博　士　論　文

Training Sri Lankan public health midwives on intimate partner violence: a pre- and post-intervention study

（スリランカにおける親密なパートナーによる暴力に関する
助産師向けトレーニングの前後比較研究）

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DEVAW	Declaration on the Elimination of Violence Against Women
DV	Domestic violence
GBV	Gender based violence
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization
IPV	Intimate partner violence
NGO	Non-governmental organization
MOH	Ministry of Health
PHM	Public health midwife
SRH	Sexual and reproductive health
UK	United Kingdom
UN	United Nations
US	United States
WHO	World Health Organization

Abstract

Introduction

In 2009, the Sri Lankan Ministry of Health trained its public health midwives (PHMs) on intimate partner violence (IPV). I evaluated the training's efficacy in improving the PHMs' knowledge, perceived responsibility, barriers, and self-confidence in identifying and managing IPV sufferers in Kany, Sri Lanka.

Methods

I conducted this study from August 2009 to September 2010 in Kandy district. I used a self-administered structured questionnaire for data collection. Using the Wilcoxon signed-rank test, I compared the PHMs' pre- and post-intervention IPV prevention knowledge, perceived responsibility, barriers, and self-confidence scores. I computed the Minimally Important Differences (MIDs) and the Reliable Change Indices (RCIs) for the four variables, and computed the number of PHMs who showed reliable changes, and important improvements in their scores, after the training.

Results

After the training, the PHMs (n = 408) showed significant improvements ($p < 0.001$) in their perceived responsibility (3.20 vs. 4.60), self-confidence (1.81 vs. 2.75), barriers reduction (2.43 vs. 1.14), and IPV prevention knowledge scores (0.62 vs. 0.88). Moreover, 94.1%, 96.6%, 97.8%, and 98.3% of the PHMs showed important improvement in their perceived responsibility, barriers, IPV knowledge, and self-confidence scores respectively, exceeding the MID. Although, 64.5%, 80.1%, and 93.6% of the PHMs showed reliable improvement in their perceived responsibility, self-confidence, and barrier reduction respectively (above RCI), only 42.4% of the PHMs improved their IPV prevention knowledge above the RCI.

Conclusions

The Sri Lankan partner violence prevention training was associated with improvements in perceived responsibility, barrier reduction, and self-confidence in managing partner violence sufferers, among some of the midwives. Midwives partner violence prevention knowledge did not improve in a similar manner.

Key words: intimate partner violence; Sri Lanka; public health midwives; training; evaluation

1. Introduction

Intimate partner violence (IPV) is a public health problem that cuts across countries, societies and cultures [1-8]. Both women and men could be the sufferers of IPV [6, 8]. However, compared to men, a significantly higher number of women experience IPV and are injured or killed by their abusive male partners [8-20]. This situation is especially seen in developing countries where a majority of women are economically dependent on their husbands [15-21].

1.1 The definitions of IPV

The term "intimate partner violence" describes physical violence, sexual violence, and psychological violence (including controlling behaviours) by a current or former intimate partner. A person can experience this violence within their marital and cohabiting relationships, or after being seperated. Hence, the "intimate male partner" in this definition includes husbands, ex-husbands, boyfriends, ex-boyfriends, or wives, ex-wives, girlfriends, and ex-girlfriends [6, 8-12]. The experience of IPV during the past 12 months is termed "current abuse". The experience of IPV at least once in a person's lifetime is termed "ever abuse" [4].

The acts of physical violence include hitting, slapping, burning, threatening with a weapon, actually using a weapon, etc. The acts of sexual violence include forced sex, pornography, unwanted sexual acts, etc. The acts of psychological violence include shouting, intimidating, threatening, scaring, etc. The acts of controlling behaviours include keeping a person from seeing friends or family, insisting a person to tell where she/he has been all the time, preventing a person from accessing services, etc. [3-6].

The terms “domestic violence” (DV) and gender-based violence (GBV) both include IPV [8, 22-24]. Other than including IPV, DV also includes child abuse, elder abuse, and abuse by any member of the household [8]. GBV includes IPV, DV, as well as community violence and workplace violence [24, 25].

