lanka.

A brief summary of the three coordination networks is presented below.

### **The Mangrove, Batticaloa District**

The Mangrove was set up within the first couple of weeks following the tsunami disaster of December 2004, to meet the key identified needs for coordination and capacity building of actors seeking to provide mental health and psychosocial care services in the district of Batticaloa. The key objectives of The Mangrove were as follows

- To facilitate technical support to all organisations involved in psychosocial response to the tsunami disaster (and other events causing human suffering), to enhance the quality of services provided to affected persons.
- To coordinate and synchronise the various efforts by state, non-government and other groups to provide psychosocial interventions for persons affected by the tsunami disaster (and other events causing human suffering)
- To liaise with the state institutions and other agencies involved in relief, resettlement and reconstruction work to promote practices that enhance or protect the psychosocial wellbeing of affected populations.

*Source: <http://www.themangrove.blogspot.com/2005/02/information-on-mangrove-psychosocial.html>*

A core group, broadly representing service providers at the initial meeting, was given responsibility to design a concept endorsed by the organisations in attendance and

operationalise a unit to guide and support psychosocial services. It functioned as “an informal network of local and international non-governmental, bilateral and government agencies working in the Batticaloa district.” The Mangrove ceased functioning in 2007, and was succeeded by several later coordination mechanisms led by individual NGOs or the Regional Director of Health Services (RDHS) office. These were often short-lived or varied in their level of activity and participation over time.

### **Mental Health Task Force /Psychosocial Forum, Jaffna District**

The Mental Health Task Force (MHTF) was a very informal system of coordination for the Jaffna district that was initially lead by Shanthiham (a key MHPSS non-governmental organisation in Jaffna). Membership was of voluntary participation. In time, it came to function as a formal body chaired by the Regional Director of Health Services (RDHS) under the technical guidance of the District Psychiatrist, based on a directive of the Government Agent of the time and was named the Psychosocial Forum (PSF) (Krishnakumar et al. 2008). It was coordinated by a staff member of the RDHS who was appointed under the graduate appointment scheme that coincided with the RDHS taking responsibility for the PSF. Support for the coordination mechanism during the period subsequent to the tsunami disaster of December 2004 was received from different UN agencies providing mental health and psychosocial services.

The forum objectives included (Krishnakumar et al. 2008):

- Understanding and discussion of the psychosocial needs in the communities,
- Coordinating, monitoring and evaluating psychosocial activities and progress in implementation,
- Ensuring and improving the quality of services,
- Getting guidance from consultants; avoiding the duplication of service and improve cooperation,
- Planning for the future,
- Identifying the lapses and gaps of services.

The Forum also established the District Level Psychosocial Technical Evaluation Committee (DLPTEC) which served as an advisory body on project proposals submitted by organisations.

### **The Psychosocial Forum (PSF) of Vavuniya NGO Consortium**

The Vavuniya NGO Consortium was formed in 2005, with the objectives of networking, sharing information and mitigating duplication. The Consortium had sub-committees, based on the needs of the district needs at that time, and the Psychosocial Forum was one such sub-committee. It was an intense period of war, displacement, and resettlement. Organisations were

doing various levels of psychosocial and mental health work, which included counselling and play-groups.

The PSF had its own governing process. Initially *Medicins sans Frontieres* (MSF) had established the PSF as an informal independent entity in 2001, and soon after, the War Trauma and Psychosocial Support Programme joined as a co-facilitator of the PSF. Eventually, the PSF was brought under the Vavuniya NGO Consortium, where it functioned as one of its sub-committees. The Consortium was a registered entity and there was no separate registration for sub-committees. The PSF worked closely with the Mental Health Unit of the Vavuniya Hospital based on the needs at the time. The members of the PSF included missionary sisters, international organisations and local organisations such as SHADE (the successor to the MSF mission). The Vavuniya NGO Consortium had close connections with government agencies, UN agencies and INGOs.

## **Methodology**

This case study drew on a secondary data review as well as primary data collection that utilised in-depth key informant interviews to extract information. The secondary data review consisted of reviewing existing documentation of the coordination mechanisms in Colombo, Jaffna, Vavuniya and Batticaloa, where relevant material related to approaches to transition and sustainability issues were extracted for analysis.

In terms of primary data, the study concentrated only on the regions of Jaffna, Vavuniya and Batticaloa due to limited time and resource availability. A list of key informants was generated amongst stakeholders directly involved in coordination activities in these regions – covering the varying periods of their functioning – including those closely involved in these activities and others who were more distant or excluded from these. A structured guide using the six thematic areas was used in conducting in-depth key informant interviews. The interview questionnaire utilised was developed based on the three research questions related to the objective of the study,

1. What role(s) have (specific) coordination mechanisms played in relation to MHPSS responses in relation to emergencies?
2. What were the challenges in sustaining the activities of the respective mechanisms?
3. How did stakeholders respond to these challenges, and what factors have helped or hindered the coordination mechanisms in sustaining their work?

Four in-depth key informant interviews were carried out in Jaffna and Vavuniya respectively, while seven in-depth key informant interviews were conducted in Batticaloa. The data generated through these interviews was then subjected to thematic analysis utilising NVivo, a qualitative data analysis software package.

There were three main limitations to this study: There was a lack of clarity in the recollection of transitioning points or remembering the sequence in which factors of

change occurred, where memories of events occasionally conflicted among actors linked to the same coordination bodies. This may be due to the role each actor played within these coordination bodies, as well as the fact that recollecting time sequences of events that occurred over a period of a decade becomes less clear over time. Secondly, most actors requested for confidentiality in providing sensitive information on certain topics as it involved either politically sensitive information or information on actors currently involved in the field. Finally, the tight fieldwork time-frame and distances, difficulties in scheduling and rescheduling appointments impacted the participation of some service providers involved in coordination networks in the regions studied.

### **A Decade in Review: Coordination Mechanisms and its Phases of Transition**

There were three key catalysts for transition that directly affected the sustainability of the coordination networks and return of investment for the period under review. Firstly, the internal functioning or operationalisation of coordination networks i.e. the way in which the network supported and developed its capacity, good leadership and strong networking influenced the sustainability of the network. Secondly, the external context of government and power dynamics where the network's circles of influence and ability to negotiate power influenced and shaped its sustainability during the conflict and in post war Sri Lanka. Thirdly and finally, the ways in which the functioning of the internal network converged with the external context determined the network's sustainability in a post war context.

### **Transition Catalysts**

<b>Period</b>	<b>Key Elements that Functioned as Catalysts for Transition</b>
Disaster	1. Internal operationalisation or functioning – support and development of internal capacity, good leadership and strong networking.
Active conflict	2. Context of government and power dynamics. Network's circles of influence and ability to negotiate power.
Post war	3. Outcomes of the way in which the internal functioning of the network converged with the external contexts.

The following section discusses these three key catalysts, the factors that supported sustainability of the network during transitions, and the challenges that obstructed its smooth functioning and in consequence impacted sustainability.

### **Disaster and the Operationalisation of Coordination Networks**

Major post disaster responses see an influx of service providers with good intentions trying to support survivors. However, despite these benign intentions there can often be duplication of services and targeting, sometimes doing harm as well as good. This was

certainly the case in relation to service provision of MHPSS services after the 2004 Indian Ocean tsunami disaster (Galappatti 2005; Wickramage 2006). As one interviewee phrased it, *“with the 2004 tsunami, there was an immense need for coordination. Lot of misuse happened, wrong medicines were given to the victims, and wrong therapies were given by so called counsellors and a lot of duplication of services”*. All 17 key informants cited this as the main reason for establishing coordination networks. One interviewee from Jaffna noted. *“after tsunami a lot of NGOs have started working on psychosocial issues, including government sectors like the Education Ministry. There was a need to coordinate to avoid duplication and also ensure quality of services, quality of resource persons, quality of counsellors etc.”* In narrating the development of the coordination network in Batticaloa, another key informant emphasised this need for coordination: *“Many new organisations and INGOs came in.... In order to stop duplication, the need for a coordination focal point was identified as essential.”*

Coordination therefore became essential to mitigate duplication, network with other similar institutions, and ensure appropriate therapies and treatments were provided by persons with the relevant skills. This study found that avoiding duplication and improving the quality of services provided were the main reasons for operationalising coordination networks.

The north and east of Sri Lanka was also embattled by conflict between government forces and the LTTE during this period. This further reinforced the need for coordination, as displacement and resettlement was not just for communities impacted by the disaster but also for those impacted by conflict. MHPSS services were not only challenged by duplication and poor quality of services but also by the external restrictions on reaching tsunami-affected communities located in war-torn areas. A key informant from Vavuniya clearly highlighted this issue and the need for coordination in addressing this challenge: *“It was the peak of war. There was rampant displacement and resettlement, camps were set up and organisations were doing various levels of psychosocial (PS) and Mental Health (MH) work, ranging from counselling to play groups to children’s clubs, etc. The first objective of the ...network was to share information and improve coordination to avoid duplication, village allocation etc. Immediately after the tsunami hit we had so many meetings and discussions on how the(network) is going to intervene and decided we will send small teams of counsellors to Vanni to provide service. But we had a big challenge in getting permission.”*

Therefore, there was a need for a coordination focal point to not only avoid duplication and improve quality of services, but also to network and negotiate with local authorities in relation to access and activities. This study found that within the operationalisation process, (i) the networks’ capacity building process, (ii) the role of leadership in steering the network and (iii) interactions between and within networks were decisive factors that determined how sustainable these coordination networks would be in the long run.

### **The Role of Capacity Building in Operationalising Coordination Networks**

Capacity building in this instance referred to how networks strengthened and utilised their skills, convening power and the networks themselves to sustain their mandates and functionality. Based on key informant interviews, the study found that sustainability of the coordination mechanism was strongly influenced by the way in which the network



supported and developed its capacity. The three mechanisms analysed in this study had three varying approaches to using capacity building to support their networks.

The Mangrove's approach was oriented towards processes that were external to its own infrastructure and aimed at strengthening the role of public institutions. It was established as a temporary network attempting to strengthen the capacity of the MHPSS service sectors functioning in Batticaloa through capacity-building for Mental Health Units in government hospitals, university courses on counselling, setting up referral desks in remote DS divisions etc. – in the words of a key informant, *“We attempted to shift coordination to and establish a referral system in the state sector... but when the war started we couldn't continue that.”*

On the other hand, the MHTF/PSF Jaffna had an approach aimed towards improving and strengthening the network's internal capacity, although the network also provided training for the MHPSS service sectors. Specifically, MHTF/PSF did organisational mapping, village needs assessments, training programmes and thematic discussions. Moreover, a technical committee was also set up to provide guidance on ethical issues and training guidelines to its members, and to oversee and ensure high quality service provision that guaranteed the approval for MH and PS programmes from the Government Agent (GA). This too, was a mechanism through which capacity building of network members took place. This process is also discussed further below. According to one of the key informants from this network, *“the learning component was identified as an important entity for sustainability. Otherwise it is just coordination meetings, you don't learn much from them.”*

PSF Vavuniya had yet another approach, where the strengthening and use of capacity building for MHPSS came externally from the NGO Consortium and internally through the PSF network's own initiatives. The PSF functioned autonomously under the Consortium, which had registered status. Finances for the PSF activities came from the membership fee and from member organisations (especially MSF). The PSF had close links with MHPSS organisations in the district, as well as with government agents and the mental health ward. Sometimes, these connections were enabled or facilitated through the Consortium. What was significant, however, was that irrespective of the approach, capacity building was deemed as essential to sustaining the network's long-term objectives.

While the networks' structure determined how each network approached capacity building, it was also challenging in ways the networks did not foresee. For instance, the NGO Consortium management structure proved challenging for the PSF Vavuniya in supporting its attempts to build capacity; the need for constant coordination with and seeking of approval from the NGO Consortium impacted the PSF Vavuniya's efficiency in capacity building. One of the key informants noted, *“The Consortium had the authority over PSF at times. Especially when it came to getting money for bigger activities such as the mental health day celebrations or conducting awareness programmes in the villages or getting banners or a sign-board. Getting authorisation from the President was difficult at times. It was mainly because they had different points of view. But overall the Consortium did a good job. It was a strong body.”*

The Mangrove on the other hand faced external challenges that impacted its approach to sustainable capacity building and required the network to re-direct its capacity building mechanisms. For example, initially, the network's long-term objective aimed at building coordination mechanisms with the central involvement of the Mental Health Units in Batticaloa. However, when there was a transfer of one of the key doctors involved in this process, the network made a strategic decision to change its course of action as well – focusing on developing a relationship with the Eastern University instead and sustaining 3-4 cycles of capacity building. When institutional leadership changed within the relevant structures of the University, the collaboration foundered and the capacity building programmes deteriorated in quality. In other words, building sustainable networks depended not just on strengthening its capacity but also on adapting to changes that challenged the network's governing structures and strategies.

### **The Role of Leadership and Personnel in Advancing the Agenda of Coordination Networks and its Good Practices in MHPSS**

In all three case studies of networks, the setting up of the network was driven by visionary and perceptive leadership of reputed individuals or institutions in the MHPSS sector. This helped in expanding the networks' membership, consequently strengthening the network. For instance, leadership was perceived as being a reason for members joining the network. Equally, leaders played a role in managing member relationships, both with the network and with one another, as suggested by the following quote, *“Coordination sometimes happens only for the sake of coordination. Unhealthy relationships can be a risk for coordination, and also the person who coordinates should have skills of problem management, dispute management, know the context, know the members well and also have some technical background.”*

Leadership, was seen by key informants from all three networks as important in the setting-up of coordination networks. However, the networks differed in how they perceived the role of leadership in advancing the agenda of coordination networks and good practices. For The Mangrove, good leadership was perceived as being decentralised with no central leadership given to an institution or individual, but spread through a 7-person core-group and a coordinator/advisor delegated to facilitate the networks activities. PSF Vavuniya followed a more linear power structure where, decision-making was more often in the hands of the NGO Consortium. MHTF/PSF Jaffna associated leadership with respected individual mentors who spearheaded the operationalisation of the network.

In terms of its impact on sustainability, strong individual and institutional leadership within the network was also perceived by the informants as being crucial in maintaining binding links between network members. Where good work relationships were maintained among members, there were always one or two individuals in leadership or facilitator roles to enable positive collaborative work relationships. For example, in one of the case study networks, there was an efficient individual who took on the role of a coordinator, managing the network functions and keeping in close contact with its members. This coordinator was a full-time paid staff member of the RDHS (under the graduate appointment scheme) who was committed to the work. In contrast, most technical team members functioned on a

voluntary basis and had other commitments as well. That the coordinator could dedicate time to the task was seen as essential in advancing that particular network's objectives.

Conversely, personal agendas and needs of individuals and leaders could also play a disruptive role in coordination. One example that highlighted this was an incidence of one government officer attempting to keep out another officer in order to protect his own territory. As noted by one of the respondents, *"The person in the govt. position who could coordinate, does not function well with others. He likes to show off his own work. Does not like the presence of outside persons and is autocratic. For example, as per a request by the Zonal Director, they got a Resource Person – an outside Psychiatrist. This got the person very upset... There is a dilemma as they (the members of the network) would like not to upset (the person) in the area, though they would prefer to use the Psychiatrist."* There were also different mediating roles played by those in leadership positions within the network. For example, The Mangrove having strong government personnel active in the network helped to mediate and strengthen the relationship between the state and the NGO sector. In the Vavuniya PSF, it was the Consortium which was the legal entity that negotiated with the state as well as the military for approvals.

### **Networking for Better Coordination**

Networking was evidently a key element of the coordination mechanisms. Networking between organisations, institutions and individuals were undertaken in order to:

- (i) share information, i.e. for those providing services to identify what and where the needs were and to provide information on existing needs to those who could provide services,
- (ii) create space for discussion and support to one another,
- (iii) have access to skills and resources external to the geographic area as well as connect external resources with different local services,
- (iv) enable vertical and horizontal networking.

#### *i. Sharing Information*

Networking supported the sharing of information. A key reason identified was the need for more even distribution of services. Members from the different networks pointed out that sharing information was vital for this purpose. One member put it succinctly, *"Mainly to stop duplication, and also sometimes everyone went to the same place and some places received no services, especially remote areas, this mechanism identified those areas and provided information on that."* Information-sharing also took place across regions and into the national level forums as well: for example, *"Every month we had an activity review, and fed that (information) into the INGO forum and UN sectoral meetings. We identified needs and shared the information. We also maintained close coordination with the G.A."* Providing contextual information to those who were not of the locality and providing services in the area was another aspect of information sharing that networking was able to accomplish. One of the members from The Mangrove noted: *"(Knowledge of) local relationships and knowledge about local dynamics was important. Knowing social dynamics, local politics, and political affiliations of stakeholders were all very important."*

Networking also helped in conducting and sharing common needs assessments in consultation with villages and through the participation of multiple agencies, pooling resources. A psychosocial worker involved in coordination within the Batticaloa District mentioned of other services provided through networking: “[during] consultation for water and sanitation, we were part of protection and PS cluster and organised visits to camps, talked to people, identified suitable places to set up toilets and bathing places. Psychiatric Doctors trained nursing officers, teachers, counsellors and NGO staff to identify issues... When people went to the police station to identify bodies, Mangrove personnel supported by accompanying them and also put up a tent for tea.”-

Even though the language used to describe the working of the networks referred to ‘sharing’, it was not always embraced as positive by all organisations, due to the power dynamics between the different members. Sometimes there was resentment and feelings of being coerced into sharing information, and at other times, information sharing was one way, where non-governmental organisations had to share information with the state officials. For the state officials it became a monitoring mechanism “to know what is happening.” One state sector official strongly emphasised “they *have* to share information with us.” The unequal power implied in this statement could be a deterrent for organisations to share information with authorities.

#### *ii. Space for Discussion and to Support One Another*

The regular meeting space was identified as an important space which was open to all, and which provided opportunities for discussion among many different actors. The links with state services through the network were also identified as important for the members when responding to identified psychosocial issues. For example, in Vavuniya, the links between the Mental Health Unit and PS organisations were appreciated by, both the Mental Health Units as well as member organisations, for they provided the opportunity for referral and follow-up of clients. The links between the Mental Health Unit and Social Economic & Environmental Developers (SEED) is an example of this. SEED referred children with special needs to the Mental Health Unit, and they in turn referred children with special needs to SEED who took on the follow-up activities or included the child at their school.

The collective space was also seen as important to bring actual ground level experiences and information to be shared with different levels of decision-making actors. This was important to make informed decisions on services that were needed, and the ever-changing conflict context. An important concern that was raised in the interviews was the need for sensitivity to the power of different members of the network. Local organisations and community-based organisations would have much less power to influence decisions than the UN or a government official. In effective networks, being sensitive to the languages that the meetings were conducted in and enabling local and community actors to speak was recognised as very important.

#### *iii. Access to Skills and Resources*

Both government and non-governmental organisations mutually appreciated the access to resources made available through networks. Government staff appreciated the access

to resources on the ground: *“At that time also there was a collaborative work with the Mental Health Units and NGOs, like ESCO, CARITAS, Alcohol[ics]Anonymous.... ESCO had good grassroots programmes, they trained grassroots people to be supporters in MH work. It was effective and they worked with our unit at the Valaichenai hospital.”* Non-governmental organisations for their part appreciated the ‘good image’ they cultivated working within and collaborating with the government structure. The links between district and national level coordination mechanisms were viewed as a means of accessing important resources.

#### *iv. Vertical and Horizontal Networking*

In the post tsunami context, coordination mechanisms were valued quite highly for bringing together government and non-governmental organisations. Local and international NGOs, government institutions i.e. the Mental Health Unit of the Hospital, the Ministry of Education, the Ministry of Social Services and Ministry of Women’s and Children’s Affairs, UN organisations, religious organisations providing PS services and community based organisations were networked and working together. However, there were mixed experiences when the state took over the role of coordination. The nature of collaboration and power dynamics shifted. As one interviewee shared, *“When government started running (the coordination) the role of NGOs became different, we became only observers. There were CRPOs, WDOs, social workers, DS office people, and the dynamics changed...”*

The coordination mechanisms also became the point through which negotiations took place with decision-making authorities such as the RDHS and GA. For example, The Mangrove provided a forum through which it became possible for MHPSS actors to link with other services such as water, sanitation and protection. Therefore, links were created both horizontally among actors within the district as well as vertically to national forums.

It was clear that emergencies such as disaster and war created the need and enthusiasm to work collaboratively. There was an organic movement of different actors to share information and resources and work collaboratively. The external risks and threats also became motivating factors for organisations to work together and to work collaboratively with the state. One of the key informants pointed out that, *“during war time everyone had the urge to work, do something for the people, they were ready to coordinate, ready to come for a discussion, now things have changed, everyone is secure in their own place and no one is ready to come to a common forum.”* Though the need for networking still existed and the need for sharing of experiences and peer support was identified, it was not seen as a priority in work strategies. This also raises concerns for sustainability of networks.

### **Transition in Government and Power Dynamics during Escalated Conflict**

The escalation of active conflict and the resultant change in government approaches to both MHPSS services and coordination and the shifts in power, marked the second transition catalyst for these networks. The external context impacted significantly on the coordination networks, eventually leading to their dismantling or dysfunctionality. The networks’ circles of influence (or how important the network members were) consequently influenced how

well the network could negotiate power in a conflict-ridden period. This shaped how the network was steered in the post war context.

Coordination, depending on its processes for implementation, can also be a space that provides access to power. In Batticaloa, for instance the past experience of the LTTE's influence over the local NGO coordination body *Inayam* had caused MHPSS organisations to be wary of forming a coordination mechanism prior to the tsunami disaster. This underscores the role of power dynamics in coordination, and how levels and sources of power impact on voluntary participation of actors.

### **Circles of Influence**

When strategically managed, power and influence were clearly used by individuals, organisations and the network itself to support the sustainability of coordination. However, this was challenged when there were conflicting circles of influence or influential members who challenged the mandate of the network. These circles of influence therefore impacted sustainability of the coordination mechanisms.

The coordination mechanisms provided access to other individuals with influence, i.e. individuals with standing that could offer leadership, voice, make decisions and obtain approval from authorities. For instance, at a point when sub-standard projects were creating a negative reputation for PS work in general, a Technical Committee was set-up within the coordination mechanism in Jaffna to help organisations come up with better proposals and to identify projects that were required. The approval of the committee was at that time a necessity to get mandatory GA approval for implementation of projects at that time. This technical committee, which was part of the coordination structure, provided organisations with access to technical support and support with obtaining approval.

As one respondent expressed it, *“At that time there was an unwritten agreement, I could even say, if the technical committee approved (the proposal), the GA would approve (it), or the other way, no approval from the technical committee meant no approval from the GA.”* The influence of the members of the network who formed the committee therefore, pervaded every project implemented in the district. Another example of the influence of the coordination network took place during the time of war when PS work was curtailed by the government and GAs called on coordination bodies to take on the role of verifying service providers: *“(Due to) links with the hospital, relief work was allowed. PS staff (who worked in relief work) ...through relief work ...talked to people (and were able to provide PS support).”*

The coordination mechanism functioning within or with the government structures provided space for required services to continue to be provided. The lead government doctor responsible for Mental Health care taking the lead or being actively involved in the network provided the institutional backing and sense of legitimacy for the coordination mechanism. Individual personalities, their reputation or referent power and their approaches were often key in exerting influence in times of conflict.

Illustrations of divergent versions of these included the following: *“(X) was the (network) president most of the high crisis time. Very dynamic and powerful, sometimes very autocratic, but now I feel during crisis time, ... if you are not like him you would never be able to move forward. If you are flexible, an ‘ok let’s discuss and decide’ type, it’s difficult. We were a bit upset with his leadership sometimes, but now when I see what happened after he left, I feel he was a good lead ... He had a name, even UN, and INGOs were ready to listen ... (The network) had its strong stands, we had close connections with Government agencies, UN agencies and INGOs... there were times UN had its own sector meetings, INGOs had their meetings, we were part of all and had good working relationships. There were times we were in the strong decision making and influencing body.”*

As evidenced above, autocratic styles as well as more diplomatic approaches to leadership were felt to have been of value in different contexts.

### **Challenges due to Influence or the Lack Thereof**

Where individuals were able to work well together with others, or were able to bring people together, work took place smoothly. Where the ability to bring people together was lacking, there was a sense of ‘resistance’ and ‘divisions’, and a consequent lack of coordination. Particularly those in positions of authority who could not function well with others imposed regulations to restrict their work. This placed other members of the network in a dilemma – having to choose sides or show loyalty to those in power while continuing to work with the marginalised. It was felt that the mere existence of a structure in itself could not sustain coordination without the presence of an individual who had knowledge of context and the ability to work well with people.

At times, however, it was the lack of influence that challenged coordination. The coordination structures could not wield influence against political parties or armed groups for example, the TMVP in Batticaloa during the war. In such social contexts where physical threats were very real and there were individuals or groups that supported those capable of physical threat, coordination was not able to continue. The space for humanitarian work simply shrank.

### **Negotiating Power**

Another dimension related to circles of influence was the network’s ability to negotiate with external actors and government bureaucracies. Of particular interest is the way in which the ability to negotiate power supported the network’s functioning and presence during escalated conflict. Having links to or being a part of a government structure was perceived as important for enabling psychosocial work during the period of conflict. The network provided access in getting clearances for special identity cards for staff of member organisations and approvals for training programmes. In highly militarised contexts where there was heavy surveillance of non governmental organisations and humanitarian actors, the network provided a safe space to negotiate protection of staff as well as access to areas to carry out psychosocial support work.

### *Where Negotiation Worked*

The following examples illustrate the value of negotiating power in the conflict context. Key informants from the Vavuniya PSF noted, *“After 2006, A9 (main access road to the north) closed within the peninsula and there were also so many checkpoints, checking on humanitarian workers as well, members (of the network) expressed the problem at the meetings and we took action on this. Under DPDHS we got special ID cards for PS workers. That really helped their security and mobility”*. Within a context where humanitarian and psychosocial workers themselves faced threats, negotiating with the authorities for ID cards and t-shirts was crucial to provide PS services in the areas that required it. For example, during the period when resettlement camps were set up, the government placed restrictions primarily on PS work; however, working within the NGO Consortium in Vavuniya meant that PS workers could constitute part of the relief teams to provide support and guidance, as the Consortium was able to negotiate access with the authorities.

A further example was an instance when individuals with connections to armed actors created trouble for staff and members of a network, spreading false information discrediting members carrying leadership roles within the network. Existing regional conflicts (i.e. north vs. east) were used to raise suspicion and question the credibility of the roles of specific network members. Well-connected members of the network had to then use leverage through local and national networks to counteract the false information and defuse the tussle for power.

In another instance, counsellors of the Mental Health Units were released to work in communities alongside community workers of NGOs due to the good collaborative relationship between the state and NGOs. Through activities such as the periodic identification of needs, reviews of activities etc., information was gathered and made available. Feeding back such information to the government and other bodies of authority such as the INGO forums, and UN sectoral meetings helped maintain close coordination. Providing authorities with the information that they had access to, gave the NGO network members a means of negotiating the power differences.

### *Where Negotiation Didn't Work*

The existence of a network did not always translate into the ability to negotiate. The following story shared by a member of The Mangrove network illustrated this point: *“In 2005 the Thiraimadu Resettlement started, and in 2006 Mangrove tried to get its members to work on certain issues, but it was so difficult. It was difficult to get (in touch with) the heads of organisations - once they got funding, [and] they got their territory. There was a play area for children that needed to be set up, we tried to work on that, but it didn't happen. There was a lot of duplication.”*

Coordination was also used as a means of controlling other actors in the sector. Authorities lacking clarity on what psychosocial work entailed, also hindered the ability to collaborate and negotiate work. For instance, it was reported that the northern coordination structure was suspended after instructions were received from the Governor to halt psychosocial work – and that the decision to suspend PSF activities was partly linked to lack of clarity



around the nature of PS work. A key informant from the MHTF Jaffna said, *“After the Presidential TF came in, it all became difficult. The GA had to approve the project and you had to get PTF clearance. But, for organisations doing PS work it became double the hassle, after the war ended in 2009. The reason was no one was clear what is PS... So for GA also it was difficult to challenge the PTF and give approval. For some time technical committee tried to influence the GA on this. But in 2009 it all came to a halt. GA officially sent a letter to stop the activities of the PSF.”*

#### *Factors that Aid Negotiation*

*Leadership style* was one factor that aided negotiation. The ability to bring together diverse actors, initiate and generate enthusiasm for collective work, neutrality and impartiality, the ability to negotiate firmly with international actors, the ability to negotiate with the state, were all seen as qualities which were valuable for the leadership of a network. A clear non-alignment with powerful actors such as armed groups was important to maintain credibility.

The *recognition of an individual or organisation* also provided negotiating power. This was achieved by partnering with state or INGO actors. Civil society actors often aligned with health sector services to access conflict affected communities. This was particularly the case in the post war context when trying to access camps with displaced populations was heavily controlled by the military. Partnering with the health sector also aided in getting approvals and linking with other government sectors such as Probation and Child Care services, DS offices, and divisional level task forces. The relationship with the health sector facilitated a good relationship with the GA, aiding in issues such as obtaining approvals, security clearance, dealing with the Ministry of Defense or being exempted from having to deal with them and other security related issues.

Partnering with INGOs also provided negotiating power against the threat of violence and sometimes against armed actors. A psychosocial worker involved in coordination within the Batticaloa district stated: *“In 2007 with the Karuna split, things became a bit more difficult. Child protection was a concern and discussions happened around that. PS support for child friendly spaces was done mainly by SAVE, ESCO, UNICEF, I participated in those meetings as well”.*

While *linking with government structures* had its advantages, disadvantages were also identified. For instance, *“the Government structure is very formal and hierarchical. NGOs may find difficulty with the hierarchy”* was one comment from a respondent. Where there was a lack of interest or ability amongst the individuals who were identified by the government to undertake leadership, coordination suffered as a result. Coordination was therefore dependent on the skills of whoever was responsible for the coordination at the time. The need to train government officers on how to run coordination (if the government were to take on this responsibility), while understanding that there will be both time and support required to manage transitioning from one person to another was identified as a way of dealing with limitations of skill and experience of those appointed to leadership positions.

Government regulation that does not allow or makes it difficult for their staff to participate as needed was also found to be a stumbling block to coordination. One respondent phrased

it as: *“Now even within the hospital things have changed, earlier I had the freedom to do many things outside, I was part of the (network), I was part of GBV task force, I was part of the Education Ministry programme and I used to go for WHO meetings in Colombo. Now I cannot do things like that, I have to get permission, I have to wait for approval and many times I was told ‘ah you don’t have to go for this meeting’.”*

*The incorporation and mediation of state power* was one way in which negotiating power was obtained. In Jaffna the MHTF/PSF had a Technical Committee that had to approve all projects before they were sent to the GA for approval. In some ways coordination meant the acquiring of power and partnership between the state and some powerful actors within the non-state sector.

### **Steering Coordination Mechanisms**

*The circle of influence of the networks and their capabilities and willingness to negotiate with external power dynamics* during this period influenced how the networks phased out or re-designed their mandate and functions, consequently impacting the sustainability and continuity of the networks.

The Government placed restrictions on doing PS work during the war. As a result, organisations did not want to be part of a PS network as it raised their visibility as PS service providers. The reduction in funding for PS work, the closing down of organisations doing PS work, and burnout of individuals working in the PS sector were all factors that contributed to the reduction or closing down of coordination activities.

The perceived need for coordination also changed over time – the influx of organisations during the tsunami was followed by the curtailing of PS work during the war. This changed coordination needs and the possibilities for coordination. Within the framework of these external factors, the perceived threat to state security during the conflict was a key tipping point that led to phasing out or diminution of coordination space. The fear of the coordination mechanism being used as a point of exerting power on its members through coercion or by politicisation and the risks to individuals were highlighted by participants in the study.

The termination of the coordination mechanisms took on different forms. Some participants mentioned not phasing out but a ‘dying out’ of the mechanism due to various external contexts. In some instances, the leadership does not seem to have consciously engaged with these situations to negotiate means of ensuring sustainability. In other instances, there seems to have been conscious decisions to shut down the mechanism, based on an awareness of the risks, i.e. one leader said *“we decided we would not renew our mandate, we decided this at a meeting, we decided we would not renew the mandate for coordination and let it lapse.”* A strategy for letting it lapse was decided due to political risks identified by the core leadership group. The need to ensure autonomy, the need for equality of power between members and the need to ensure that authority was not ‘captured’ and abused also seem to have driven the decision to wind down one coordination structure.

### *Other Factors that Negatively Impacted on the Sustainability of Coordination Mechanisms*

There were other factors that impacted on the sustainability of the coordination mechanisms. The following were some of the other factors highlighted by respondents:

- The *lack of a second tier of leadership* being developed, also disrupted coordination as it was not possible to sustain the mechanism.
- *Politicisation* was another impediment to coordination. *“In contrast to the east, in the north after war, government had restriction on services but humanitarian activity was not politicised and not targeted. In the east it became so difficult to function (due to politicisation).”*
- Members of a network using the coordination space to highlight faults or find fault with work by fellow actors in the field was found to disrupt coordination. This was highlighted as being due to the appointment of individuals who lacked psychosocial sensitivity to roles of facilitating coordination. It is evident that when individuals in positions of responsibility for coordination were not aware of the sensitivity required in the use of their power, where power was badly managed, or managed with limited awareness and where there was aggressive use of power (i.e. using political connections, to further their mandate) coordination efforts seem to have been counterproductive.

### **Sustaining Coordination Mechanisms in a Post-war Setting**

In the present post-war situation, there is neither government policy for the coordination of MHPSS services nor are there very many NGOs providing MHPSS services. Within this setting the need for coordination itself was questioned by some of the participants in the study. At the same time, a counter-argument has been made that in order to improve available services and ensure non-duplication of efficient services, coordination of services continue to be a valuable component to MHPSS. This section looks at internal operations immediately after a disaster, and the external contextual influences that shaped the networks continuity in a post conflict setting.

### **Sustainable Management of Resources**

The coordination mechanisms studied had differing methods of accessing resources. The Mangrove structure was deliberately designed to function without resources being sought for itself, so as not to place itself in competition with its members for funding. Organisations loaned material, personnel and other resources i.e. vehicles and stationary towards the functioning of The Mangrove and its activities. Other mechanisms used membership fees and donor funding to secure resources for their functioning.

Difficulty in securing finances for larger activities of the networks was only mentioned by the Vavuniya PSF. However, administration costs seem not to have been an issue in any of the networks as they were borne by active members of the coordination mechanisms at the time i.e. vehicles and transport costs were supported by different organisations within the network. Smaller activities also seem to have secured funds that were offered by organisations present in the mechanisms at that point. It is unsurprising that the exit

of many NGOs from providing for PS services due to funding reductions has also led to the departure of the NGOs from membership fee-based coordination mechanisms and reduced the number of network-led activities as well.

Formal financial support from the government for coordination was not available in any of the structures studied which tallies with the lack of any mention of coordination in the National Mental Health Policy. That government space, and at times personnel, were being allocated for the purposes of supporting coordination was however evident.

The management and control of finances was mentioned as a difficulty for some coordination mechanisms, given the lack of a legally registered structure. However, overall neither the access nor management of finances seems to have had significant impact on the sustainability of the coordination mechanism, beyond the impact of reduced funding for PS work in general, which reduced membership numbers and perhaps, therefore, the felt need and real ability for coordination. With MHPSS services not receiving priority in resource allocation, it follows that MHPSS coordination does not receive priority either, and therefore is not funded.

### **Strategic Planning and Personnel Management**

The networks' strategic planning impacted the sustainability of the structures.

The Mangrove in Batticaloa was set up as a temporary structure, described, by a respondent as even a "*kind of an activity*" rather than a structure. Sustainability was therefore not part of its mandate. Its continued functioning was reviewed every 6 months until a decision was made to phase out. The decision to phase out was not made in as participatory a manner as initially planned, since this was not felt possible in the prevailing security situation. The Jaffna PSF began with the lead of Shanthiham, however leadership later shifted to being under the RDHS. Both the Jaffna and Vavuniya PSFs seem to have lost steam with the exit of the large number of organisations from providing PS services. None of the 3 structures studied had identified strategies for sustainability nor had policies for continued coordination – in some instances, this might have also been due to reservations on whether it was safe to continue or sustain coordination in certain repressive contexts.

Ensuring that meetings provided information i.e. on needs, gaps in services and geographic areas of service provision, knowledge on themes of interest to member organisations, was a means used to ensure participation. However, this required that individuals took on the responsibility of coordination including planning the meetings. Being dependent on a number of limited individuals to spearhead and direct the structures was perhaps detrimental in terms of their sustainability. At the same time, the qualities that made some people more suitable and effective in taking on the mantle of coordination responsibility means recognising the importance of individuals in sustaining effective coordination mechanisms.

## Conclusion

None of the coordination mechanisms studied have sustained to the time of this study. The particularly strong challenges of the transitional phases had a disruptive effect on these mechanisms and sustaining them was variously seen to be risky, counterproductive and even unnecessary. Nonetheless, coordination of MHPSS services in order to avoid duplication, ensure good coverage, identify needs and gaps, and build capacity of individuals and institutions were valued aspects and were perceived as having improved quality of services and even avoided harm.

The three coordination mechanisms in this study were set-up in the post-emergency context to improve MHPSS service delivery and to reduce harm. They were seen as a means to build capacity, advance good MHPSS practice and to ensure a shared space that enabled information-sharing, access to resources and negotiating on behalf of organisations and personnel in the conflict period. This latter function became significantly important in the escalation of conflict and repressive regulation of MHPSS services.

It was noted that the more influential and connected the members of the network – and most especially, the leadership of the network – the better the chances of the network to fulfill its negotiating role. Influence was gained by being well-recognised, respected and credible in the MHPSS sector (generating willingness of other organisations to participate, for example). This was further enhanced through connections to the state healthcare system or state administrative agencies (generating the ability to play a ‘guarantor’ role for other PS workers from the network, for example). These qualities of effective leaders also meant that the networks were heavily dependent on the availability and willingness of key individuals – and not much attention was placed on developing a second-tier of possible leadership. These elements of influence and power also shaped the way that the coordination mechanisms were steered in the post-conflict context.

There was no noted special emphasis on strategic planning for ensuring the sustainability and continuation of coordination mechanisms found by this study. Nevertheless, two key aspects impacted sustainability of the coordination mechanisms: one was the reduction in funding for MHPSS work that halted organisations from providing them, and the second was the highly restrictive and regulatory environment imposed on MHPSS services in the post-conflict context, in some contexts where such services were expressly forbidden by the government. In these circumstances, the reduced number of organisations that provided MHPSS services led to the closing down of some networks while the risk posed to personnel and organisations led other networks to decide to shut down.

The study of these three coordination mechanisms indicate that coordination is highly sensitive to politics and power, and as such the continuation and sustainability of these mechanisms is very dependent on context, as well as the inherent capacity of those leading coordination to negotiate this.