1.2 The global context of IPV

1.2.1 Historical background

For long, many accepted IPV as an inevitable part of a marital relationship [1-8]. Hitting the wife or forcing her to have sex was considered normal and the right of a husband [3-8]. In 1979, this acceptance was first challenged when the United Nations (UN) adopted “The Convention on the Elimination of all forms of Discrimination Against Women” (CEDAW) [1, 26]. CEDAW is an international bill of women’s rights. In 1993, the “World Conference on Human Rights” held in Vienna, Austria introduced the “Declaration on the Elimination of Violence against Women” [27]. This declaration led several governments and civil societies to acknowledge that violence against women (including IPV) is a public, policy, and human rights concern. In the 1995 Beijing World Conference on Women, 189 governments signed on to a “Platform for Action” to prevent violence against women, including IPV [27].

Through these initiatives, governments increasingly recognized the need to develop broad multi-sectoral approaches to prevent IPV [1, 6, 28]. They started passing laws to criminalize IPV [1, 29-34], and improved the support services available for abused women. However, the response was not as aggressive in developing countries. In spite of having IPV laws, the conviction rates were minimal, and only a few IPV support services were available for the sufferers [33-38].

Lack of documented evidence on IPV was one reason for the poor IPV response in developing countries [1, 6]. IPV prevention was difficult for the governments when there was limited IPV data to guide policy implementation and monitoring [1, 6]. As one solution to this problem, in collaboration with research teams in ten countries, the WHO conducted a multi-country study in 2005 to provide internationally comparable data on IPV [3]. This study also introduced a tool to collect IPV data, and proposed ethical and safety guidelines for IPV studies [3-5, 39, 40].

1.2.2 The global prevalence and associations of IPV

The prevalence of IPV differs across countries; the prevalence is much higher in developing countries than in developed countries [1, 3, 4, 7-12]. In a 2005 WHO multi-country study, the lifetime prevalence of IPV ranged from 71% in an Ethiopian province to 15% in a Japanese city [1, 3]. In a 2013 WHO study, the reported lifetime IPV prevalence was 36.6% in Africa, 29.8% in the Americas, 25.4% in Europe, and 37.7% in South-East Asia [7].

Several factors are associated with IPV. The female factors include low level of education, low economic status, young age, high number of children, witnessing of parental IPV, and poor social support for the sufferers [13-21, 40-50]. The male factors include low education levels, poor economic status, young age, low level of communication with the sufferer, alcohol consumption, patriarchal attitudes, witnessing parental IPV, and being violent toward other men [1, 6, 51, 52] . The social factors include economic inequality between men and women, low levels of female mobility, negative gender role attitudes, and little or no support by the extended family in the incidences of IPV [42-46]. Also, separated or divorced marital status, marital conflicts and extra-marital affairs have been commonly associated with IPV [43, 45].

1.3 Health effects of IPV

IPV can cause several physical, psychological, sexual, and reproductive health problems among sufferers [53-62]. The physical consequences of IPV include abdominal or thoracic injuries, bruises, cuts, burns, fractures, gastrointestinal disorders, etc.; some of these physical effects might persisit even after the violence ends [6, 56]. Some sexual and reproductive health consequences of IPV include pregnancy complications, miscarriage, sexual dysfunction or injuries, and sexually transmitted infections including HIV/AIDS [8, 63–67]. The psychological and behavioural consequences include depression and anxiety, feeling of shame and guilt, alcohol and drug abuse, unsafe sexual behaviours, suicide, and homicide [60, 68, 69].

Several external manifestations of IPV are associated with underlying biological mechanisms [69, 70]. For example, chronic stress caused by IPV can affect the sufferer's mental health and cognitive functioning [68, 69]. The stress response can compromise the immune system [70]. Sustained or acutely elevated stress can cause cardiovascular disease, hypertension, and insulin-dependent diabetes [69, 70].

1.4 Addressing IPV at health settings

Most IPV sufferers seek health care at some point in their lives [1, 6]. This is in contrast to the fact that they will rarely seek help from the police or other legal or social services [24, 25, 40]. This makes the health care setting an important place where IPV sufferers can be identified, provided with support and referred if necessary to specialized services [22, 23, 25, 71–85].

Among the health facilities as well, the community health care facilities have a greater opportunity to identify and assist IPV sufferers; this is especially true in developing countries [24, 25, 76, 82, 83]. Although many women in developing countries do not seek professional

health care for illnesses, almost 80% of pregnant women meet a skilled health worker at least once during their antenatal period; this happens mostly at a community health care institution. Furthermore, contraceptive prevalence is steadily increasing in developing countries where women visit community health workers for contraception [82, 83]. This gives the community health workers the opportunity to identify IPV sufferers and provide necessary services at the community level. Such identification can improve the sufferers' health [82, 83].

The increasing understanding of the adverse health consequences of IPV encouraged governments to introduce IPV prevention services at health settings. International organizations encouraged governments to do so, and provided guidelines on how it should be done [24-27]. Especially, the following international organizations published guidelines for health sector IPV interventions: United Nations Population Fund (UNFPA), World Health Organization (WHO), International Planned Parenthood Federation (IPPF), and the United States Centers for Disease Control and Prevention (CDC) [24-27, 82, 83].

1.4.1 Guidelines for planning IPV interventions at health settings

In 2001, the UNFPA published a program guide on how to implement IPV services in health settings [24]. Then, in 2004, the IPPF of the Western Pacific region published a resource manual on how to improve health sector response for IPV in developing countries [25]. In 2010, the US CDC published guidelines on how to train health workers in the primary prevention of IPV [83]. In 2013, WHO published its clinical and policy guidelines on how to respond to IPV at health settings [22].

These guides provided recommendations on how to introduce IPV services at health settings and train health workers to provide culturally sensitive IPV services [24, 25, 82, 83].

They recommended that IPV interventions should have institutional support and provide the health workers with initial and ongoing training on IPV. However, only a few developing countries adapted these guidelines and introduced IPV prevention services in health settings.

1.4.2 Health sector IPV interventions in developing countries

In 2006, Bangladesh implemented one-stop crisis centers for the sufferers of DV [84]. The centers provided acute care, counselling, and legal assistance to the sufferers. The lack of trained human resources was a program limitation. In 2009, Sri Lanka's Ministry of Health (MOH) integrated IPV services into the primary health care, and trained its most widespread community health workers – the public health midwives (PHMs) – on IPV. The effectiveness of this program was not assessed at the community level [85]. In 2011, Malaysia scaled up its one-stop crisis centers to provide IPV services, with the support of women's NGOs [86]. However, the Malaysian MOH lacked policies and financial resources to sustain those services. In 2013, the Family Planning Association of Sri Lanka (FPASL) integrated IPV screening, counselling, and referrals into their routine sexual and reproductive health (SRH) services. Limited availability of trained staff was a key program limitation [87].

Introducing IPV interventions in developing countries could be a challenging task. Most countries lack trained health prfessionals, necessary infrastructure, and financial resources. Furthermore, they have only a limited number of referral resources [7, 53]. In contrast, IPV interventions have been effective in developed countries because health workers quickly recognize IPV problems and respond appropriately. Health workers in developed countries receive IPV training during their undergraduate education [88-91].

A quick assessment of IPV followed by appropriate counselling can tremendously improve resource utilization and safety planning for the sufferers [92-102]. Training health workers on IPV is a crucial first step for introducing IPV services in health settings, especially in developing countries [24, 25].

1.4.3 Training health workers on IPV

To provide IPV services, health workers need adequate skills and a good understanding of IPV. This is because IPV is a sensitive issue, and an inadequately trained health worker can do more harm than good to IPV sufferers [82, 83]. For example, health workers might hold negative IPV-related attitudes and blame sufferers for IPV; this can aggravate IPV and adversely affect the sufferers' health. The health workers might fail to notice warning signs of suicide or homicide, and inadvertently put a sufferer's life in danger [22, 82, 83].

To provide health workers a good understanding of IPV, their trainings should be designed by local experts who are familiar with the societal and cultural expectations of the setting [82, 83, 95]. Such well-designed trainings should be delivered by experienced and competent trainers, in the trainees' local language. The trainees should then be followed up, evaluated, and provided with supportive supervision for their IPV services [24, 25, 73, 82, 83, 95].

1.4.4 Effectiveness of IPV training: a review of literature

To evaluate the effectiveness of health worker IPV training, I conducted a literature review in the databases of MEDLINE®, POPLINE®, and PsycINFO®, using the Medical Subject Heading (MeSH) key words "intimate partner violence", "domestic violence", "violence against

women", "abuse", "education", "training", "health professionals", "health care providers" and "health workers". I reviewed the articles that were written in English and published after January 2000 to review more recent liturature. Several studies evaluated IPV programs at health settings [92-94, 96-98], but did not evaluate the training component of it. I excluded them from the analysis.