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# Sustaining NGO Services for Mental Health and Psychosocial Support in Sri Lanka during Transition Periods, 2004-2014

By Maleeka Salih, Ermiza Tegal, Marsha Cassiere-Daniel and Ananda Galappatti<sup>4</sup>

## Introduction

The experiences of Non-Governmental Organisations (NGOs) working in the humanitarian Mental Health and Psychosocial Support (MHPSS) sector in Sri Lanka over the past decade have demonstrated a particular vulnerability to changing political conditions, financing trends, and economic conditions. In recent years, there have been anecdotal accounts that rather than the scale of services expanding or contracting in response to the level of need in affected communities, the levels of activity of NGO service providers have been influenced by external factors related to changes in their operational contexts. The challenges faced by service providers in responding to transitions in the sector have implications for a) the sustainability of services for persons in need of support and b) for loss of investment (in terms of finance, effort and time contributed to institutional and human resource development) and innovation during preceding years. Even so, there is limited literature on the sustainability of MHPSS services (especially by NGOs) in the transition from emergency response within Sri Lanka or indeed internationally (see Patel et al. 2011; Galappatti and Cader 2016).

This chapter attempts to gain insight into some key challenges associated with sustaining services in the context of post-emergency transitions, as well as to identify factors that exacerbated and mitigated these with reference to NGO MHPSS service providers in Sri Lanka. Whilst the research findings aim to contribute to the literature on sustainability of humanitarian MHPSS services, these insights will also be utilised to inform local efforts to ensure the continuity of MHPSS services to those in need.

## Methodology

The main research questions of the study were as follows:

- i. What challenges have non-government MHPSS service providers experienced as a result of transitions in their operational context?
- ii. What strategies have these service providers used to respond to these transitions, and what factors have been important in shaping their resilience or vulnerability to these changes?
- iii. How have transitions impacted the quality or nature of work within the organisation?

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Data collection for the study was comprised of two components:

- a) The first component comprised of case studies from 3 organisations identified based on geographic diversity (headquartered in Jaffna, Vavuniya, and Colombo but working in several locations around the country – though more concentrated in the north), representation of issues across the timeline under study and willingness to meet study requirements. This included an overview of relevant institutional documents (i.e. annual reports, organisational evaluation reports, project proposals and reports, strategic plans, organograms, etc.), from which information related to transition issues were extracted. In addition, we conducted 12 qualitative interviews with key stakeholders currently and previously involved in management of the selected organisations. These interviews were intended to expand on the issues identified and to explore the ways in which the institution and its service providers responded to these transitions,
- b) The second component constituted a one-day consultation workshop with a reference group of 19 managers and technical resource persons employed by or associated with NGOs working in the MHPSS sector across Sri Lanka. This workshop included a number of small-group exercises that were used to identify common challenges and factors mediating vulnerability and resilience of NGOs providing MHPSS services. The consultation also included the generation of a set of recommendations to key stakeholders.

Data collected from these two sources was analysed using the NVivo qualitative analysis software package and also manually reviewed by two independent reviewers to identify key themes. All identifiable details related to specific organisations or individuals were removed or anonymised.

It must be noted that this study relies exclusively on reports from purposively selected NGO service providers and technical personnel working with these. As such it is neither exhaustive in scope nor perspective. However, it does present credible (and frank) insider views of the constraints faced by NGOs in relation to sustainability of the MHPSS services they offer.

### **A Brief History of the NGO MHPSS Sector in Sri Lanka**

The start of the non-governmental MHPSS sector in Sri Lanka can be traced to the political violence of the mid 1980s, when anti-Tamil riots and ethnic violence across the country and a brutal repression of insurgency in the south mobilised a number of civil society attempts to respond to the attendant suffering and distress. Though few in number, these initiatives focused on the provision of services following a centre-based individual clinical model of therapy, very much in line with global approaches of the time. By the late 1990s and early 2000s, however, many practitioners had felt the limitations of the predominantly clinical approach and had recognised the broader social and structural factors that impacted



psychological and social aspects of wellbeing. In order to respond to these, some services incorporated community development elements, for example supplementing MHPSS services with livelihoods support or integrating MHPSS services into resettlement, child protection, or gender-based violence responses. Increasingly, psychosocial support featured in the repertoire of services or activities offered by development and humanitarian agencies in northern and eastern Sri Lanka (Galappatti 2014).

This latter ‘integrated’ approach boomed following the 2002 ceasefire agreement: many agencies that had previously not engaged with the MHPSS needs of the communities in which they worked then began to implement MHPSS programmes. This increase in the size of the sector is reflected in the ‘Directory of Psychosocial Services’ published by the Psychosocial Support Programme, International War-Trauma and Humanitarian Intervention (IWTIH) Trust, where the number of initiatives included went from 70 in the 2001 edition to 130 in 2003 (Psychosocial Support Programme 2001; 2003). In addition, there was emerging recognition of MHPSS by the Sri Lankan state. During this time, donor agencies supported the government in initiating a number of initiatives integrating MHPSS elements into public services, for example in child protection (e.g. training of govt. officers to provide psychosocial support) and education (e.g. Master Counsellors in schools). Many of these initiatives were piloted in the north and east of Sri Lanka.

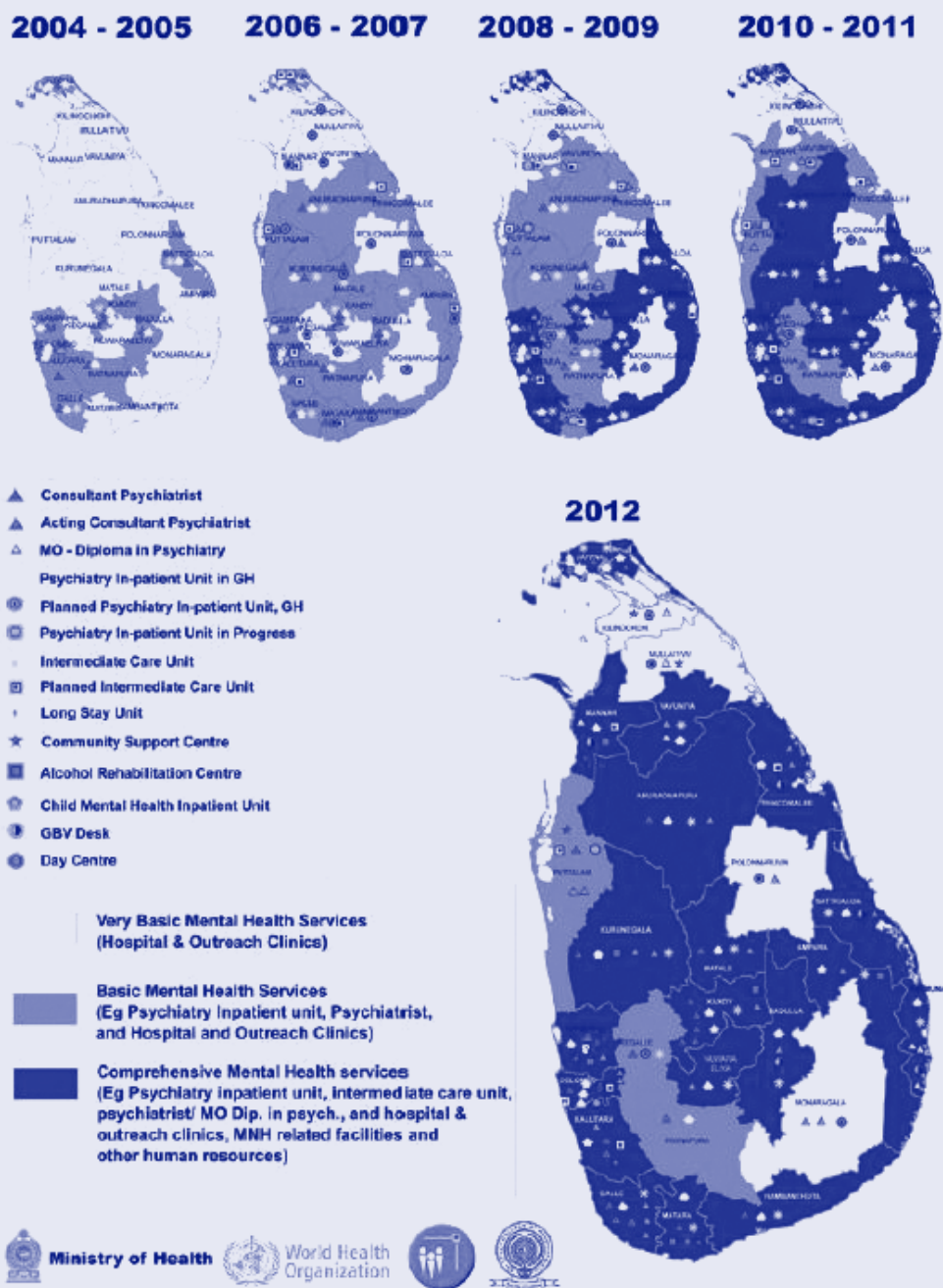
These different attempts at MHPSS provision resulted in several variants of integrated models, each with their strengths and weaknesses (see Galappatti 2014 for descriptions of the various integrated models). Integrated services are more acceptable to beneficiaries, they are more sustainable and scalable, but at the same time, require greater insight and contextualisation. There is also a greater risk of invisibility of MHPSS services, and potential that seamless integration results in confusion about ‘what is psychosocial’ thus ‘mainstreaming MHPSS out of existence’. Furthermore, inter-sectoral work requires cross-disciplinary skills, knowledge and co-operation amongst practitioners. Integrated approaches are also not easy to promote with policy-makers, or fund-raise for with donors because of the widespread popular perception of MHPSS as primarily professional therapy or as grassroots level befriending for vulnerable individuals and groups.

The aftermath of the Indian Ocean tsunami in December 2004 was a major jolt for the non-governmental MHPSS sector in Sri Lanka. The need for MHPSS support in the post-tsunami context was immediate and seemingly obvious, and became a key part of the media narrative within days. Although Marsden and Strang’s (2006) post-tsunami review showed there were few systematic needs assessments used in setting up the MHPSS response to the disaster, the perceived need and supply-side factors (i.e. availability of resources) resulted in massive expansion of the sector – especially non-governmental services. Whereas the conflict in the north and east of Sri Lanka had meant a concentration of MHPSS work in these regions, the tsunami brought MHPSS interventions across the island to all tsunami-affected coastal areas. The level of MHPSS interventions were unprecedented. A Tsunami Evaluation Coalition (TEC) report (Parakrama 2007) enumerates 374 MHPSS actors across the affected districts, although this is likely to be a significant underestimate. Galappatti

(2016) reports that in the Eastern District of Batticaloa alone, there were over 70 (mostly non-state) MHPSS actors active in just the first 6 months following the disaster. MHPSS needs in post-tsunami recovery context were varied and complex, requiring a range of different approaches. Beyond the effects of loss, grief and fears on emotional status and psychological functioning, MHPSS needs also included the challenges of adjusting to new social roles and livelihoods, disruption of social support networks, increased risks of gender-based violence (GBV), and a greater need for child protection initiatives. Furthermore, a sometimes insensitive or poorly implemented humanitarian response itself caused further difficulties and exacerbated distress experienced by affected people.

Nonetheless, the scale of the humanitarian response also represented an unprecedented level of resources for expansion and development of MHPSS services. Indeed, the coverage of both state and NGO MHPSS services was boosted, capacity was built in several parts of the country simultaneously as well as at national and local levels, and overall, the quality of services could be said to have improved. In some parts of the country, innovation and maturity of approaches was driven by strong state and non-governmental collaboration at local level, improving gender based violence (GBV), child protection and mental health services. Some of the tsunami aid was directed towards strengthening core public MHPSS services, for example, supporting the government in finalising the national mental health policy. The use of the tsunami crisis as an opportunity to ‘build (MHPSS services) back better’ has been well noted and Sri Lanka described as a poster-child for development of mental health services after an emergency (WHO, 2013).

As seen in Figure 1, mental health services offered through the Sri Lankan state health sector grew steadily in the years after the tsunami, a very likely impact of the push for action on national policy, training, and recruitment of cadre for positions at provincial and district levels at the time. Alongside the development of clinical MHPSS services, community-based mental health activities also saw an improvement, though not at the same scale. There was also significant growth in the numbers of community-based government personnel involved in provision of psychosocial support in the sectors of education, child protection, and women’s empowerment, although these have not received quite the same level of attention or investment as in the health sector.



At about the same period of time (2006-2008) that the state services began to

Figure 1: Growth of State Mental Health Services 2004-2012 (WHO)

show growth in coverage and capacity, the post-tsunami aid directed to the NGO sector began to decline and come to an end – with the consequence that many organisations struggled to continue their work in the affected areas and to sustain services. In the north and east of the country, this was complicated by the resumption of active warfare from 2006-2009, encompassing a period of intense conflict with massive displacement, exposure of civilians to violence, forced recruitment, bombardment, and massive loss of life, property and livelihoods. In war-affected post-tsunami areas, many gains made by families and communities during brief recovery periods were lost or undermined by violence and displacement. Additionally, the broad MHPSS sector struggled to respond to the conflict context and issues. The immediate post-war period was characterised by difficult relations between the political, military and administrative elements of the state and humanitarian actors (both international and local), which impacted significantly on the activities of non-government organisations working on MHPSS issues in conflict-affected regions.

### Transitions 2004 to 2014

Galappatti (2016) has mapped the growth and decline in the scale of MHPSS services in the context of crisis and emergency into six major overall phases (see Figure 2).

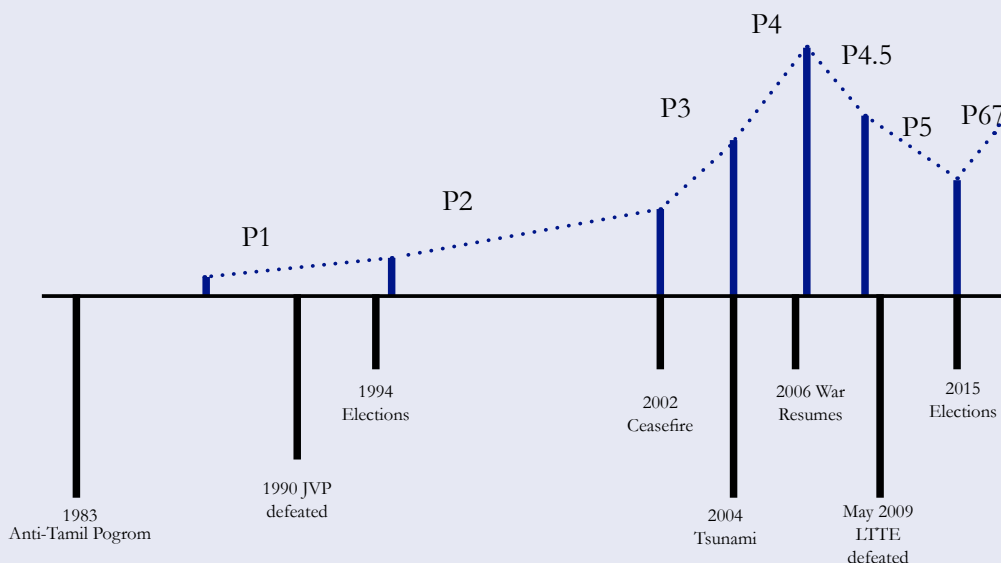


Figure 2. Timeline of MHPSS sector development in Sri Lanka (Galappatti 2016)

This review focuses on the decade from 2004 to 2015, encompassing the following major transitions in the external and operational context of phases (P4, P4.5 and P5 respectively on the timeline in Figure 2) as follows:

- Transition from post-tsunami response (2005) to escalation in war related violence (mid-2006)

- Transition from period of escalated conflict and full-blown war (late 2006) to the end of fighting with the defeat of the LTTE (mid-2009).
- The post war context (mid-2009) to just prior to the change of political regime (end of 2014)

## **Findings**

Several main thematic issues arose from the key-informant interviews and workshop sessions that generated material for this study. In line with assurances given to study respondents, the findings reported and examples given below do not contain any information that might identify given respondents or specific organisations to which they referred. The focus rather is on describing the factors that impacted on sustainability of NGO services for MHPSS. These have been organised into themes, not necessarily listed in order of priority or significance. The views expressed below reflect common or shared perspectives of the study participants, except where divergent views are highlighted.

### **Key Factors that Affected Sustainability of NGO MHPSS Services**

#### **Political, Regulatory and Administrative Constraints on NGO MHPSS Services**

Historically, the field of MHPSS has not been viewed as politically sensitive by any of the conflicting parties in Sri Lanka, and in fact has been characterised as relatively a-political by some commentators (Galappatti 2003; 2014). As such NGO services for MHPSS were able to function with few political or regulatory constraints. During the period following the 2004 tsunami disaster, the lack of regulatory or coordination frameworks was associated with a chaotic and uneven MHPSS response, although several effective approaches to address this also emerged from joint government and NGO initiatives in the tsunami-affected areas (Galappatti 2005; Wickramage 2006; Krishnakumar et al., 2008). These were largely voluntary forms of coordination and were facilitative rather than regulatory in nature, although some (typically associated with the health sector and district administration) did appear to play a more formal authoritative role as gatekeepers over what projects were implemented (Cassiere-Daniel and Salih 2016, this volume).

At the end of the war (2009), there were explicit constraints placed on MHPSS interventions in the Northern Province of Sri Lanka. Study participants highlighted security restrictions on NGO provision of MHPSS support (along with other humanitarian services) to the approx. 300,000 displaced persons interred in the Menik Farm camp complex after having experienced unprecedented hardships and traumatic events during the final months of the war. Participants also described denials and resistance towards approval of MHPSS related projects by the Presidential Task Force that formally reviewed all humanitarian and non-government activities in the Northern Province. The disbanding of the health-sector led Jaffna District Psychosocial Task Force by the then Governor of the Northern Province, was also seen as reflective of a view of psychosocial support as ‘politically sensitive’. There was a perception that this political sensitivity was because of the risks that therapeutic encounters represented for gathering of evidence for future ‘war crimes’ advocacy and cases

by critics of the Sri Lankan government's prosecution of the war, or that social interventions might be a basis for mobilisation of resistance to the post-war security arrangements in the Northern Province.

State sector MHPSS services, especially those related to the health sector, were able to work with fewer constraints in the Northern Province, and working in formal collaboration with government bodies sometimes enabled NGOs to work openly to provide services. Collaboration was not straightforward, as in at least one instance, state sector service providers had to breach client confidentiality and provide counselling session reports to their line-Ministry, which some NGOs feared might be passed on to intelligence services for security screening. It was felt that in some instances, like work with families of missing persons, survivors of torture or ex-combatants, there could be conflicts of interest or risks associated with working closely with government systems that either included or liaised closely with armed forces that might be implicated in clients' problems. In other instances, there were much more positive experiences of local-level collaboration between public sector service providers and NGOs – often on an informal case-management level, but also sometimes in relation to local mechanisms to deal with issues such as GBV or child protection concerns. At a national-level, obtaining approval for work through central government ministries often meant that NGOs had to comply with the programmatic priorities or staff qualification requirements decided by senior ministry officials – which some felt were not always appropriate or feasible within the implementation context.

Difficulties with obtaining permission to independently implement explicit 'psychosocial' programmes in the Northern Province led many NGOs to reframe their work as other types of interventions into which MHPSS elements were integrated. Some felt this forced them to be 'underhand' about their work, and felt it created strain on staff and their organisations. Some also spoke about the potential loss of focus on MHPSS issues, because of this reframing.