Majority of the previous IPV prevention trainings were conducted in developed countries. They aimed at improving health workers' knowledge, responsibility, confidence, and practices in managing IPV sufferers, while reducing their perceived barriers. Trainings included different categories of health workers (e.g. nurses, doctors, midwives. etc.), and varied in their content and the method of implementation. They improved one or more domains of health workers' IPV prevention knowledge, skills, responsibility, confidence, and practices; none improved all of those domains [97-102].

A 2002 study in Minneapolis, USA included 3 intervention and 2 comparison hospitals and evaluated a non-profit health care based IPV screening program: the WomanKind program. Health workers at WomanKind hospitals showed significantly higher knowledge, attitudes, beliefs and behaviors on IPV prevention, than those at comparison hospitals [96]. A 2004 Northwestern US study assessed the efficacy of a DV training conducted in a primary health care maintenance organization (HMO). The training significantly improved clinicians' *(n* = 137) inquiry about DV. Their knowledge about DV did not significantly improve between the baseline and follow-up [97].

A 2004 UK study examined the effectiveness of a DV training for 79 community midwives [98]. Just after the intervention, and at six months' follow-up, the midwives showed increase in their knowledge of IPV, and positive attitudes toward asking a patient about IPV. The

common barriers for IPV inquiries were lack of time, and the presence of a family member [98]. A 2005 study in a Washington county assesed the effectiveness of a two-hour IPV workshop for health workers. The participants' *(n* = 187) summary scores improved significantly for the responsibility to identify IPV, empathy, and respecting patients' autonomy. The barriers on providing IPV services did not reduce [99].

A 2006 US study assessed an online IPV education program for physicians (23 physicians in the intervention group and 29 in the control group) [100]. The program improved the physicians' attitudes, beliefs, and self-reported practices on IPV. Their actual knowledge improved only marginally (p=0.06). A 2007 Israeli study evaluated the efficacy of a national DV training program conducted by the Israeli Ministry of Health (MOH) [101]. It found that the training improved the physicians' IPV knowledge and screening skills in a six-month follow-up period, but not their knowledge of IPV legislations [101].

A 2011 US cluster randomized control study assessed a two-hour IPV training program for clinicians in 24 intervention practices and 24 control practices [91]. After one year, the intervention practices referred 223 sufferers to advocacy services. The control practices made only 12 referrals [91]. A 2013 Greek intervention study included 25 GPs (11 in the intervention group and 14 in the control group) and evaluated an intensive IPV education program. In the intervention group, the physicians' IPV knowledge and their perceived preparedness improved significantly. However, their IPV case detection did not improve [102].

1.5 The Sri Lankan context of IPV

1.5.1 The prevalence and association of IPV

Sri Lanka is a developing country in the South Asian region with a population of 19.1 million; 51% of that population is female [103, 104]. Sri Lankan women enjoy a relatively better standard of living compared to the other South Asian women. They have a higher life expectancy, higher literacy rate, lower birth rate, and higher age at marriage [103-106]. In 2012, the life expectancy of Sri Lankan women was 75 years, the literacy rate was 91%, and the age at marriage was 25 years. In the same year, among Indian women, the life expectancy was 63 years, the literacy rate was 74%, the age at marriage was 22 years [105]. However, patriarchal gender norms widely exist in Sri Lanka and a considerable number of women experience IPV [107-118].

Sri Lanka has only a few published IPV studies. The first was a 1982 study which involved 60 married women who were repeatedly assaulted by their husbands. Of all, 62% were assaulted by weapons such as sticks, firewood, and kitchen knives [109]. In 1999, a cross-sectional study included 417 rural married women between 18–49 years of age, and reported a 30% prevalence of physical IPV. IPV was associated with early marriage, low income, and large families [111].

A 2001 study included 1200 pregnant women between 15 and 49 years old, and reported a 4.7% prevalence of physical abuse during the current pregnancy. Of them, 20% were abused at least once a week [112]. A community-based cross-sectional study conducted in the Western Province in 2006 reported a 34% lifetime prevalence of physical IPV [43]. In a community-based cross-sectional study conducted in 2007 in the Central Province, wives were more likely to experience ever and current psychological abuse by husbands if they did not believe that "a good

wife always obeys her husband" [42]. In patriarchal Sri Lankan society, the family expects wives to uphold cultural and family values, and act in a manner that does not bring shame to the family. Marital conflicts are considered personal matters in Sri Lanka. Possibly, Sri Lankan wives accept the common cultural norms, in order to reduce IPV [42, 115].

A common belief in Sri Lanka, even among medical students and police officers, is that IPV is a personal matter that outsiders should not intervene in [115-118]. The laws against IPV identify the physical and psychological IPV, but not the sexual IPV [115, 118]. IPV support services such as shelters and legal aid programs are largely inadequate to assist the high number of IPV sufferers [119-126].

These studies suggest that the prevalence of IPV is high in Sri Lanka. Health workers and police officers bear a major responsibility in combating IPV in any country. However, a considerable proportion of health workers and police officers in Sri Lanka believe that IPV is a personal matter in which outsiders should not intervene. This situation can lead the IPV sufferers to experience institutional abuse, and make them loose confidence in the legal and medical systems for their safety. To improve this situation, Sri Lanka needs IPV prevention trainings for health workers and police officers; research should evaluate the effectiveness of the trainings, and suggest possible improvements as appropriate.

1.5.2 The interventions for IPV prevention in Sri Lanka

Sri Lanka was one of the first countries in South Asia to ratify the CEDAW in 1981 [124]. Then, in 1993, Sri Lanka subscribed to the UN's "Declaration on the Elimination of Violence Against Women (DEVAW)" [118]. With these initiatives, the Sri Lankan Ministry of Women's Affairs established the "National Committee on Women" in March 1993, and

formulated a Women's Charter [119]. In the same year, 50 NGOs working on gender issues came together and formed a forum (The Sri Lanka Women's NGO Forum) to function as an advocacy body on women's rights [120]. Some of the NGOs also provide free legal counseling and assistance to the sufferers [121].

Subsequently, in 1995, Sri Lanka subscribed to the Beijing "Platform for Action" to prevent violence against women [115, 118]. In the same year, the Ministry of Women's Affairs established its first three shelters for IPV sufferers and their children. These shelters temporarily accommodate IPV sufferers till they find a safe place to live, away from the abusive husbands [36, 119]. By 2015, Sri Lanka had 13 such shelters.

In 1995, Sri Lanka amended the penal code to recognize physical abuse and rape of a spouse; a rape was an offence only when the spouse was under 16 years old or judicially separated [122-124]. Subsequently, in 2005, a specific legislation against DV was introduced to provide protection orders against acts of physical violence, and severe psychological violence by a spouse. However, the law on marital rape did not change [123].

In 1996, the department of police established women's desks in 36 main police stations in Sri Lanka [124]. These desks receive only the complaints on DV and IPV. The desks are headed by female police officers to address the complaints of DV/IPV in a gender-sensitive manner. By 2015, all police stations in Sri lanka had women desks [124]. However, these desks still lack trained female police officers.

Although these initiatives improved IPV services in Sri Lanka, they are still not adequate to serve the large number of IPV sufferers. Furthermore, the professional response for IPV is inadequate in Sri Lanka [115, 118, 125]. An average of 4,000 cases of domestic violence are reported to the police every month. However, nearly 80% get settled when police officers

convince wives to drop the charges [115]. Health professionals provide medical assistance to the sufferers of IPV, but rarely inquire about the violence [107, 108]. The laws against IPV provide a 12-month protection order against the acts of physical and psychological violence by husbands. However, the poor monitoring after issuing of the protection order leads wives to be battered despite the availability of the law [116].

1.5.3 Health sector responses for IPV prevention in Sri Lanka

In 2001, the Sri Lanka Medical Association (SLMA) established a "Women's Health Committee" [126] which initiated the sensitizing of health policy makers on IPV. In 2005, the Sri Lankan MOH established a consultant position to address IPV at health settings (a Gender Focal Point) [127, 128]. This appointment intensified the health sector involvement in IPV prevention. With this appointment, the MOH introduced one-stop crisis centers *(n* = 5) at selected secondary and tertiary care hospitals to provide medical care, psychological counselling, and legal advice for IPV sufferers; at present, there are 30 such crisis centers [127].

Because the MOH networked with local IPV support services, the crisis centers could refer IPV sufferers for different services. Some services provided financial assistance to the sufferers and trained them for self-employment [129]. However, only a minority of IPV sufferers benefited from the crisis centers. This is because the majority of IPV sufferers do not seek care from these centers.