There were also contradictory policy-level messages in relation to MHPSS services. Even as NGOs faced constraints on the ground, which were often highlighted by international critics of the government (ICG 2012; HRW 2013), the government in the post-war period claimed that there was no formal ban on this work. Indeed, the Lessons Learned and Reconciliation Commission (LLRC 2011) advocated for the need for psychosocial support provision, as did the later Presidential Commission to Investigate Into Complaints Regarding Missing Persons (PCICMP 2015), which actually made a detailed proposal for psychosocial and counselling services in 2015. Despite conciliatory shifts by the post-war government, perceived to be in response to international pressure, it was only after the election of a new President and establishment of a new government in January 2015 that NGOs perceived a significant shift in the political climate in relation to MHPSS services in the Northern Province.

It appears that there was a lack of clarity and consistency about the regulatory and administrative mechanisms that impacted on NGO MHPSS services. Even in the Northern Province, it was clear that in some instances, military commanders on the ground identified a need for MHPSS services and were explicitly supportive of NGOs delivering services without

formal permission from the Presidential Task Force (which was eventually disbanded in July 2014). Similarly, in other parts of the country, administrative approval processes for NGO activity involving District and Divisional Secretaries, and their designated subordinates, were reported to be somewhat personalistic in nature – with some officials being open to NGOs working on MHPSS issues and others being unsupportive or hostile. Some of this was reflective of the broader political climate within government that was unfavourable to NGOs and also to issues perceived to be potentially detrimental to the political interests of the state.

Concurrent with concerns about chaotic and unregulated post-tsunami aid delivery, the 2006 resumption of active conflict hostilities and consequent growing tensions between the government of Sri Lanka and humanitarian agencies, there was a shift towards greater oversight, regulation and control of NGO activities throughout the country and especially in districts within or bordering the conflict-affected areas. Procedures (mentioned above) for regular reporting to and approvals by local administrators were put in place, which made NGOs vulnerable to the particular officers and officials whose recommendations or approvals were required for the NGOs to be able to work – leading to unequal collaborative relationships, and on occasion coercive or exploitative dynamics with these personnel. These mechanisms were described by participants as creating both an additional burden of work as well as introducing uncertainties and delays to the progress of project-based services. The implementation of these procedures, coupled with the increase in government services and personnel intervening in the same programmatic space (i.e. health, education, social care, women’s empowerment and child protection, etc.) as NGOs, meant that the dynamics of coordination and collaboration between government and non-government actors shifted towards the state actors playing an often more authoritative and dominant role. This was perceived to be a problem in the context of officials who exploited this power or who exercised it in a partial or ineffective way.

### **Availability of Operational Funds and other Resources**

Study participants highlighted the availability and scarcity of resources, especially donor funding, as a key factor impacting on sustainability of NGO MHPSS services. Whilst the post-tsunami period was characterised as a period of unprecedented abundance in terms of financing for MHPSS services in Sri Lanka, the period that followed this from 2008/9 onwards was increasingly marked by a decline in availability of funding. One reason given for this was the exhaustion (and non-renewal) of the funding committed as a part of the response to the 2004 tsunami disaster.

From 2007, the increasingly uneasy relationship between the incumbent government and international donors also meant that many of the traditional donors to MHPSS (i.e. bilateral aid agencies and foreign missions from European and North-American countries) began to downscale, delay and cease funding MHPSS services. The limitation of independent humanitarian access to the Northern Province in the period from late 2008 onwards was seen to further contribute to donor reluctance to fund MHPSS services in the area or even elsewhere, with devastating effects for service providers who had relied on these. That the

war had ended and the fact that Sri Lanka had recently achieved ‘middle-income country’ status was also seen as feeding into the rationale for donors to ‘step back’ from funding in Sri Lanka and prioritise other contexts seen as having more urgent needs or better prospects for productive engagement by the international community (e.g. Myanmar). Most donors who did remain engaged with Sri Lanka’s post war context were often seen to prioritise material needs such as shelter and livelihoods, rather than MHPSS activities.

A few participants also highlighted how global issues also impacted on funding in Sri Lanka. The global financial crisis was felt to have a direct effect on funding from donor countries affected by this, especially on donors that draw on individual or small group donations as the source of funds to be disbursed in Sri Lanka. The fact that there were a number of large scale, high profile “Level 3” emergencies (i.e. the numerous Middle-East crises that unfolded after the ‘Arab Spring’, typhoon Haiyan in the Philippines, the major Nepal earthquake, etc.) for which the global humanitarian system was mobilised was also seen to be a reason for Sri Lanka’s post-war context being de-prioritised for funding.

The almost exclusive dependence of NGO MHPSS services (almost exclusively in some cases) on international donors (and their local intermediaries) was also related to a lack of in-country funding sources and limited local fund-raising strategies on the part of NGOs – whose efforts in this area tended to generate piece-meal charitable donations that were neither structural nor sectoral in nature. One participant also highlighted the fact that few NGOs had the internal capacity or insight to anticipate donor trends and adjust fund-raising strategies accordingly (e.g. anticipating that a change in government in a donor country was leading to changes in bilateral funding priorities, and seeking out new financing sources in advance of current funding coming to an end – rather than being surprised too late when they are informed that funding to Sri Lanka or on post-conflict issues would not be extended).

Participants also spoke about how limited financial resources meant that they could not always afford to hire the staff they needed to address new priorities or re-orient their organisations’ work. Some also mentioned the legal and moral burden of carrying long-standing staff members who may not be ideally suited to new areas of work (in which there might be better funding opportunities). Others described the loss of personnel to other organisations and staff leaving for other careers when their NGO experienced gaps or cut-backs in funding. Some spoke about closure or scaling back of services, even when they perceived that there were significant MHPSS needs to be met in their communities. Participants also highlighted the fact that expansion of staffing and development of resource-intensive models for intervention took place during the years of post-tsunami abundance for the MHPSS sector, which proved challenging to sustain once these levels of funding declined considerably. There was also acknowledgement that few NGOs seriously considered how their work might be sustained realistically in the absence of long-term funding, and that many ideas put forward on the transfer of responsibility for service provisioning to communities themselves or to the state sector were unrealistic and likely to fail.



A final point that participants made about access to funding was that donors had increasingly shifted from institutional ‘core’ funding to ‘programme only’ funding, leaving NGOs with limited resources for organisational overheads and no buffer in the case of gaps or delays in project funding.

### **Demand for and Usage of NGO MHPSS Services**

An ongoing demand for and use of MHPSS interventions is also a factor impacting on the need and ability to sustain services. Where NGOs were able to demonstrate utilisation of their services (in terms of user numbers) they were able to justify the continuation of their work – whereas when numbers of service users declined they were often compelled to close or scale-down these services. Therefore, perceptions within the affected communities about the relevance, quality and accessibility of MHPSS services were key mediators of demand and utilisation.

The approach to MHPSS provision was important for defining the relevance of services to users. Many studies have noted a range of ongoing psychosocial and mental health problems resulting from protracted conflict in Sri Lanka and the 2004 tsunami (Fernando and Weerackody 2009; Somasundaram 2010; Somasundaram and Sivayokan 2013; Senarath et al. 2014; Sritharan and Sritharan 2014). The emphasis of NGO services has often been on addressing ‘trauma’ through counselling or explicitly therapeutic activities, although for many affected people, the priorities of dealing with the demands of everyday life and survival – to find and maintain work, to provide for children’s needs, education and security and to rebuilding homes – have meant that they have little time or inclination to seek out counselling services, unless they are referred to these or recognise their problems as relevant to these services. The lack of familiarity with counselling as a means of addressing problems has led some NGOs to adopt a strategy of seeking out clients proactively. For others, combining services with other forms of support (such as health, legal, material aid or other practical assistance) was a means of engaging clients who did not recognise a need for explicitly therapeutic support.

A further factor in people’s uptake of and receptivity to MHPSS services are the popular cultural understandings of mental health and illness and how potential service users and those in distress understand or give meaning to their own psychological and social states and circumstances. This is also related to how others in their broader social context respond to and treat those who are in need of or seek MHPSS services.

Some participants described that in the immediate post-war context in the Northern Province, there were risks associated with seeking (and providing) MHPSS services in community and institutional settings, especially in relation to experiences of violence. Visiting psychosocial and community workers were subject to military surveillance and both they and clients might be observed or questioned about the nature of their interactions. Similarly, recreational activities for older children and youth would be attended or subject to scrutiny by intelligence personnel concerned with possible mobilisation of political resistance. There were also reports that suggested that at the end of the war, military or undercover personnel

were present in hospital wards. Collective healing or memorial processes such as public cultural rituals were also subject to restrictions by the security forces.

One participant reported the expectation in their NGO that client numbers would decrease in the post-war context in the north of the country. However, their experience had been the opposite, with numbers of service users (such as families of the disappeared, survivors of bombing, etc.) seeking assistance increasing. The participant attributed this to these service users not wanting to approach government health or social services, possibly because of the state's role in the conflict and the specific events that produced their suffering.

One of the key points highlighted in the interviews was the impact of effective services on maintaining demand for services and on the retention of users. One participant noted that the development of an effective assessment tool helped service users see for themselves their progress across the different sessions, and that this was important in creating trust, increasing the number of service users, raising the confidence of the service providers and overall, making a good case for continued funding of services. In contrast, interviews in organisations where there have been no or little attention given to evaluation of services noted that, 'still there is uncertainty about the positive changes and quality aspects of (our) services'.

According to the interviewees and participants in the consultation workshop, effectiveness of services was also demonstrably improved through inter-sectoral collaboration. Their view was that MHPSS services could not be delivered solely through NGOs, the state healthcare system or social welfare services, instead what was needed was for complementary services to work together. Participant interviews underscored that providing services together with partners, whether state agencies or not, helped improve quality of service to users. When service users presented with acute mental illness, it was essential to be able to refer them to the government hospital for clinical care. At the same time, community-based and rehabilitative mental health initiatives provided by NGOs were felt to play an important role that the state was unable to fulfil. Similarly, MHPSS NGOs working with healthcare service providers, law enforcement officials, lawyers, other NGOs and gender activists helped to ensure a comprehensive and effective support service to women and children experiencing gender based and/or domestic violence.

Accessibility of services was seen to be affected by availability of transport infrastructure and, for poorer clients by availability of assistance with transport costs. The presence of barriers to travel, such as checkpoints, restrictions on free movement of persons or NGOs, and other sources of risk during the war and in some areas even during the post war period, was identified as a hindrance to clients accessing services – or services proactively accessing clients. Close linkages between service providers (including state and NGOs) was also seen as a means of increasing access, with deterioration in the quality of inter-sectoral collaboration in the post-war years undermining this.

### **Internal Capacity and Governance of NGO MHPSS Services**

Participants also spoke about factors within MHPSS service providing non-government organisations which affected their ability to respond to changes in the external context, or affected their vulnerability at an institutional level. Internal capacity was seen as important in terms of knowledge and skills to respond to challenges in fund-raising, negotiating with uncooperative or hostile regulatory bodies, forging partnerships with others in the field, and being able to take on new approaches or focus of work.

The management and governance of institutions was also seen to be an important source of resilience or vulnerability in the face of external challenges. There were examples shared of how systems for staff care and supervision helped to support personnel and sustain services through periods of extremely difficult and stressful work, and also how the breakdown of these systems could result in impacts on staff and the organisation that threatened and ultimately undermined the organisational ability to play a vital role in delivering and leading MHPSS services. Examples were shared about how management errors and poor internal relationships resulted in threats to the organisation in terms of staff conflict and even legal proceedings that affected the organisation financially. Proactive management was also seen to have been successful in reorienting its mission as a conflict-focused MHPSS NGO in order to adjust to post-war funding and operational realities, and shifting to work with a new underserved population in Sri Lanka.

The ability for organisational leadership to transition smoothly was seen to be important for sustainability. The inability of some organisations to shift from visionary or charismatic founders to a second generation of leadership was described as a barrier to adaptation and continuity, especially where founders were ageing or unwell. This was also seen as a problem for renewal of organisational vision and approach in response to a changing context – something that many NGOs faced in post-war Sri Lanka.

### **Conclusion and Way Forward**

This review has been concerned with the sustainability challenges faced by non-governmental MHPSS service providers during transitions in the period 2004-2014, which proved to be a particularly challenging time for non-governmental organisations in general, and for MHPSS NGOs in particular. The participants in the study highlighted a number of challenges flowing from the political context and systems of administration that NGOs had to operate within, especially in areas affected by the conflict. They also unsurprisingly identified shifts in funding trends by donors as another factor, but were also reflective about the poor capacity of NGOs to anticipate and adapt to these. There was considerable self-critical commentary on other deficits in internal capacity that made organisations vulnerable to transitions and external challenges, as well as positive examples. Although not as powerful or as immediate a factor as the others mentioned above, there was also reflection on how the sustainability of MHPSS services provided by NGOs ultimately hinged on their ability to provide relevant, good quality and accessible services to persons in affected communities.

Although it is beyond the scope of this review, it is important to note that there were significant changes in the external operational context for NGO MHPSS services after the change of Sri Lanka's political regime when Presidential Elections in January 2015 also led to the formation of a new government with an explicit agenda for governance reform and addressing the legacy of Sri Lanka's long ethno-nationalist conflict. There were swift reversals of some of the more antagonistic rhetoric and overtly controlling approaches to coordination of NGOs, although at the time of writing many of the more subtly coercive administrative mechanisms that participants spoke about remain in place. The government has been more explicit about the need for psychosocial support to survivors of conflict, and for the need to work in partnership with NGOs. There have already been strong indications that international donors will support the current government's overall agenda, and seem poised to invest in services for post-war communities including possibly MHPSS supports through the government and NGOs.

In this context, the recommendations below generated by the participants involved in the study process may stimulate NGOs working in the area of MHPSS to adopt strategies to overcome current challenges identified and mitigate these in the future.

## **Recommendations**

### **1. Collaboration for Sectoral Funding**

- Initiate collective strategising and engagement of development stakeholders on financial sustainability of MHPSS sector services in Sri Lanka, especially those provided by NGOs;
- Establish a coalition of local and national-level practitioners and policy-makers to develop in-country fund-raising capacities and systems;
- Engage international donors/agencies interested in MHPSS issues in Sri Lanka to advise the sector on global funding trends and how to respond to these;
- Lobby government to fund both state sector MHPSS services and also NGO services;
- Implement initiatives to increase institutional capacity around financial and sustainability planning for MHPSS NGOs;
- Invest in public communication and advocacy for better recognition and acknowledgement of value of contributions of MHPSS services provided by NGOs;
- Develop advocacy strategies to ensure acknowledgement of MHPSS services as part of citizen's entitlements (along with right to health, education, etc).

### **2. Collaboration on Improving Services and Knowledge [for sustainability and cohesion within the field]**

- Identify sustained sources of funding for developing and implementing a system for sharing sectoral knowledge on effective and contextually relevant MHPSS services;
- Ensure allocations of funds for systematic data collection to monitor project processes, outputs and outcomes – for learning and for use in fund-raising and reporting;

- Ensure compliance with global standards, to improve quality, and adopt common frameworks to be able to work and advocate collectively;
- Recognise the political dynamics impacting on MHPSS issues and service provision, and develop approaches for negotiating these;
- Establish accountability mechanisms for MHPSS practice that ensure quality for clients and prevent bad practice, but retain diversity of field and autonomy of NGOs;
- Commit to periodic external evaluation processes, and collaborate on peer evaluation and learning processes, to strengthen services and to increase and broaden the evidence base for varied MHPSS interventions in Sri Lanka;
- Improve processes for internal review and improvement of management and governance processes, including succession planning.

### 3. Collaboration on Advocacy and Lobbying

- Articulate a vision for NGO and government collaboration in relation to MHPSS services. This should also link to a broader collective inclusive process to create vision, strategies and actions for sector development to be used in policy-level advocacy with the government;
- Undertake policy advocacy with the government in relation to MHPSS approaches in Sri Lanka's post-war context, using existing commitments (i.e. LLRC, CRPD, UNHRC Resolution, etc.) and mechanisms (i.e. ONUR Task Force) as a platform for this.

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Counselling Assistants, Ministry of Women and Child Affairs  
Source : Gemunu Amarasinghe 2016



# Surviving Transitions: A Case Study of the Preventing Gender-Based Violence Task Force, Batticaloa, 2004-2015

By Zainab Ibrahim<sup>5</sup>

## Introduction

In 2004, a Preventing Gender-Based Violence (PGBV) Task Force was established in the Batticaloa District in the Eastern Province of Sri Lanka, to help coordinate a multi-stakeholder response to violence against women. Despite the high degree of perceived success of this initiative, the PGBV Task Force experienced numerous transitions that presented challenges to its functioning. These include the context of a tsunami in December 2004 that caused extensive destruction along Sri Lanka's coastline, militarisation that included armed conflict between state and non-state actors, and the emergence of paramilitary groups that had a strong presence in the District. Armed conflict between the Government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE) formally ended in May 2009.

There were also factors inherent to the structure and functioning of the Task Force itself that affected its operations both positively and negatively, such as its governing ideology and politics over time, changing leadership, changing roles of government in the Task Force, changing relationships between government actors and civil society groups, the availability of resources, the capacity of actors working in this area, among others. How all of these factors changed the nature of the space in Batticaloa for civil society organisations and activists over time, has also been an important consideration in the functioning of the Task Force. These periods and points of transition and the responses of the Task Force are significant because it has shaped the evolution of the Task Force and the nature of its work in addressing violence against women in the Batticaloa District which has 14 Divisional Secretariat Divisions. The Task Force continues to operate in the Batticaloa District at the time of this report.

Reflecting on the work of the Task Force also provides a means of taking stock at this stage and identifying the changing relevance of the Task Force to the needs of the district in addressing violence against women. This chapter studies the diverse roles and strategies adopted by the Task Force to respond to these transitions and what this has meant for its sustainability, both in terms of its structure as well as in the content of its work. In order to analyse how the Task Force responded to changing contexts and circumstances and to understand the implications of this, a framework provided by research on *'Transitioning Mental Health and Psychosocial Support: From short-term emergency to sustainable post-disaster development'* (P.P Patel et al., Humanitarian Action Summit 2011) was used. This framework considers five

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thematic areas to successfully transition from emergency and conflict to a post-conflict phase: 1) The role of the government, which considered the availability of policies or frameworks that were in place, the importance of new policies not undermining existing structures in a way that inhibits sustainability, the extent of government buy-in in terms of resources and support, and the extent to which government dynamics affect service delivery; 2) Human resources and training, which considered the importance of training existing staff in public services who are also mentored and supervised over long periods of time, and the importance of locating these practitioners in areas where services are over-extended; 3) Programming and services, which considered the importance of systems of response and support in a holistic way, which also included the formation of partnerships; 4) Research and monitoring, which also considered the importance of systems to collect and maintain data; 5) Sustainable financing, which included implications when there is a sudden influx of cash, as well as when donors pull out rapidly. These thematic areas are taken into consideration in each section of the findings of the study.

## **Background and Context of the Batticaloa District**

The Batticaloa District has a population of 526,567. Located in the Eastern Province of Sri Lanka, the predominant ethnic group is Sri Lankan Tamil followed by Muslims (DCS 2012). Batticaloa District Secretariat statistics for 2013, however, put the population at 582,323, of which 297,151 are women and 285,172 are men. There are 28,976 women-headed households in the Batticaloa District (Batticaloa District Secretariat 2015). The economy of Batticaloa is predominantly based on agriculture and fishing.