Sri Lanka has a well-developed network of community health workers called the public health midwives (PHMs) who can assist IPV sufferers at the community level. They can provide emotional support, and empower sufferers to prevent IPV; such an empowerment can improve the sufferers' safety and wellbeing [23-25].

1.5.4 Introducing an IPV training to public health midwives in Sri Lanka

Identifying this community health care network (the PHMs) as an IPV prevention resource, in 2009 the MOH trained its PHMs on IPV prevention [128, 130]. The training aimed to improve the midwives' skills in identifying and assisting IPV sufferers at the community level. MOH expected the PHMs to integrate IPV services into their routine community health services.

In Sri Lanka, PHMs are the grassroots level maternal and child health workers. They provide family planning services, antenatal care, postnatal care, child immunizations, and gynecological services to the community [127, 128]. The Sri Lankan MOH recruits PHMs from the localities in which they are likely to work; females older than 18 who have a minimum of 10 years of formal education are selected for 18 months of midwife training. PHMs conduct field visits in order to assure the health and wellbeing of their allocated population (around 800 women in the reproductive age, and their children) [128]. PHMs provide their services free of charge, irrespective of their careseekers' economic standards; even the poorest women in the most rural areas of Sri Lanka receive the services of a PHM [106].

The PHMs' dedicated service has helped Sri Lanka achieve the best reproductive health indices in the South Asian region. For example, in 2013, the maternal mortality rate in Sri Lanka was 29 per 100,000 live births compared to 190, 190, and 170 in India, Nepal, and Bangladesh, respectively [112]. In 2013, 75% of all Sri Lankan pregnant women were registered with PHMs before the eighth week of pregnancy. Furthermore, 99% of pregnant women had their blood group tested before the delivery, and received timely Rubella and Tetanus vaccinations [127]. Because PHMs provide a free and friendly service, women in the community treat PHMs with respect, and consider them as trusted and dependable friends. Since PHMs visit women in their

homes, they can observe women in the environment where IPV occurs. As the PHMs are female, they can build trusting relationships with women in the community. MOH considered all these positive factors when introducing the IPV prevention training to the PHMs.

1.6 Rationale of the study

In Sri Lanka, one out of every three women experiences IPV, but rarely discloses her experience of violence till it becomes severe [114-120]. As a result, sufferers of IPV present to health care institutions with serious IPV-related health consequences such as fractures, severe depression, unsafe abortions or suicidal attempts. Some succumb to the injuries of IPV [121]. If these sufferers can be identified at the community level, health workers can provide them with the necessary assistance during the early stages of violence, and prevent them from developing serious health problems associated with IPV.

To recognize and assist IPV sufferers, health workers need IPV prevention training [24, 25]. This is because untrained health workers can do more harm than good to IPV sufferers. They might blame sufferers for their IPV experiences and aggravate the problem. Furthermore, lack of IPV prevention training might reduce the health workers' perceived responsibility and confidence in managing IPV sufferers [95].

IPV prevention training is especially important in a country like Sri Lanka. In Sri Lanka, many consider IPV as a private family matter that outsiders should not intervene in. A divorce or a separation, even due to severe IPV, can stigmatize a woman. Furthermore, a considerable number of Sri Lankan women are economically dependent on their husbands, and might find it difficult to leave their abusive relationships – Sri Lanka has only a limited number of IPV prevention services to support them [108, 115, 118]. Because of these reasons, Sri Lankan health

workers need to be trained to best utilize the available resources and provide culturally-sensitive IPV services.

Even among the health workers, community health workers have a better opportunity to identify and assist IPV sufferers than other health workers [82, 83]. In Sri Lanka, the most common community health workers are the PHMs. They provide reproductive and child health care services at the community level [106, 128]. During their home visits, PHMs can observe women at the places of violence, and assist them appropriately. Moreover, being female, PHMs are likely to develop trusting relationships with IPV sufferers, which can improve the sufferers' IPV disclosures.

After considering these factors, the Ministry of Health of Sri Lanka trained its PHMs on IPV prevention in 2009. The purpose of this training was to improve the PHMs' ability in identifying and managing IPV sufferers at the community level. UNFPA provided the financial assistance [128, 130]. Before introducing the program nationwide, the MOH first piloted a program with PHMs in one district (Kandy) to assess its efficacy in improving PHMs' IPV prevention knowledge and their responsibility and confidence in managing sufferers.

1.7 Research Objective

The objective of this study was to evaluate the efficacy of the PHMs' pilot IPV prevention training in improving the PHMs' IPV knowledge, perceived barriers, responsibility, and confidence in identifying and managing IPV sufferers in Kandy, Sri Lanka.

The results of this study will be useful for the Sri Lankan MOH in training PHMs on IPV prevention. Other developing countries might learn lessons from this training and provide IPV prevention training to their community health workers.

2. Methods

2.1 Study design

I conducted this pre- and post-intervention survey between August 2009 and September 2010, in the Kandy district (Appendix 1). I conducted the pre-intervention survey just before the training (intervention), and conducted the post-intervention survey six months after the training.

2.2 Study area

Kandy is the second-largest district in Sri Lanka, with a population of 1.4 million. Of that population, 12.1% live in urban areas, 82% live in rural areas, and 5.9% live in tea plantation estate areas [104]. People of three ethnicities live in those three areas. They are Sinhalese (70%), Muslims (14%), and Tamils (8%). They speak two main languages, Sinhala and Tamil [110]. Although the three ethnicities have minor cultural variations, women's status, male dominance, and societal beliefs are similar among the three ethnicities [103, 104].

The female literacy in Kandy varies in urban, rural, and tea plantation estate sectors. In urban areas, the literacy is 95%, in rural areas it is 91%, and in the estate areas it is 75%. These figures are similar to the total female literacy rates in Sri Lanka, in the three sectors. Of the total population in Kandy, 25% of women and 62% of men participate in the labor force. The total married population is 45% [104]. As living together without being married is uncommon in Sri Lanka [36, 108], the married population might be the at-risk population for IPV in Kandy, excluding dating violence.

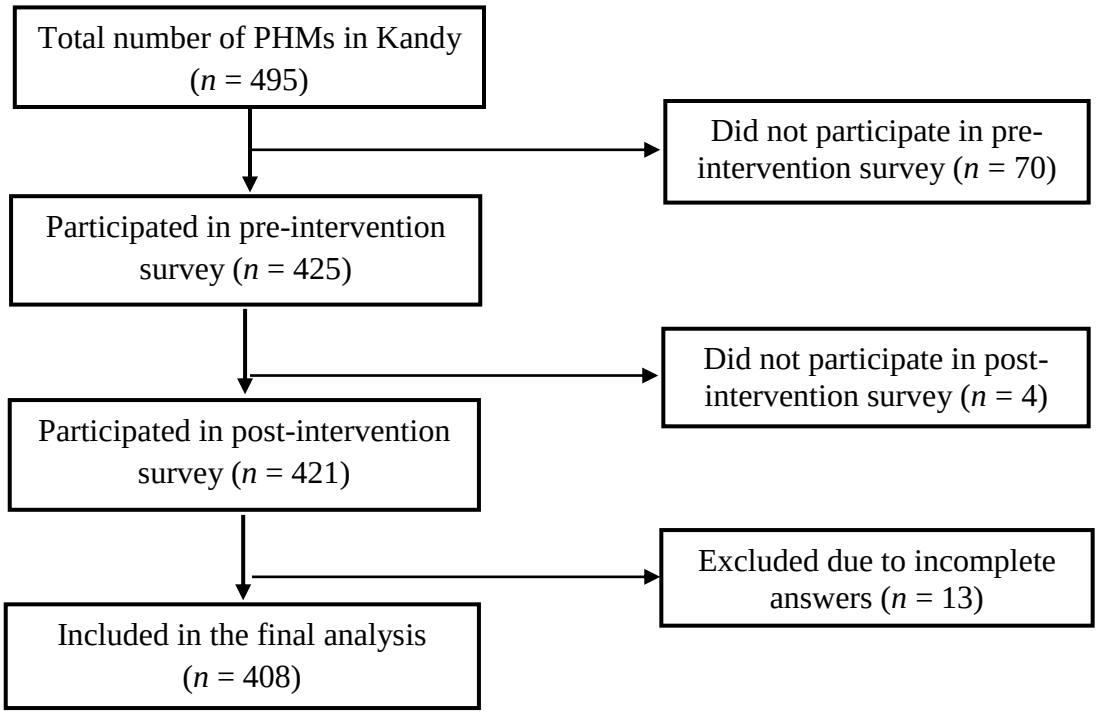
The basic health care unit in Sri Lanka is called a Medical Officer of Health area: one community physician (a Medical Officer of Health) is responsible for the primary health care services in one area. In each area, 15-35 PHMs provide primary health care services to the