Periods of emergency and armed conflict characterised the operating environment of the Batticaloa District for at least the first five years of the life of the Task Force which began in 2004. Batticaloa saw heavy military presence by Sri Lankan armed forces, and supported by the paramilitary group the Tamil Makkal Viduthalai Pulikal (TMVP), a faction that had broken away from the Liberation Tigers of Tamil Eelam (LTTE) in March 2004. The LTTE was largely defeated in the east of the country in 2007 but the TMVP continued to operate with a great deal of impunity in government controlled areas. Prior to 2004, the LTTE had partial control of the Batticaloa District on the western side of the lagoon as well as the north of the District. They exerted strong control over local populations, also tightly controlling or taking over trade union and NGO coordination bodies, openly asserting themselves in the District during the ceasefire that came into effect in 2002. The threat of violence often ensured there was no opposition (Galappatti n.d.).

In December 2004, the Indian Ocean tsunami caused terrible destruction for coastal communities in Sri Lanka. In Batticaloa, an estimated 3177 died or were missing and 255,000 people were affected. The aftermath of the tsunami overwhelmed the District, and armed hostilities were temporarily halted, although briefly, and a low-level hum of violence continued by all armed actors that now operated in the District. Coordination committees/task forces were set up under the Government Agent (GA), chaired by an official representing a Government institution and co-chaired by a development agency. Networks were also set

up, such as the Women's Coalition for Disaster Management (WCDM), which played an important role in dealing with issues affecting women in this context.

### **State-NGO Relations:**

In 2006, the election of a President on a hardline, nationalistic platform saw a full-scale return to war. The priorities of the government at this time also emphasised broader development agendas of building large infrastructure. For instance, in 2007 with the capture of the last LTTE stronghold in the east, the government announced a large development programme for the east called 'Nagenahira Navodaya' (Eastern Awakening) which included plans for large scale industrial development and infrastructure. This was also indicative of the general government direction of development, which emphasised 'hardware' projects – usually taken to mean infrastructure, over 'software' projects that included areas of work such as gender based violence. This period also marked a certain shift in donor priorities. At this time, anti-NGO rhetoric also became institutionalised: NGOs were increasingly viewed with suspicion and seen as having vested interests that were political and/or financial. Numerous humanitarian organisations were labelled as pro-terrorist. This is a trend that also continued for several years after the formal end of armed conflict in 2009 (International Crisis Group 2009; Dibbert 2014). These observations on changing donor priorities, mistrust and restriction of NGOs, was reiterated by several interviews in this study.

New government regulations were put in place to restrict the activities of humanitarian actors, especially international NGOs, such as visa restrictions for international aid workers. Local government officials had also begun to adopt an authoritarian approach in dealing with NGOs. (Galappatti n.d.). In Batticaloa, within Tamil nationalist discourse there was also an anti-NGO rhetoric that claimed for instance, that there was sexual exploitation of women working in NGOs, with some groups publicly calling for women NGO workers to leave their jobs or face violent consequences. Allegations and threats also caused families to restrict some women from going to work (Emmanuel 2009). Since mid-2008, there was a deterioration of the security situation in Batticaloa with political killings, enforced disappearances, robberies, extortion and attacks on police and army outposts (Crisis Group 2009). The war between the Government of Sri Lanka and the LTTE formally ended through military intervention, on May 18<sup>th</sup> 2009.

### **The Role of the Military in State-NGO Relations in the East**

The militarised apparatus of the state also played a significant role in this context of increasingly difficult state-NGO relations, which spilled over into administrative functions as well. Soon after the end of the war, the Ministry of Defence and Urban Development regulated local and foreign NGOs. Policy decisions about development work was made by the Central Government through the Nation Building Ministry, which was effectively controlled by Presidential Advisor and President Mahinda Rajapaksa's brother – Basil Rajapaksa. (International Crisis Group 2009). In a gazette notice issued on April 30<sup>th</sup> 2010, a

National Secretariat for Non-Governmental Organisations in Sri Lanka (NGO Secretariat) was brought under the purview of the Ministry of Defence and Urban Development. All NGOs and INGOs operating in Sri Lanka were required to register with this NGO Secretariat at the level in which the NGO was operating – national or district, and receive approval for plans before implementation.

In 2014, the government announced that all non-profit organisations would have to formally register with the NGO Secretariat as NGOs, or face penalties of severe financial restrictions. In the same year, the Defence Ministry also banned NGOs from holding press conferences, awareness campaigns, training programmes for journalists, workshops and disseminating press releases. (AFP, 2014).

### **Militarisation and Violence against Women and Girls**

The Report of the Leader of the Opposition's Commission on Prevention of Violence (2014) points to increasingly grievous and sexualised violence against women and girls in Sri Lanka. It also refers to the impact of increased militarisation and protracted armed conflict which has led to a deeply entrenched culture of violence and impunity in the country. Fear and insecurity, especially in conflict affected areas of the north and east have also made these crimes difficult to report. The same report also drew attention to a trend in sexual violence against minority women in the north and east by armed forces. While information is limited, with women and girls reluctant to report incidents due to fear of repercussions, the report provides the only available data for 2011 from police statistics, of 445 incidents reportedly committed by the Army alone. Other categories include police (105 incidents) and Home Guards (78 incidents) (ibid. p.35).

Thirty years of armed conflict has had a significant impact on the lives of women in Batticaloa – loss of family members due to the conflict, disappearances and arrests, multiple displacements, loss of livelihoods and assets and an increase in poverty. All of these factors have made women more vulnerable and with even less power to escape and take action against violence. The report also points to acts of control and intimidation such as military officials or proxies attending civil functions and meetings held by local communities as well as by local and international NGOs; allegations of coercion and transactional sex in exchange for being able to access services in the District, and harassment and intimidation of survivors and witnesses.

### **Establishment of the Task Force**

The establishment of the PGBV Task Force has its roots in programmes to address Gender-Based Violence by the international NGO, CARE International Sri Lanka, although the approach at inception was to create an independent network. It was to be a space where civil society organisations, local and international NGOs and government officials could work together in a relatively equal structure, on the issue of GBV. This independence was closely guarded at different points of the Task Force's history, and is an important aspect in the discussion of how the Task Force responded to changing contexts and circumstances.

In 2001, CARE conducted a gender audit which pointed to limited awareness and integration of issues of gender in the organisation's programmes. This led to the setting up of a Gender Working Group that drafted what it called a 'gender strategy' to inform its work, with GBV identified as a focus area across its projects. In November 2003, CARE Sri Lanka began working in Batticaloa initially through its 'Prevention of Gender Based Violence (PGBV) project. This project operated under different names in its lifetime, also being called the Gender Power Relations Project in 2005. In 2008, as funding for the project was coming to a close, the PGBV project was then merged with another CARE Sri Lanka project called 'Women Headed Households for Development and Peace' and together, renamed BRIDGE, which itself had three subsequent phases in the following years. Based on project documents, Batticaloa was selected because of estimates of a high incidence of reported GBV in the district, and the large number of organisations working on women's rights in Batticaloa at the time. Batticaloa is also among the three lowest ranked districts on the Human Development Index and ranks the highest on the Gender Inequality Index (Sri Lanka Human Development Report 2012).

Meetings of the PGBV Task Force were underway by June 2004 between CARE and interested stakeholders. Facilitating the setting up of a District Level Task Force was one approach within the stated goal of CARE to "strengthen civil society to influence policy and socio-cultural norms to ensure the realisation of women's rights to freedom from gender based violence," over a period of 3 years. The goal of the Task Force was to "facilitate a coordinated and systematic community response to both prevent GBV and support survivors of GBV." (CARE 2014, p.32). A core group was formed, initially with interested individuals who came together to initiate the Task Force and then later, with a representative from each sector related to the issue of PGBV. Task Force meetings were held every second month, and core group meetings were held monthly. CARE facilitated the formation of the Task Force and provided logistical support until its formal relationship with the Task Force ended in 2008.

In 2004, through the PGBV project, CARE published a brief report titled: 'Towards a Rights Based Approach to Ending Gender Based Violence – A Batticaloa Perspective'. This report mapped the main service providers who were working on the issue of GBV in the District at the time, identified gaps in the system and set out recommendations of the Task Force for key sectors – medical, police, legal and social services – involved in GBV prevention and response. Coordination was identified as an area of weakness, especially in relation to linkages with government service providers. The Task Force did not handle cases, but it did develop case-handling systems including formats for recording cases handled, preventing overlap in the event of multiple agencies handling the same case. This report also advised linking the Task Force to national priorities and concerns through national institutions for instance, with the view that this would be a way of making the Task Force a sustainable entity. Initial attempts to combine efforts with existing networks did not materialise due to differences in vision and approach.

One of the first interventions by the Task Force was closely linked to the health sector. The setting up of a GBV Desk in the Batticaloa Hospital in 2005, where women survivors of

violence could be referred to for follow-up care and intervention such as legal and judicial support, links to community workers and safe houses. There were three main factors that led to the health sector being selected as a point of entry into tackling the issue of GBV. 1) The close involvement and leadership provided by the District psychiatrist in the Task Force. 2) Health systems often being a first point of contact for women who have suffered violence (many survivors of GBV often came to the hospital with different complaints and these cases would get missed or proper services would not be provided). A Desk such as this facilitated referral both within the hospital and from outside. 3) Health systems being identified as a priority area for strengthening by the Task Force.

The first GBV Desk was attached to the Mental Health Unit of the Batticaloa Teaching Hospital. This Desk became the point of contact where cases of GBV identified within the hospital could be referred to, or for outside agencies to refer cases to the Hospital. The functioning of the Task Force and the GBV Desk were closely linked, serving to build capacity in the overall response to GBV at the time. This is discussed further in the section on Evolutions in Structure, later in this chapter. There are now GBV Desks set up in Hospitals in Valachchenai, Kalawanchikudy and Chenkalady in the Batticaloa District and Kalmunai and Akkaraipattu in the Ampara District. There are also Desks in other parts of the country including Matara, Nuwara Eliya, Vavuniya, Anuradhapura and Kandy.

In 2009, the PGBV Task Force was brought directly under the office of the Government Agent (GA) in Batticaloa, a step which has had significant implications for the functioning of the Task Force. What this means is that the GA chairs the Task Force, but it remains an informal body, not absorbed into formal government structures.

In 2010, the District Level Task Force was expanded to set up 14 Divisional Level Task Forces in each of the DS Divisions in the District. The DS Division Task Forces were to form a link between community level mobilisation around GBV and the District Level Task Force. The government appointed Women's Development Officer (WDO) is the focal point for each DS level Task Force.

At the time of this report, the Task Force had seen considerable changes in context as well as circumstances and people that formed the network. It was also in a process of transitioning through a change in leadership since it was brought under the GA's office. The GBV Desks also function as government health desks - called 'Mithuru Piyasa' centres - and have been absorbed into District Hospitals. The Mithuru Piyasa centres were set up with the support of the UNFPA.

## **Methodology**

There was an initial review of existing documentation of GBV services in Batticaloa and the GBV Task Force for relevant information related to the history, structure as well as approaches adopted by the Task Force over time. The literature review also explored issues of transition and sustainability. Through these and discussions with people who were

associated with the Task Force at various points, a list of key informants were generated. Several of these people continue to be associated with or closely involved with the Task Force.

A total of 19 semi-structured interviews were conducted in Tamil and English (as appropriate) by two researchers over a two-week period in July and August 2015 in Batticaloa and Colombo. An effort was made to keep the interview pool representative of a variety of stakeholders who were involved in the Task Force in different capacities, representing the government and non-government organisations. These interviews generated qualitative data that was then subject to thematic analysis. Each interview was given descriptive codes based on emerging themes, and common ideas were clustered, which also helped frame how the information would be presented. A few follow-up meetings were held in Batticaloa in November with available interviewees to discuss some of the initial findings and broad themes arising from a first round of data analysis. No respondent has been identified in this study.

The objectives of this study were to explore:

1. The role of the GBV Task Force in relation to GBV services in Batticaloa,
2. The challenges in sustaining the role and activities of the GBV Task Force,
3. How stakeholders responded to these challenges, and the factors that have helped or hindered the GBV Task Force in sustaining its work,

An evaluation of how well the Task Force succeeded in its objective of contributing to a reduction of violence against women was outside the scope of this report. One limitation in this case study is that interviews were based on events that took place at different points over a decade. Attempts were made to cross-check and confirm information through available literature and other interviews. Some information that could not be verified in this way was excluded.

### **The PGBV Task Force in Periods of Transition**

The Task Force appears to have faced varying transitions over the 11-year period between 2004 and 2015.

- transitions in external context;
- transitions in politics and ideology;
- transitions in structure;
- transitions in leadership

The following section looks at the Task Force in terms of these transitions and the ways in which it responded to them.

## Transitions in External Context

The PGBV Task Force was set up just prior to the tsunami in December 2004 and operated in parallel to other prominent coordination structures that dealt with a wider spectrum of gender-issues in the post-tsunami context such as the Women's Coalition for Disaster Management (WCDM) (WCB n.d.). Some individuals and organisations involved with the Task Force were also involved with WCDM, and this has been a feature of other networks that operated or currently operate in the District. The context of emergency raised a host of broader GBV related concerns to ensure the safety and rights of women and girls.

In interviews, some saw the WCDM and the Task Force as playing complementary roles during the tsunami, with the WCDM taking on an activist role, and the Task Force taking on a professional services role. Others saw the WCDM as best placed in taking the lead in handling issues of gender-based violence in a post-tsunami period despite the presence of the Task Force for several reasons: gender was its focal area, unlike other members of the Task Force who also had competing responsibilities and priorities of reconstruction and rehabilitation. Therefore, bringing multiple actors together through the Task Force in the aftermath of the tsunami was also difficult. In addition, the Task Force having been newly formed just before the tsunami was still a limited group and did not represent the majority of gender and women's rights groups at the time. Tsunami related issues of gender were also broader than the role of the Task Force and the WCDM was seen as better equipped to take on the role of addressing these concerns.

The WCDM was also a civil society network and government officials were not members - that made it relatively more independent in dealing with cases that involved armed actors including the military. An instance was given of a case in 2005 where an unidentified woman was raped and killed and whose body was found in a classroom in Central College Batticaloa. The school was located within a high security zone and therefore the incident was thought to have involved military and/or paramilitary. As one person in the core group of the Task Force at the time said,

*"When there was a murder and rape in Central College, individuals in the Task Force would give informal support but not through the Task Force, not publicly. These were politically sensitive cases and I didn't think of even calling a Task Force meeting. I couldn't think of anyone (within the government) who would take the case seriously. The trust part was lacking in dealing with cases of a sensitive nature, which was political or involved the military. We had experience dealing with cases of this nature through our women's rights network and so we went through those channels."*  
(Respondent 1)

There was however, a conflicting report of this incident where another official in the Task Force at the time stated that the Task Force in fact organised protection for the family and raised the case with the police.

Cases of violence against women that were linked to the conflict and armed actors were often dealt with outside formal networks. There was however indirect support provided by



some members of the Task Force, including government officials who could not be seen to be openly involved in cases such as these. This also raises an interesting question of how government officials negotiated their multiple identities in such situations. Consequently, services too were mediated through these identities. So, for instance, there were minority Tamil and Muslim government officials who provided information and support in specific cases of violence against women where the military was thought to be implicated, at their own risk. At the same time, Tamil government officials from the north of Sri Lanka also faced greater risk or hostility due to regional factionalism that was unleashed by eastern LTTE cadres breaking away from the main militant group to form the TMVP. A member of the WCDM reflecting on this period, immediately after the tsunami and the role of the Task Force in relation to WCDM, raised a point about the importance of engaging with government officials as well, but the need to also be able to do that from an independent space.

*“One must definitely engage with this issue and with the government. But it is also important to engage from an independent space because women’s organisations and civil society has a different role to play and independent spaces have a very important role to show how things can be done differently. Without this you lose the space to model and show different ways to do something. The state can’t always do that. The state apparatus can’t be innovative unless state officials can push those boundaries.” (Respondent 2)*

After the tsunami, some Government officials who were closely associated with the Task Force were transferred. This transfer of officials was a challenge as buy-in and support for the work of the Task Force had to be repeatedly re-negotiated. This continues to be a challenge for the Task Force across the time period of the study.

*“It was a huge challenge to organise the network at that time. People were also being transferred... This is a challenge even today. You establish linkages with them, explain the issues to them and then they come for two meetings, and after that they get transferred. And then we have to start again.” (Respondent 1)*

While smaller meetings of members took place, it took about a year to bring the Task Force back to full strength. It can be argued that the Task Force played a role in establishing systemic protections: building links and networks in the ‘now’ appeared to help in the ‘later’, such as when sensitive cases came up related to alleged abuses by various actors in the aftermath of the tsunami, and in the later years of escalated armed conflict. The Task Force has been referred to as a ‘node’ – through which linkages and relationships formed, which could facilitate action even outside the formal structure of the Task Force.

*“Where the Task Force helped was that [through this] we had links with officials outside the [regular] official framework. We had officials who we were linked to through the Task Force who advised us on what to do and not to do. For a particular case, two officials advised us not to take it up any further so as not to get into any trouble. That is how it works even now. The forum helped us to get to know relevant people and build contacts to take action. (Respondent 1)*

The Task Force in turn appeared to give government officials a stronger grasp on what GBV was; enough to see it as a problem that needed to be dealt with, and gave them contacts as to where they could seek support in their work, from specific individuals and organisations working in Batticaloa at the time. During the development of the Task Force in 2004–2005 and in the few years after, civil society actors and organisations were seen as having a responsibility to deal with these issues and did not face the kind of pressures from the government that it faced in later years. During the war, government officials including the police had no access to some militant-controlled areas and depended on these actors and organisations to deal with cases and coordinate responses in such locations. Government officials were seen as largely supportive of this at the time.

The context of the disaster, emergency and conflict prior to May 2009 also developed new skill sets among civil society actors, giving them the capacity to respond in these contexts. The period after the end of the war in May 2009, in contrast, was seen as bringing with it new dimensions of needs as social and economic conditions changed along with community relations and institutions, requiring that new methods of working be learnt and applied. For instance, the relationship between the government and NGOs had changed significantly from when the Task Force was set up, changing the status quo and therefore the nature of the response needed. This is discussed in more detail in the following section of this chapter.

*“One of the main changes after the end of the war, was that the Government could now access community areas and government officials could visit. So our role at the time needed to change to support the government. This was the reality at the time.” (Respondent 3)*

There was some self-reflection by members on the slowness of NGOs to adapt to changing circumstances post-war and the need for NGOs to adapt to new realities.

*“Now there are many layers and structures and we can’t bypass these also. At Divisional Level we have to figure out who will respond. The skills that civil society has, needs to be updated to respond to current contexts. We were used to a certain type of funding and resources, even staff and people. Now funding is drying up, it is difficult to hire people in the same way. Now we need to function differently, build skills in networking and advocacy and focus on long-term responses.” (Respondent 3)*

In 2010, members of the Core Group of the Task Force met with the GA at a meeting held on violence against women in the District. The GA at this meeting was reportedly aggressive, with his concerns being that the issue of violence against women was largely being dealt with outside formal state structures and therefore, in some sense, outside of their jurisdiction and control. There was an emphasis that this way of working needed to be changed. It was this meeting that prompted the process of bringing the Task Force under the auspices of the District Secretariat of Batticaloa. However, this is still not a formal appointment and the Task Force continues to be an informal body, but with some trappings of formality. This peculiar position has resulted in complexities in its functioning, which is dealt with later in the section on transitions in structure.

Related to this move to involve the government in a more formal leadership role in the Task Force, was a context of deteriorating state-NGO relations, and the increased role of the military in regulating NGOs and INGOs. According to one member of the Task Force and an INGO member at the time, the government was instructing them and other NGOs to “not do ‘software’ programmes like these (referring to GBV focused programmes) and that ‘hardware’ programmes (usually taken to mean infrastructure) was what was needed.” Donors and NGOs were withdrawing from this highly restrictive and constrained operational context in Batticaloa. The focus of work was also being diverted to the north where the war was primarily being fought, with PGBV not being seen as the ‘primary’ need of the hour. Several NGOs who were members of the Task Force faced increased administrative restrictions as discussed earlier.

*“You have to give the concept note and budget to get the approval. Then you have to give the reports to the Kachcheri. At one point they ask a lot of questions on the training component, and then they ask to remove that. If you submit the concept note and budget for approval it will sleep on their table, and when they are approved, we will pass our deadlines to finish the programmes and this is a problem with the donors then.” (Respondent 4)*

Some NGOs faced intimidation from the Criminal Investigation Department (CID).

*“We faced lot of challenges from the CID. They came to the office also, came to trainings. Once they came to the office and asked for the budget. I told them I cannot show it to them, that I have to get the Board’s permission. Once they asked for Defence Ministry registration and I told them we are a social service organisation, that there is no need to register with (the Ministry of) Defence.” (Respondent 5)*

Following the loss of some members due to this changing context and fears that collaboration within the Task Force would collapse - which could also result in a loss of funding - bringing the Task Force under formal auspices of the GA’s office was seen as the best compromise. But Task-Force members were however, optimistic that this could be a win-win solution if the transition was managed well.

*“We understood that it was going to be difficult to operate in this new context. We wanted to implement programmes at village level to talk about the prevention of GBV but we needed funds for this. Other organisations were dropping their PGBV programmes and focus of work was shifting to the north. This was a challenge for organisations in the Task Force and we thought our collaboration would collapse.*

*The core group discussed this and realised that if we continued in this way, the Task Force won’t survive. So we needed to incorporate with the government so that it would be sustainable. We recognised also that there was a space for the government in this.” (Respondent 6)*

This transition to being chaired by the GA’s office, how the process was managed and the implications are discussed in detail in the section on transitions in structure.

The changing context tied the Task Force in some respects to immediate response to GBV rather than prevention and long-term solutions to GBV. In the context of emergency or even conflict, facilitating coordination around services appeared to be more possible, supported by the urgency of these contexts. In a context of post-war and relative stability, there is a question of the adequacy of a ‘response’ approach.

The skills people acquired, were also tied closely to working within these contexts – negotiating partnerships, working with a range of actors, learning to work with local government officials. The networking allowed for an improved quality of response, including in situations where these skills and relationships became crucial with sensitive cases that could not be dealt with openly. The Task Force functioned in parallel to another structure called the WCDM. Some members were part of both. In interviews – there was quiet collaboration by members of the Task Force including some government officials and support where they could not openly deal with sensitive cases themselves. This underscores the importance that some people interviewed raised – the importance of also maintaining spaces outside of government, to maintain an independence of action. Collaboration with the government has meant that the Task Force needed and needs to move slowly in some respects, this may not necessarily be the case for other coordination structures. This negotiation of space was especially crucial in times of conflict, emergency and deteriorating relations between the government and NGOs.

## Transitions in Politics and Ideology

### Was/is the Task Force Feminist in its Orientation?

When the Task Force began, it had a clear vision of coordinating responses and services for women affected by violence in the Batticaloa District, by bringing all relevant actors together. Trying to interrogate this further to identify the ideology or politics that guided the work of the Task Force in addressing violence against women, and if this politics was feminist, was a much more complex exercise. There appeared to be stronger counter-ideology than a specific ideology being articulated – responses to what people perceived gender and or feminism to be and where they wanted the Task Force to be located in relation to that definition. So for instance, as one founding member of the Task Force explained, in cases of violence, he felt women’s needs and wants were being hijacked by what he said were ‘theoretically feminist’ agendas. These approaches as it was described, were positioned in opposition to ‘practical approaches’ described as meeting women’s immediate needs or wants as a person having faced or facing GBV.

*“The problem with these organisations was that they.... came from a political process of gender rights in a much broader sense, and not a client perspective, from the perspective of individual rights. So what the individual may have wanted or needed was not considered. Or what is practically possible for that individual at that time. So the question was if what I was doing was the best for my client, because they were getting hijacked for these broader concerns, goals and issues. For example, to one case conference, an organisation brought a reporter (to highlight the issue) – they*

*were not aware of the concerns, they were not looking at it from an individual point of view. To me, these people were taking liberties with peoples' emotions and bodies.” (Respondent 7)*

Criticism from women's rights groups on the other hand saw this approach as protectionist - where women are seen as victims needing protection and support - and not challenging a status quo, keeping families together despite abuse for instance. This issue of violence against women being trivialised as a disruption in otherwise happy households was also raised in a study (Kodikara, 2014) that looked at counselling services for intimate partner violence for women in the districts of Batticaloa and Anuradhapura. This was coupled with the concern that even as widespread intervention is on the one hand a sign of success of the movement against violence, that it is also becoming increasingly depoliticised, lacking a sound gender analysis and de-linked from feminist principles (ibid.). The terms 'gender' and 'feminism' took on varied meanings for several of those interviewed, generally seen by most who referred to these terms as being concepts in opposition to each other.

For instance, a government official with the District Secretariat Office said that 'differing ideologies' have made it difficult for NGOs to come together and put up a united front in dealing with GBV, which has been an issue for the functioning of the Task Force. He described this difference as some organisations being more 'feminist' in their approach, versus others working on 'gender'. It was not very clear, however, what this official meant by the use of these terms and how they conflicted. In response to the tsunami, some people interviewed said the WCDM was more 'feminist' and therefore the best placed to respond in the circumstances, with a women's rights agenda firmly in the foreground.

*“WCDM is different from Task Force. Task Force is to deal with GBV, general issues. But WCDM initiated after tsunami very much women focused.” (Respondent 8). Or as another person said, “WCDM is mainly on a feminist point of view.” (Respondent 9)*

In the early years of the Task Force, people interviewed said there was a consciousness of power structures that could operate within the Task Force, and efforts were made to level these power dynamics as far as possible. For instance, in consciously creating an environment at meetings for women to actively participate, in arranging seating in less hierarchical ways and so on.

*“Whoever was involved at the time were conscious of the 'how' of working and tried to challenge that. This involved being aware of social hierarchies when it (the Task Force) was set up. People recognised this and tried to consciously remove that. Challenging power hierarchies such as gender and class was in the way of working and in the response.” (Respondent 2)*

What appears to be different over time is the loss of this subtlety. Today there are enduring concerns about the capacity of people working in this field, especially from within government ranks. But as one person also said, there are many individuals even from within the government bureaucracy who want to actively work on rights of women, but they in turn come up against a patriarchal and bureaucratic government system that slows them

down. How this bureaucracy was and continues to be negotiated, formally and informally, is an important factor in how the Task Force transitioned over time.

### **Protection Versus Rights**

Over time, with the shift in structure and leadership in changing contexts, the Task Force appears to have shifted to a more protectionist approach to violence against women versus a rights based approach. There is an increased emphasis now therefore on mediation and a dependence on safe houses as a catch-all solution.

*“Why the Task Force was formed - the objectives are not now practiced. It was decided to provide rights based services to affected women. Now what WDOs do is, if they identify a woman with a problem, they send that amma (older woman/mother) to the safe house. They think, that’s it, problem solved.”*

*I recently had a case - one mother, husband died, three children. Amma gave the land to her children. Now they are not letting her live and there is no maintenance for the mother. I tried to talk to the DS office, they just referred the Amma to the crisis centre. She was there for 4-5 months. The children have even beaten her. [Women’s organisation] helped in medical (support). But we have no other means to help her more on this. The DS office said they can’t, so I am also helpless. But it was not the case when Task Force was functioning.” (Respondent 10)*

Still others cautioned that local cultures and contexts had to be taken into account in deciding responses and approaches when intervening to prevent violence against women. Others acknowledged a struggle in trying to balance a need for rights based approaches with local contexts.

*“It’s not that I object to feminism. But the community we work with and the community I live in are not sensitive towards feminism. It (the community) is very much family oriented. Whatever decision I make it’s based on family. We cannot go and talk about feminism with people, they will not accept it. We have to be careful about what we are doing and what we are talking about. It has to be done with much carefulness. The outside world view of feminism is that you cut your hair short, you wear big chains and big earrings and you are against men. So we have to be careful. And also yes, we do more mediation because family is important for us.” (Respondent 5)*

*“We have to do rights based work. In feminism also there are different layers and our work should focus on rights. But I agree we cannot say it aloud, but we have to somehow work towards it.” (Respondent 9)*

For one other activist who was interviewed, there are concerns over the overall policy direction of the government in working on violence against women, and what this then means for a Task Force that is chaired by the GA of the Batticaloa District Secretariat. This adds to arguments made earlier in this study about some opting to not integrate too closely with the Task Force as it is now, to maintain some independence of approach.

*“There are reservations about coming under the state because it becomes about protection. Women are not seen as adults. The state becomes the guardian for ‘women and children’ – women are seen in a ‘vulnerable and needs to be protected’ kind of frame. The same actors that involved in child protection are also involved here, and from the Ministry [Ministry of Women and Child Affairs] onwards women and children are lumped together. Then, this approach is what is dictated by the government. When it comes to GBV and domestic violence, community male hierarchies get implicated – there are male state officials who play into this vulnerability of women. There is a risk that these officials are going to look at it in this way and their patriarchal attitudes are going to influence the response to GBV.” (Respondent 2)*

It can be argued that it appeared to be easier in some respects to have a more unifying vision in contexts of disaster, emergency and conflict. This was because response to violence against women became the primary option and coordination crucial even in the face of diverse ideological perspectives. As one official with the Task Force explained, access to services was limited, and needs were immediate and often urgent during situations of conflict and emergency. It was described as a general approach of “supporting a person after disaster.”

*“But even after, with some normalcy now, this attitude is continuing and the empowerment approach is not being considered and there is still a general approach of trauma and disaster mode – it has not gone into a higher level. So women who are affected come again and again for support – they are not empowered to face the situation. This idea of safe-houses also feeds into this idea. The question (to women) of ‘what are you going to do for your own future’ is not asked.” (Respondent 11)*

In a post-conflict situation, which better allows for considerations of prevention of violence, the importance of this politics becomes harder to ignore or the lack of unifying politics becomes more evident. In interviews for this study, there was a spectrum of views expressed by people who continue to be a part of or are closely associated with the Task Force, including those with influence on shaping the continued direction of the Task Force. There was an opinion expressed for instance, that the direction of the Task Force should move towards ‘gender neutrality,’ with focus on the family and family dynamic. From this perspective, the ‘feminist’ point of view of taking the approach of women as victims needing support is seen as being counter-productive. Gender neutrality was seen as the opposite of this approach.

*“Because of the approach that women and children are the affected group, they will continuously be supported, not empowered. So it is a counter-productive thing. The whole GBV Task Force was on this ‘feminist’ side and not the other end. Personally I feel that gender neutrality is a better idea – that would allow for more agreement rather than disagreement. It is difficult to break this tradition though.” (Respondent 11)*

Yet another long-time member of the Task Force reflected on the importance of having an ideological framework to provide checks and balances so that women’s participation in

the Task Force itself is not endangered and spaces for women are not blocked. But he also raised the issue of who would then be responsible to provide that guidance.

What appears to be clear in multiple interviews conducted is that, a lack of clarity on what gender means to the different actors is perhaps pulling the Task Force in different directions in its response to violence against women. The term 'gender' itself may be clouding the politics on what violence against women is, by using it as a broad umbrella term that could mean many things. A question to consider would be if this increased neutrality is doing a bigger dis-service by clouding meanings of what violence against women is, what is really meant by rights for women facing violence and the specificity of demands for women in the Batticaloa District. As noted by Andrea Cornwall (2007), the political and analytical bite of the term gender is being blunted both by the lack of specificity in its use and a process of domestication by development agencies. And in this process, the required emphasis of this work on transforming unequal and unjust power relations, is being forgotten. It has also been seen by writers such as Cornwall and others (for instance: Mukopadhyay 2004) as a problem of translation into institutional contexts.

This lack of agreement on the politics that needs to guide the work done also begs the question as to how well coordination can occur when moving beyond response through provision of services, to proactive work on prevention. In a post-conflict, post-emergency situation, how does one find common ground to combat violence against women? The different ideological positions that have existed throughout the life of the Task Force do not appear to have been resolved. It is just that in a situation of relative stability, post-emergency, the fissures appear to be more evident and even more critical perhaps in shaping prevention and response of the Task Force to GBV. The Task Force can be viewed, on the one hand, as a place that brought people with different ideological perspectives together to find common ground to coordinate services and responses, and to work together despite these differences. However, with subsequent changes in leadership and operating context, power dynamics have shifted and government and non-government actors are no longer necessarily equal partners. This change in the balance of power inevitably has implications for its function as a collaborative platform, and shifts in which approaches are privileged over others will impact on the qualitative nature of services for women affected by GBV.

### **Transitions in Structure and Functioning**

In 2004-2005, the Task Force wanted to build a common agenda for addressing GBV, rather than have different actors pursue independent actions. This brought about more effective coordination and stronger linkages, but also created opportunities for members of the Task Force to develop a professional identity as against an organisational identity – to see themselves as working on the issue of GBV instead of simply on an organisation's (changeable) mandate. During this period, the Task Force was intended to be a body for advocacy and coordination, and not intended as a mechanism for management of cases. Strong government intervention was always expected, but through participation



by individuals as members of the Task Force who were formally equal to other non-government members.

A mapping exercise of the organisations working on issues of GBV in the Batticaloa District was conducted by CARE Sri Lanka in 2004 and identified coordination as the biggest challenge between and within organisations. The presence of civil society organisations working on addressing GBV in Batticaloa made it a conducive place to start, while the high levels of GBV reported from the District made it a timely intervention.

*“We needed to make stakeholders come together and see it as a whole or combined effort and not one person’s responsibility to handle different aspects like mental and psychosocial health or legal services... Nowadays the government sees itself as having a clear link between state and civil society, but this was not the case before.” (Respondent 1)*

For some members, the purpose of the Task Force was in forcing government services to be accountable for working on the issue of violence against women.

*“For me the role of the task force was in influencing government to take on a more accountable position. For instance, are the WDOs, other positions within the government working on GBV, doing a good job? Do they have the capacity?” (Respondent 12)*

There was an initial reluctance by some actors to participate in the Task Force. Parallels could be drawn with an experience shared by another coordination network on mental and psychosocial support in Batticaloa called The Mangrove, where certain local actors kept away at the start, as they did not see themselves as belonging to the world of NGOs, government or humanitarian assistance and so, carefully kept their distance (Galappatti n.d.). A leading women’s rights organisation in Batticaloa said they did not want to get too involved or integrate too deeply with the Task Force due to reservations about bringing GBV under the state, where government officials have control over the functioning of the network and GBV responses. This was described with reference to parallel experiences with child protection mechanisms in Batticaloa. Collaborative systems initially worked well to integrate child protection services in Batticaloa and a temporary safe house was set up for children in crisis, run by a local child-focused organisation. However, after a donor pressured the NGO to hand this over to the Department of Probation and Child Care, the safe house lost its child-centred orientation and quality of care decreased. There were issues of follow-up – probation officers had to be pushed to respond quickly so that children did not get stuck in the system for long periods.

*“Progressive ways of working changed and seeing that made us nervous.” (Respondent 2)*

There were other reasons as well, such as a reluctance to concede ‘territory’ in this field of work. There were different NGOs working in specific geographic areas and there was a reluctance to overlap. Within NGOs as well, different people would be appointed to different networks on the same issue. This happened to a great extent in the aftermath of the tsunami

as more funds came in. This issue of ‘territory’ was also evident at the start when CARE tried to find the best space to contribute from within existing networks, prior to setting up a separate structure. The Oxfam funded ‘Ending Violence Against Women’ network was in operation at the time, supporting a network of small women’s organisations, local NGOs and rural development societies running micro-credit programmes and livelihood activities. As one member said,

*“We tried working with Oxfam. But there was a resistance to inviting any other international organisations into Batticaloa. They wanted us to find ways to support the work they were doing. They didn’t seem to be working with government agencies though, which was the main problem, and so we decided to broaden the scope and see who was involved at a broader level.” (Respondent 13)*

This initial tension however, gave way to most prominent actors in the District coming on board the Task Force, roughly within the first year of its operations and members were often part of multiple networks that were leveraged as required based on context. For instance, most actors working on GBV in post-tsunami response, concentrated their activities through a different broader network (WCDM discussed in the previous section) rather than the PGBV Task Force.

There appeared to be improved coordination in the first few years of the Task Force, as people began dealing with cases together, developing joint proposals and sharing proposals and projects. The loss of key people and changes in leadership and the structure of the Task Force however, saw this coordinated approach fracture over time. A lawyer who was interviewed said that individuals from NGOs now came to him independently on cases, based sometimes on personal contacts, as distinct from earlier joint efforts. There appear to be issues of coordination and data management now, with less ‘sharing’ of cases and information. This has resulted in multiple ‘claims’ on cases by different NGOs.

*“There is no shared information. Organisations are not ready to share information. One organisation takes the case. They enter the data, another organisation working in the area also deals (with) it, and they also show it as their case. Then sometime they refer the case, then whatever organisation they refer it to, also shows it as their case.” (Respondent 14)*

*For big issues such as women’s issues or human rights issues, you can’t work alone as entities, you have to work together. It has to be a joint force. Now what we all most of the time do is work alone. Case conferences are important for GBV, but then all relevant parties should be invited. If it needs legal action, you have to take legal action, you need confidence for it. We are ready but they (the GBV Desk) are not ready.” (Respondent 14)*

## **Evolution in Structure**

The Task Force appears to have evolved from a coordination and advocacy body at a District Level, to one where difficult cases would be brought when they could not be handled at Divisional Level. Difficult cases were described as those where multiple people were involved,

or accessing services was difficult. The primary focus of the District Secretariat at present is maintaining the Divisional Level Task Force (DLTF) network and the GBV Desks in some hospitals.

The District Level Task Force did not appear to be viewed as intrinsically linked to GBV response in the same way as it had been before. The District Level Task Force is seen as external in some way, if not entirely relevant to the work that goes on at other levels of division and village. Some Task Force members saw it as important that the GBV Desk be tightly linked to the District Level Task Force, with fears that this connection is eroding. The DLTF functioned as a 'node' through which much-needed links were made to other services that were then leveraged in response to cases. This leverage was not just in numbers of contacts, but also in terms of influence. In interviews for this study it was reported that in other areas where the PGBV Desk is run entirely by health services personnel with no links to a Task Force, (such as in Kalmunai, Trincomalee, Kurunegala, Matara), nurses at the Desk are on rotation and have few links to the community in the area. Conversely, the GBV Desk in Valaichenai which has an ex-staff member of the Batticaloa Desk, is said to be functioning well in terms of linkages to other community services and facilitated by the Task Force structure.

*“The health sector alone cannot meet the needs of GBV survivors. If the Task Force was not there I would have never set up a Desk. Other desks set up in a ham-handed way is actually harmful.*

*The Task Force was a node and provided links for the Desk. The women at the Desk used to take the women (who came/were referred to the Desk) to the services or linked them up directly to the services, telling them ‘go and say my name’ so that they could access the services faster. Now, they had no links to the Task Force. Women who came to the Desk saw different people at different times.” (Respondent 7)*

Small local NGOs continued to maintain links to the Divisional Level Task Forces that helped in the functioning of these task forces. There are varied views, however, on the effectiveness of the Divisional Level Task Forces and village level action groups. On the one hand is the assumption that setting up the structure itself at multiple levels was a success, while others emphasised concerns over lack of capacity of staffing at these different levels.

Some people interviewed conflate the GBV Desk as being the Task Force in some way. When they talk of the Task Force functioning well, they talk of the PGBV Desks and the Divisional Level Task Forces functioning well. Some see the District Task Force as being needed for broader joint advocacy or difficulties that cannot be resolved at divisional level. This appeared to reflect a changing perception of the relevance of a District Level network of this kind. Some officials feel that recognition for the Task Force needs to come from a national level if it is to be included as a priority at the District level.

## **The Changing Role of the Government in the Task Force**

The role of government institutions in the Task Force - moving from one of participant to one of chair – has been one of the more divisive points of transition, and has raised questions as to the role of the government and the state in a coordination mechanism such as this.

In the early years, links between local government services and NGOs were seen as a mutually useful arrangement. These government services did not appear, in the early stages of the Task Force, to have community level reach to respond to GBV in the way that local civil society organisations in Batticaloa did. Therefore, there was a certain willingness to play a supportive role to local NGOs. There were clear benefits to coordination of having government services represented on the Task Force, which included improved access to services, stronger trust and cooperation between government and non-government actors.

Early members of the Task Force say that there was always a vision for strong government participation in the Task Force through its various agencies, and their intervention. However, this early participation in a seeming spirit of collaboration, maintained by a relatively flat power structure, appears to have lapsed into an authoritarian state bureaucratic role in later years, which has resulted in diverse, often divisive views.

There have been varied reactions to this transition:

1. An acknowledgment of the difficulties yet seeing the role of the government in leading the Task Force as an important and necessary move for reasons of a) sustainability; b) being the need of the hour due to a power imbalance in relations between the government and NGOs and therefore inevitable in some sense.

*“The involvement of the government sector is important for this to be successful. Sometimes they can dominate the process and bring civil society into their agenda, but it depends on how you deal with it.” (Respondent 3)*

There were divergent rationales expressed by different stakeholders, due to different perspectives and motivations, but also due to differing access to information. Early concerns in handing over the Task Force to the GA's office, was the capacity and commitment of government officials to address the issue of GBV, both in prevention and response. A clear Terms of Reference (TOR) for the Task Force, followed by training for local government officials was seen as an important step in addressing this gap. A clear TOR was seen on the one hand as being important in establishing a clear mandate and role for the government. But a person interviewed for this report commenting on the TOR drafting process said that references were made to keeping the TOR intentionally broad so that there would be ‘space to manoeuvre’ and ensure interests of civil society actors could still be maintained within the bureaucratic governance of the state.

While the process of handing it over to the GA's office was at least a year in the making, most people interviewed agreed that the once-regular meetings have since become less frequent and the Task Force process has stalled. In some cases, once regular participants of the Task Force meetings are sometimes no longer informed or invited for meetings. Another view was that the meetings had become too large – with 80 people or more sometimes - affecting productive decision-making. On the other hand, supporters, even cautious ones, point to the establishment of a network of 14 Divisional Level Task Forces with Women's Development Officers, the replication of the GBV desks in the Batticaloa District and support of global policy initiatives such as the UN 1325 resolution as important contributions of the government in broad-basing the response to GBV. This is in addition to the national legislation enacted on the Prevention of Domestic Violence Act of 2005, and ratification of the global Convention on Elimination of all forms of Discrimination Against Women (CEDAW). Admittedly though, there are concerns of capacity at all levels of this structure.

The Task Force has also faced criticism from women's rights groups.

*“The government wasn't really for participatory ways of working. There was criticism from women's groups that we compromised. There were concerns that the government would try to take over all initiatives of civil society that they had been working on for so long and bring it into their agenda. We did compromise on some things, but we got their (the government) commitment to work..... A collective decision-making process was still included in the TOR.” (Respondent 3)*

For supporters of this position, it is also the role of civil society actors to push for government action and accountability in tackling the issue of GBV. Finding a way to build personal relationships with government officials through the Task Force, even at an individual level, has been seen as important in building trust. Another suggestion has been to link the District level process to national forums to better influence policy, in the hope that this will feed back into commitment at local level. However, there continues to be a struggle, both conceptually and at a practical level of implementation, between the need for the government to take ownership so that work of this nature is sustained in the long-term vs. a lack of responsibility and accountability on the part of government in playing this role. This situation is further complicated by government insistence however, on playing a role of providing direction as well as leading implementation, coupled with heightened regulation of non-government actors working in this area.

*“There are issues in terms of the attitudes of the government, how they respect local people and also women. But the government has a system from village to district and we need to ensure that gets included. There needs to be some balance. You have to force them (the government) to take responsibility... We have to continue to do this. We need to invest in them taking responsibility as well... We can't just say they are not doing it, so just leave it. It has to be a parallel system I think. It is difficult for a few organisations to put pressure on the government but there should be pressure from different actors at different levels. Not just district level.” (Respondent 12)*

The work of the Task Force under the government is still seen as being in a transitional period, needing two to three years to reach a level of progress. Members of the Task Force also point to gains made, however, which include greater awareness of GBV support services available, the ongoing functioning of divisional and village level committees, and higher numbers of referrals to the Desk.

2. The District Secretariat office as chair is now responsible for the Task Force and therefore has to give direction. The responsibility of the rest of the Task Force is to follow and support this direction.

*“The current structure doesn’t need funding. The responsibility for awareness and training is with the government. If they need support, then we can provide that. In a meeting it is possible to suggest what the needs are, but there haven’t been meetings.”*  
(Respondent 11)

3. It is seen as a betrayal of the original mandate and vision for the Task Force and changing the ‘essence’ of the Task Force, which included its lack of bureaucracy.

There were concerns that once the Task Force was handed over to the government, the openness that characterised the Task Force would be lost. With this, collaboration in a coordinated way would gradually erode, and power hierarchies would dominate. Horizontal government structures were seen as weak, and as one doctor who worked with the Task Force said, “There are no guidelines (in the government structures) for working together.” Giving the chair to the GA who was not a person with capacity in the area of GBV, while excluding other organisations with expertise, was seen as a retrograde step.

*“From the day they have decided to handover to the government, that’s the full stop for the Task Force. I was not for it. But most of the people in the Task Force thought for sustainability it’s a good strategy. But unfortunately it didn’t happen (that way). The problem with the government structure is that no one wants to take responsibility.”* (Respondent 14)

Further, the idea that handing the Task Force over to the government would strengthen sustainability was seen as implausible, largely due to the high turnover in government staff.

*“The idea that the government is sustainable is a myth. Government officials get transferred all the time. The buy-in and smooth functioning is always an issue. We had to organise special meetings for other government officials to come and say what we had been doing and have been part of and get them to vouch for it. This happened constantly.”* (Respondent 2)

The Task Force also did not appear to have adapted well into the state bureaucracy, and the number of approvals needed for processes of the Task Force were high. There was also always the danger that officials unclear on the issues involved would dilute or distract from what was needed. In order to have a sustainable system that included the

government, incorporating the Task Force into formal roles of responsibilities of the WDOs for instance, was seen as essential. An example given was the GBV Desk which appears to have a formal policy for government involvement, once it was incorporated into the health sector.

This can be contrasted with how the Task Force is still an informal structure under the GA. The GA's chairing is not a formal appointment as per government structures or systems. Therefore, the Task Force is an informal structure with only the trappings of formality. What this means in a bureaucratic system is that meetings being scheduled and work being carried out depends on the good will and the individual commitment of officials. A further question was how sustainable a structure like this could be if patriarchal institutions lead work on violence against women.

4. While there was heavy criticism of the decision to shift to government chairing, some actors said they would continue to participate in order to build and retain advantageous links that could be leveraged when needed, and to continue involvement in the process, however reduced.

This would include the practical involvement of taking over support both financially and with technical support, of selected Divisional Level Task-Forces. Continuing to stay involved in the Task Force was seen as strategically important by a woman's rights organisation to build networks and make their presence seen and felt by state officials. There was also the view that the Task Force continues to operate in Batticaloa because there are strong women's rights activists continuing to do this work outside of government systems, while similar Task Forces in Polonnaruwa and Trincomalee are not functioning.

At least one person saw the Task Force as no longer being a mechanism through which engaging with government officials in a meaningful or effective way was possible, and therefore eschewed involvement.

### **Social Networks and Capacity Building**

There was an emphasis on sustained capacity building in the early years of the Task Force. This was largely in relation to identifying people who may be affected by GBV, and in referring cases and doing referrals in a sensitive and timely way.

The Task Force trained all 700 staff members of the Batticaloa hospital – where the GBV Desk was located - including doctors, nurses, and non-medical staff, to recognise signs of GBV. Women could then be referred from any department at the hospital to the GBV Desk, where staff members had strong links to other stakeholders such as the police, safe houses, community workers and NGOs. For the workers at the Desk, at least in the first few years of operation before the structure of the Desk itself changed, most of these links were formed through the Task Force. Initially, women from NGOs worked at the Desk on a rotating basis, with their salaries paid for by the NGOS they worked for. There was also an emphasis on joint case management through the Desk, which prevented overlap

in functions and reporting of cases multiple times by multiple organisations. There were reportedly some challenges in getting managers of organisations to agree to sharing cases, but this was overcome. This eventually also led to a reduction in competition for cases as Task Force members reported a reduction of the burden on them individually as they worked together as a case-management group. Three organisations provided legal aid free of cost. The Human Rights Commission provided training on legal aspects of settling cases to the GBV Task Force, the GBV Desk, and the Police, with the support of the Norwegian Refugee Council.

The building of social networks through the Task Force, in addition to technical skills, was an important factor in how cases were handled. How people ‘saw themselves’, the confidence they gained, as well as recognition as professionals and people with social capital in this area of work, were considered important factors in how effectively people were able to respond to cases.

Changes in the composition of the Desk together with the government playing a larger role in the Task Force as chair, has gradually changed the overall technical skill available at different levels of the GBV response mechanism, especially that of the state. Some GBV Desks are seen as functioning well, while others are reported to have issues of capacity. Two overall concerns with the appointment of nurses to the Desks though has been that it has limited field visits, and as nurses are on rotation, women who are referred to the Desk may meet different people at each visit.

When the Task Force was brought under the government, there was a recognition of potential gaps in capacity, and efforts were made to bridge this: a TOR was developed so that the functions of the Task Force were clearly laid out; a capacity building programme was conducted for all District Level staff on counselling, communication skills, leadership and knowledge of Gender Based Violence, with at least one of the trainers who had been involved in capacity building programmes in the early years of the Task Force. A government official involved in the Task Force said that the initial period when the Task Force was handed over to them was also difficult for government officials involved in the process, largely in terms of administrative and coordination capacity.

Concerns remain, however, over the capacity of officials, who work primarily at Divisional Level. There have been concerns, for instance, on the general push towards mediation as a solution to cases, concerns over loss of confidentiality because the importance of it is not appreciated by Mediation Boards; how women are treated in the referral process, and sending women to safe-houses as an easy solution in serious cases. WDOs are seen as largely bureaucratic government appointees, with most having limited information on GBV.

*Through task force, trainings have gone to WDOs as well. But in many areas their function is less, they don't like to go to the field...We force them 'come with us, come with us' and almost forcefully take them to the field, force them to conduct the DS office level task force meetings. Very few are good, they are keen to work.” (Respondent 4)*



There have also been concerns with capacity on the legal front, although suggestions of police being involved in counselling raises its own concerns:

*“When cases come here (to the hospital) some cases we have to send it to the police. The medical legal examination form has to be filled. The police are only concerned about if it is a serious injury or minor. If they have to send it to the courts they will send. Or they will send to the mediation board. Police do not do the needful to find root causes or (provide) counselling. Even after many trainings to the police Women and Child Desk, they are still the same. They treat women like criminals and women are also scared to go to the police. And if they call the husband, they treat him badly also. They even beat him at times. So people are not willing to go to the police.”*  
(Respondent 15)

The very suggestion in the quote above that the police might be involved in counselling may point to a lack of clarity about the respective roles of the different service providers and what appropriate boundaries might be for these.

Another concern has been that the Judicial Medical Officer (JMO) post, an important point of interaction in cases of GBV, is not seen as attractive enough for new recruits to the state medical service, which affects capacity in dealing with issues of GBV from a judio-medical perspective. Some of the reasons given were that: JMOs have to hold on to evidence of cases such as rape until the case is closed, which can be several years later, even if he/she is transferred elsewhere. In addition, people are appointed to the position of JMO, not necessarily through a competitive merit-based process.

*“When a person becomes a JMO on a forced basis, he is not bothered and frustrated, and doesn't like his job. When you are a JMO you can't go abroad for higher studies also. So it's an issue..... They are just there. So for GBV related (work), it is a gap.”* (Respondent 15)

Training appears to be sporadic at best, as well as beset with difficulties in sustaining networking and the building of professional linkages and relationships via a formal mechanism such as the Task Force.

*“At the end of the day, individual human connectedness is what matters, whether they call it a Task Force or not. Effectiveness is going to be in the links. A shared goal and these links are what is important. That is what is missing in Batticaloa. People think, we do our job, it will all work out, but that is not enough.”* (Respondent 7)

Overall, some members point to an overall demotivation of the Task Force, linked also to concerns over capacity of government actors. Others in turn say that this is the start of a process and capacity building will take time.

### **Funding and Resource Support for the Task Force**

The District Level Task Force was supported by CARE Sri Lanka until 2008. From 2011 to date, funding for the work of the Task Force has been from Oxfam Australia.

At Divisional Level, local and international NGOs have taken over management of a few of the Task Forces that continue to function. For instance, the NGOs Home for Human Rights, Eastern Social Development Foundation (ESDF) and NewArrow manage a few of the Task Forces between them. Most other DS Task Forces are present in name only, coming together mostly for events such as Women's Day celebrations. There is no government budget allocation for the Divisional Task Forces or if at all there are very small allocations for one-off campaigns rather than ongoing work. Limited funding has also made it difficult for staff to follow-up on cases. Some NGOs provide training for a few DS-level Task Forces, or have helped set them up.

During the early days of the GBV Desk, there was an issue when the NGOs who were supposed to be paying the salaries of the women who worked the desk defaulted in paying their full allocation. This was linked to some resentment due to the higher status and influence the women enjoyed as a result of their work at the Desk. So the Task Force arranged for them to work full-time at the Desk with their salaries paid directly by the resources the Task Force raised/received, initially by CARE, later by others. Subsequently, the caseload of these women increased and they started doing field visits as well. This was a challenge as some of the locations were not easily reached and many NGOs did not have a presence there. Therefore, the Task Force arranged for motorbikes for the GBV Desk staff to support them in this function.

Funding and resources continue to be an issue in sustaining the Task Force, with no formal mechanism to raise funds. There is continued dependence on external NGO funding.

*"It is difficult without resources. When we developed the TOR, we did not look at sustained funding. The understanding was that actors would contribute in a sustained way, but that assumption failed. Funding for gender programmes have been cut down and Oxfam GB closed down. At divisional level this is kind of okay because of local NGOs who have taken over some responsibilities in relation to some of the DS Task Forces. But they are also tied to funding from larger NGOs and INGOs as well. And so, when INGOs close down and phase out, then it affects them. We need to find some answers and alternative fund-raising mechanisms." (Respondent 3)*

Following the war, funding had been slowing down for certain allocations such as in allowances for staff attached to the GBV Desk, for equipment and furniture. There was also reduced funding for capacity building and training.

There have been other parallel challenges in funding that affects the responses of the GBV Desk. Funding has been increasingly scarce for the running of a safe-house for women, and the NGO managing it – Koinonia – is reported to be considering closing the service down as a result.

*"A safe house is very useful for GBV related work. Koinonia is running it now, but they are going to close the house in September due to a funding problem. It's going to be big challenge. If government takes over it will be like what happened to Snehatheepam. ESCO was running it*

*and the government took over and the quality of service has gone down. All the government staff need training to run a safe house, otherwise they will run a prison, not a safe-house. Like the Task Force this also will become meaningless. Without safe house it's a challenge to manage legal cases. You can't send that woman to her house, but then where to keep her?" (Respondent 5)*

The GBV Desk was absorbed into the structure of the government hospital, with the support of the Ministry of Women's Affairs. However, trained staff at the Desk were not absorbed to work in any similar capacity. Instead, they were offered staff positions in the cadre of sanitary labourers at the Batticaloa Hospital for purposes of formal employment, whilst they were to continue with their duties at the GBV Desk. The administrative and status conflicts arising from this arrangement eventually led to their departure from the Desk to join a national NGO working in the area of GBV. This has implications for sustained capacity building in government structures to address GBV.

*"External support to a GBV support desk in a hospital in Sri Lanka meant that temporary support staff were brought under management of an external agency and classified as employees which undermined prospects of these staff being absorbed into hospital structures." (Galappatti, unpublished WG report, 2011, as cited in Patel et al., 2012.)*

## Transitions in Leadership

In 2004, when planning was underway at CARE Sri Lanka to set up the PGBV Task Force, a conscious decision was taken by CARE leadership at the time to create a structure that was autonomous, functioned independently and was not 'owned' by CARE. This was seen as unusual and atypical based on previous experiences practitioners had working with INGOs in the District. The reasons for this were primarily linked to ideas of ownership seen as needing to remain collectively with members of the Task Force; maintenance of as flat a power structure as possible; and sustainability. As one of the people involved in conceptualising the Task Force said, *"As an exit strategy, I felt that this could not be a CARE project. This was important because if funding stopped, then it would continue and not collapse, because projects and NGOs come and go."*

*"The way CARE looked at it was healthy – [Name of person] knew this group would not be subservient to the CARE agenda. That was the difference between the Ending Violence Against Women (EVAW) network and this. EVAW network funded organisations. [Name of person] had the courage to set up something that was outside of CARE." (Respondent 7)*

Being able to do this was linked to specific individuals who saw the value in this and had the capacity and power within their organisations to make a case for this at the time. This is in contrast to other later instances of INGOs attempting to play a more significant management or leadership role in the Task Force. For instance, a case was brought up of one agency attempting to take over leadership of the Task Force. In an interview with a member of the Task Force – "[Name of agency] had a mandate to work on GBV. They came and discussed this and we asked them to provide support. But they wanted to do what

they wanted. They brought in a local officer to speak to the Task Force. They met members individually and tried to influence support.”

The idea of specific individuals, their personalities and leadership style being instrumental in shaping the way the Task Force operated over time, was a recurring idea. As was the converse point of view that when these individuals moved on, the nature of the Task Force and what it could do or was willing to do, also changed in fundamental ways, not necessarily in line with original objectives.

*“I think setting up a Task Force anywhere may not have been a problem as such, but we just needed to identify who would be supportive of doing this. If I had missed speaking to [name of person] for instance, then this may not have evolved the way it did. The key was to identify people - experts who were passionate about what they were working on and were willing to go beyond their job roles and give their time and ideas. It was personality driven also. Personalities were a very big part of it.” (Respondent 13)*

Many referred back to a ‘golden era’ of the Task Force under specific personalities. One specific individual who was seen as straddling a divide as a consultant for both local and international NGOs, was seen as important in obtaining initial buy-in for the idea from a wide range of stakeholders because he was a trusted figure. He helped mediate differing agendas and views on the approach of the Task Force. Specific individuals from within the medical and legal professions within the Task Force were also seen as indispensable to ensuring that services were delivered when cases were referred. Some members referred to specific individuals as being responsible for bringing people together through the force of personality or charisma, as well as personal and professional connections. While the success of the Task Force is seen as being due to its collective nature, the ability to maintain those features were often attributed to specific individuals. Success of the Task Force has been explained as: all services being brought under one umbrella for better coordination; less duplication of efforts; cases being resolved or on the way to being resolved faster; improved communication, networking and ‘friendship’ between stakeholders.

*“Cases were not pending, within a month you could get a relief for it. If its health related, health people attended to it; education, then education people attended to it; If it was psychosocial, then psychosocial related people attended to it; Same for legal. Whatever the issue, there were thematic experts. Nearly 35-40 people used to come for meetings. Earlier the Task Force was ‘immediate action’ now ‘zero’.” (Respondent 16)*

Up until 2008, however, the approach was on collective leadership, with no single person or organisation, but a ‘Core Group’ of people running the Task Force. From about 2008 leading into the period after the end of armed conflict, there was a turnover of some members of the Task Force – partly related to individuals taking on other appointments, to some members moving on, along with priorities of their organisations, in the post-war period. The loss of key members was seen by people spoken to for this study, as reducing the dynamism and effectiveness of the Task Force in several ways. For instance, the loss of a specific individual

from an international NGO working on child rights, saw a decline in child protection-related meetings being conducted. In another example given to explain this loss of effectiveness, a health sector worker was described as preferring mediation over other approaches to resolving cases of GBV. This was, therefore seen as driving the general approach of the Task Force and responses of its adjunct GBV Desks, due to his role within the Task Force.

A loss in the exchange of ideas was also flagged as an area of concern.

*“Even though this channel was there (the Task Force), there was low performance and progress. The number of members in the core group reduced from about 11 to about 5-6 people or organisations. Because of this, the sharing of information and ideas also reduced.” (Respondent 6)*

### **Changing Power Dynamics**

In the initial years of operation, the Task Force reduced both actual and perceived differences in power between local NGOs and international NGOs, between small local NGOs and big ones, between NGOs in general and government officials. Individuals with smaller NGOs reported having an equal voice at Task Force forums, as being an important aspect of their involvement.

The fact that most of the people initiating this effort were professionally qualified but did not belong to a pre-existing hierarchical structure, in addition to having strong personal relationships, helped build this initial trust. As one doctor said, “doctors getting involved also helped to break down barriers,” as they were seen as independent in some way.

*“We engaged without a hierarchy that the government had. It was with NGOs, organisational donors, field workers. In the Task Force, the hierarchy was completely broken down. Field workers would also get up and talk, so issues were discussed at service delivery points, grounded in the reality of Batticaloa. We kept it a non-hierarchical space....We had a shared humanistic philosophy. None of us got any money out of it. That would have taken the Task Force in a different direction.” (Respondent 7)*

Some of the barriers that existed between local NGOs at the time were linked to perceptions that some NGOs had academically superior credentials and/or their approach was grounded in theoretical concerns, and therefore considered themselves as more qualified to work on issues of GBV in comparison with others. Another barrier was a ‘competition for cases’, driven by donor demands that higher numbers of cases equated to performance. With a joint forum, this appeared to matter less to some members, allowing better coordination and ‘more equal’ status quo.

The social networks of grassroots workers were also built up because workers met others working in this area, at the Task Force. These connections were seen as contributing significantly to improving response, while service providers including government now knew who to refer cases to.

*“Through the Task Force, spaces opened up for people that were not accessible before. . . . People also felt like they belonged to these services too. For me, the success was that. People who were working on this felt that they were working on the well-being of women. People could interact with each other as fellow professionals rather than rural organisations. They hadn’t seen that before. When spaces opened up in this way, it then also made a difference in clients (women’s) lives.” (Respondent 7)*

This relatively flat power structure changed considerably with the shift to the GA’s office chairing of the Task Force in 2009. This immediately introduced a bureaucratic character to the Task Force structure, as well as a hierarchy of power, with government officials seen as being at the top of the pile. This changed the extent of ‘voice’ different actors had in the forum, as well as the nature of participation. In recent years, most actors within the Task Force were seen as not being as familiar with the issues, while those that were, were activists from local NGOs who had limited power at this forum.

*“We go for NGO coordination meetings, now I have been telling them to change the meeting place. . . . They normally have it at the Kacchheri as a conference call. So all the government people come and sit in front with the microphone, and NGO staff sit behind - no microphone, no one feels like saying anything. Even if you say, others will not hear, so no point. Whatever the government organises, this is the problem.” (Respondent 10)*

All actors no longer had equal power to contribute or negotiate their involvement. Most officials were men and activists primarily women, which affected the power dynamics at the Task Force further. This was further compounded by prevailing attitudes towards NGOs in general by the Sri Lankan government at this time.

*Officials started treating women’s rights activists in such a way that they started thinking that they had to obey government even if it impacts on the rights of women. We need to think of these power relationships and rights of women and see what we are doing and how we are helping the situation. I feel like the ‘rights’ part has got diluted very much through this forum, for me.” (Respondent 1)*

As nurses joined the GBV Desk in the Batticaloa Hospital along with trained NGO workers, some tensions also arose between the two, as the NGO workers were not seen as qualified enough. Power structures with people who have been with the Task Force for a long while, were also identified as restricting new people and fresh ideas from coming in, stifling the growth of the Task Force. This uneven power dynamic due to varied factors was seen as a current concern affecting the effectiveness of the Task Force even at present.

*“It’s the power dynamics that need to be balanced. With international organisations, they have some voice and role in decisions that are made. But for grassroots organisations, that is where the voice is the least. So how can one ensure that the balance between grassroots organisations and Governments exist?” (Respondent 13)*

Task Force meetings are no longer held regularly, and are usually called for ‘special’ events or when an issue cannot be handled at divisional level. There has also been a high turnover of

government officials, resulting in time spent too often on needing to update new officials. This process alone sometimes took 6 months to a year. The commitment and willingness of officials to publicly support local initiatives on GBV, has also been questioned.

*“The Task Force did not touch sensitive cases. There were big incidents that the Task Force never touched such as the two girls in Kattankudy that got beaten up (BBC News South Asia 2011), or Seema the 9-year old who was raped and killed (Colombo Page 2009). The sensitive cases, whatever that required public action, they can’t do it or won’t even come. The GA wanted a public petition outside the courthouse in Kattankudy and Tamil and Muslim women’s groups to come together. . . . . They didn’t even come. No one from the government even came.” (Respondent 2)*

Several members said they are not always informed of the meetings now, even when rarely held. The reasons were obscure and uncertain or there was a hinting of underlying professional politics between individuals or organisations that may have led to the exclusion.

*“I asked [person involved in coordination of the Task Force meetings]. She said they thought I will not come since it my mother’s death anniversary. [Name of NGO] was not invited. They have decided that this one will not come, that one will not come.” (Respondent 10)*

### **Changing INGO Agendas**

International NGOs have always played a role in the Task Force, initially with CARE Sri Lanka playing a largely secretarial and logistical role in the early years when it was set up, to varying degrees of involvement and control based on the individuals involved from CARE Sri Lanka. There were some concerns of increasing control with specific individuals, with one person interviewed calling it a ‘funder mindset’ that would say, “this is not our mandate, this is not our area, and if we don’t agree to the conditions they laid down, they could refuse to help.”

From 2009 to date, Oxfam Australia has been funding the work of the Task Force that is now under the Government Agent of Batticaloa. NGOs and INGOs have also taken on the role of managing some of the Divisional Level Task Forces, with NewArow also managing the Valaichenai and Akkaraipattu GBV Desks. The resources and effectiveness of the Task Force have also ebbed and flowed as NGOs pulled out of the District as government priorities as well as attitudes towards NGOs changed and NGO priorities also shifted to the north of the country, with funding being diverted there. There were also initial difficulties in NGOs coordinating with each other. A report by CARE in 2014 to map organisations working on GBV in Batticaloa and identify gaps said,

*“A finding that was disagreeable in organisations and individuals working in the field of social and humanitarian development was the huge egos. Most NGOs working in the field of GBV, even those working as part of a network were observed to have an unwillingness to work together with other organisations. The primary focus of such organisations was on statistics – the number of cases handled by the organisation in a particular year. The NGOs are also sometimes criticised for isolating themselves from society. There is a need for NGOs to identify with society first in order to bring about any positive changes.”*

There have been some attempts by different NGOs at different points to ‘adopt’ the Task Force as their own initiative. This followed NGOs wanting to include gender as a component of their work in various ways. However, the resources they commanded sometimes meant that there were strong attempts to dictate the agendas of the Task Force, and some efforts to find a compromise for the sake of funding. In a case after 2009, a senior doctor involved with the Task Force said,

*“There is a big bias towards the NGO mandate and to get funds you have to be flexible to that. For example, there was an organisation with a mandate to work with children. Our needs are not to work with children but they had funds and asked if it was useful to us. So they formulated a programme on how children were affected by ongoing GBV in family settings, and they conducted mobile awareness programmes, street dramas etc, where the focus was the effect of GBV on children. They couldn’t directly support the prevention or response programmes for GBV. So we couldn’t cover areas where the real need was. They were strict about their mandate. This programme was conducted for 4 months in 30 different locations.” (Respondent 11)*

Donors also demanded proof of success of their investment through the ‘number of cases’ dealt with from local NGOs. Often, due to poor coordination, there would be multiple reporting of cases, as everyone to whom one case was referred, recorded it as theirs. This ‘need for cases’ by NGOs was then built on, tying it to the Task Force mandate to set up systems so that more and more cases could be referred to NGOs. After 2009, with the Task Force under the chair of the GA’s office, UNICEF put in funding to maintain the GBV Desks, which now operate out of the Child Protection and Gender Unit of the hospitals in which they were located, and were also then branded. However, at least one person spoken to said the branding has made others ‘uncomfortable’ to be in that space, which is now ‘owned’ by an international agency or body, in this case, the UN.

There has been a tussle over time to maintain the independence of the Task Force on the one hand whilst meeting funding needs on the other, or maintaining the collective nature of the Task Force whilst preventing it becoming an NGO/INGO branded initiative that may have skewed the direction of the Task Force. For instance, a UN agency wanted to fund the GBV Task Force, but this came with requirements that it adopt its own standard operating procedures on tackling GBV in conflict situations, as well as regulations on collection of data.

*“After the tsunami, [UN agency] came and they had their mandate to form a GBV Coordination network. We said they could be a part of the Task Force but they had a problem that it was not theirs. So they formed their own network. We did have one or two Task Force meetings at their office – they wanted to fund it and they wanted to be head of the Task Force. They were not interested in forming relationships. They also didn’t have a clear idea of what was going on. We can’t work on a pre-fabricated model of a project. So [UN agency] moved out of the Task Force– they funded their own network that was also a part of ours.” (Respondent 7)*

These attempts have also translated into efforts to set up new Desks in other parts of the country and to brand existing Desks. The resistance to NGO attempts to take ‘charge’ from



within the Task Force to maintain autonomy, was linked to the power and influence of specific individuals in the Task Force, as well as the seemingly non-bureaucratic structure of the Task Force at that time.

*“The Task Force proceedings were independent of CARE; they allowed the Task Force to develop in its own way. They didn’t interfere with the philosophy or evolution of the Task Force. When [name of person] came and to some extent [name of person] they tried to control that process to some extent. We (some of us) could say no. But the partners couldn’t say that. There was a clear hierarchy between partners and funders. We fought to protect the independence of the Task Force.....we wouldn’t take nonsense,” (Respondent 7)*

## **Conclusions**

This chapter set out to identify how periods and points of transition affected the sustainability of the GBV Task Force across a decade, and how the Task Force responded and adapted to these transitions. Several people interviewed for this study argued that the PGBV Task Force in Batticaloa continues to have a role to play in working on addressing violence against women, despite reservations. The differences in opinion related to what that role should be.

The Task Force in contexts of disaster and conflict prior to the end of the war in May 2009, sustained itself through an inherent flexibility in its functioning - running in parallel to other structures, leading and/or supporting based on the need of the hour. This flexibility and attempts at fiercely maintaining its independence was also evident in relation to other external challenges such as power struggles with other NGOs and INGOs wanting to take over functions. The early years saw a clear refusal to allowing single ownership of the Task Force, and a constant effort to remain conscious of internal power hierarchies and compensate for the same as much as possible. The ability to maintain its independence in this way has been linked to the roles of specific individuals in a ‘golden era’ of the Task Force in the first 3-5 years, seen as being a period of dynamism and fresh ideas, but also strong personalities.

The contributions of the Task Force in improving coordination and awareness of GBV through these changing external contexts between varied actors including the government, has been acknowledged. There has been a mobilisation of government officials around this issue that can be linked to the Task Force: the commitment of the DS office to establishing Divisional Level Task Forces in all 14 DS divisions; the official recognition of the GBV Desk by the Ministry of Health with similar desks being set up in other districts.

The setting up of the Task Force, at least before the end of the war in 2009 was seen as investing in relationship and network building, that paid off in tangible and intangible ways. For instance: practical linkages that people used in their work, skills and capacity building, social capital or networks, friendships, and the increased confidence of smaller local NGOs and practitioners to do their work and operate on a level playing field with larger organisations and more experienced individuals. There appeared therefore, to be a levelling of power dynamics in some way – for instance, the continued public and influential

role of some women from small local NGOs. These linkages also paid off in tackling sensitive cases in post-tsunami and conflict periods where armed actors of the state were implicated, outside the formal mechanism of the Task Force. Some Task Force members at the time, including some government officials went beyond their official roles to provide indirect support for these cases, sometimes at considerable personal risk. Crucially, these personalities were seen as an important factor in the ability of the Task Force to respond to the kind of changes in context that it has seen – both internal and external. With the loss of these specific people over the years, there has been an apparent loss of vibrancy and momentum. This raises its own questions as to what this means for the sustainability of a network of this nature and how leadership needs to be envisioned.

Bringing the Task Force under the centralised leadership of the GA in 2010 has been the single most divisive factor in the functioning of the Task Force. There was an emphasis by some members on formal authority being a legitimising factor and the need to give the Task Force time to find its feet in this new relationship with the government. Others saw in this some degree of betrayal of the original mandate of the Task Force, a loss of independence and a re-assertion of power dynamics through bureaucracy. For instance, some members point to the loss of voice for smaller actors in this joint forum, with some electing to remain silent if they participate at all. There were also fears that the patriarchal ways of working in government including the dominance of ‘protectionist’ approaches, would now apply. Still others who held this latter position continue to engage with the Task Force for strategic reasons, but do not fully integrate. For some the continued relevance of the Task Force was a space that strategically engages with the government in some capacity and which could be mobilised strategically when support was needed as it was a structure recognised by government. As one activist said, *“It is like the law. You may not use it, but it is there if you need it”* (Respondent 2). At least one activist refused to engage with the Task Force in any capacity anymore as a result of this move.

Whichever view, the shifting of the Task Force under the auspices of the GA appears to have altered its approach and functioning in a fundamental way. In the context of Batticaloa with its history of violent conflict, there is also the question as to what degree people can disentangle the state – which has been predominantly the face of conflict – from this role and accept its authority on resolving violence. This is especially pertinent given that there is also a history of gendered violence perpetrated by the machinery of the state itself. Linked to this is the observation of how government officials negotiated their multiple identities in choosing to respond to cases of GBV where state actors were implicated.

The Task Force operates with all the trappings of formality, while not being truly formal as the GA being chair is not a government position. Much depends therefore, on the commitment of the GA and demands on her/his time from other formal functions. The result of this is that meetings no longer take place regularly, and at the time of writing no Task Force meeting had been held for 6 months. There is frequent turnover of government staff in senior positions in the Task Force, which means that the commitment of their positions has to be negotiated repeatedly. But on the other hand this ‘informal formality’

has brought some recognition to the work of the Task Force. It also maintains some level of government interaction however variable and/or limited, which is of strategic benefit to people working on these issues within the civil society space in Batticaloa.

There appears to be some introspection from some members of the Task Force on this: how to balance a need for sustainability that is being equated to government ownership of the Task Force, with the seemingly contradictory need to maintain openness and accountability. If the government is to play a role in the Task Force, there are questions now emerging from within the Task Force as to whether that leadership should be envisioned in a different way altogether. This re-thinking of leadership of the Task Force needs to be done in a way that does not concentrate power, especially within bureaucracy, – often patriarchal bureaucracy. There is also a need to create a common institutional culture for the Task Force that can then bring people together to deal with violence against women, despite individual personalities and approaches.

In terms of structure, there are enduring concerns related to the lack of sustained capacity building at multiple levels – within the District Level Task Force, within the Divisional Level Task forces and at the GBV Desks. There needs to be sustained capacity building over a long period for people working in all of these structures at different levels. There is also a lack of clarity as to the roles and functions at each of these levels. One suggestion has been to develop clearly defined roles for the District Level Task Force in relation to the Divisional Level Task Forces and the GBV Desks. These roles are especially important in a context of post-war and post-emergency and need to be linked more clearly with current needs. In relation to structure and functioning, there was also a suggestion that the role of the District Task Force should be to establish a participatory monitoring system to capture the process of work at all levels; this included setting up of proper referral systems using uniform formats linked to a central database, and the use of rigorous evaluation and assessment tools.

One activist cautioned that setting up structures itself may not be the answer to addressing issues of GBV, as it is not simply a ‘service response,’ but one of changing power structures and of justice; that the setting up of more structures simply sets the stage for the state to interfere even further in women’s lives without thinking through how it would do this. Therefore, there is often a perpetuating of moral censure and restrictive socio-cultural norms.

A lack of sustainable resource mobilisation and funding also continues to be a challenge. There is a need for a means of sustained resource mobilisation that allows for the independent functioning of the Task Force, separate from donor priorities and agendas. It was suggested that the role of the Task Force could be to adapt national level policies and plans to effectively meet district level and divisional level needs, and raise financing.

Ideologically, there have been diverse politics to working on violence against women that coalesced in situations of conflict and emergency around delivery of services. But in a

relatively more stable post-war situation, the fissures are now apparent, making it more difficult to find common ground in the politics around prevention of gender-based violence work. This was also clear in the varied, divergent and vague views of what gender and feminism means to people working in this field in Batticaloa at present. This continues to be one of the biggest challenges facing the Task Force today. Greater clarity and reflection on the different approaches and ideologies that are being brought to the work of the Task Force may be helpful, as would the identification of strategic ways of working together in spite of these differences and the current power dynamics at play within the structure and processes of the Task Force. Whilst this could help the Task Force play a stronger role in relation to prevention of GBV, it may also help address internal hierarchies and power imbalances within the Task Force.

In terms of how transition has affected sustainability of the entity, the idea of sustainability of the Task Force meant different things for different actors involved. On the one hand it was that the Task Force endures in changing contexts and by that measure, it has endured for just over a decade through conflict, emergency and disaster. But for other actors the question remains as to what sustainability means without considerations of accountability, and regular, effective functioning. Further, there is the concern that if the Task Force now operates through often patriarchal government systems that are protectionist in the best case, how sustainable does that make a Task Force that is supposed to work to prevent and respond to violence against women?

What has been clear in this discussion on this Task Force is that while transitions in external context have been important, there are also internal transitions that prove a significant challenge in sustaining services and coordination of these services over time. Different challenges also take on varied levels of significance as contexts change, such as the relative importance of a vision and ideology in post-war and post-emergency contexts. And the recognition of these variations is important if the Task Force hopes to stay relevant to emerging social development needs in Batticaloa.

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