women in the reproductive age (18-49 years old), under the supervision of the Medical Officer of Health; each PHM serves around 800 women in the reproductive age. For administrative purposes, the MOH refers to the PHMs working in urban and rural areas as "field PHMs". The PHMs working in tea plantation estate areas are called "estate PHMs". In Kandy, there are 22 Medical Officer of Health areas. During the study period, a total of 495 PHMs (field and estate) provided primary health care services in those 22 areas [131]. As in any other area, PHMs in Kandy also provide family planning services, antenatal care, postnatal care, and child immunizations to the community. They maintain close relationships with the women in their area; most women consider the PHM as a reliable and a trusted friend [128, 131]. Appendix 2 shows two photos of the community health services provided by PHMs.

2.3 Participants

As shown in Figure 1, I recruited all the PHMs in Kandy district *(n* = 495) for this study. Among them, 425 participated in the pre-intervention survey; the other 70 PHMs did not participate due to personal reasons (e.g., illness). For the post-intervention survey, I recruited the PHMs who participated in the pre-intervention survey *(n* = 425). Among them, four PHMs did not participate due to personal reasons. I also excluded 13 participants whose questionnaires were incomplete. Final analyses evaluated the data of 408 PHMs who had worked in Kandy for more than one year.

Figure 1. Selection of participants



2.4 The training program (intervention)

The PHMs' training program consisted of four days of training. Each day, the training was held from 9.00 to 16.00. The training was designed by two community physicians and a gynecologist. They had international training on IPV prevention and experience in providing IPV prevention services. They prepared a 60-page, A4-size training manual for the trainers (Appendix 3), in order to help them conduct the training in a timely and comprehensive manner. As per international guidelines [24, 25], the training manual was prepared in the PHMs' local language (Sinhala), matched the PHMs' professional requirements, and aimed to improve their practical IPV prevention skills (Appendix 4).

Subsequently, the MOH trained five community physicians in Kandy on how to conduct the training with PHMs. The five trainers, two of whom were female, were the most senior and experienced community physicians in Kandy in 2009; each had masters or doctoral postgraduate qualifications in public health (MBBS, MSc, +/- MD). They also held prior experience in training PHMs at the midwifery schools or in PHMs' in-service training [131].

The trainers conducted 11 four-day training programs for the PHMs working in 22 Medical Officer of Health areas (Appendix 5). They combined the PHMs of two Medical Officer of Health areas for each training program. The training was held at the office of one of the two Medical Officer of Health areas. As shown in Appendix 6, around 35 to 65 PHMs participated in each four-day training program. The contents of the training were as follows: (1) gender roles; (2) the types, acts, and health effects of IPV; (3) the domestic violence (DV) prevention law in Sri Lanka; (4) the available supportive services for IPV sufferers in the country; and (5) how to identify and assist IPV sufferers [85]. Appendix 7 provides the detailed training program.

Using role-playing and case reports, the trainers discussed how to manage IPV sufferers in different situations. Appendix 8 shows three of the case reports used in the training. Because IPV is a culturally sensitive issue in Sri Lanka [108, 118], the trainers requested the PHMs to respect cultural norms in all their interventions. They were expected to acknowledge Sri Lanka's male-centered family structure, and exercise caution when suggesting separation or divorce; this was because majority of IPV sufferers are economically dependent on the abusers. As mediators, PHMs were expected to improve the couples' mutual respect and understanding, in order to prevent further IPV.

The trainers stressed the importance of adequate privacy when inquiring about IPV and required the PHMs to keep sufferers' information confidential. As Sri Lanka has few IPV

prevention referral resources, the trainers required PHMs to network with local women's groups and social services to refer sufferers locally. PHMs could also refer sufferers to the Medical Officers of Health, who provided psychological care for the sufferers and referred them to legal services as required.

2.5 Study instrument

I used a self-administered structured questionnaire for data collection (Appendices 9-12). I prepared the questionnaire using the WHO's Multi-Country Study questionnaire on Women's Health and Domestic Violence against Women [3, 4], and the tools that were previously used for assessing the health workers' perceived responsibility [97, 99, 102], barriers [94, 96, 99, 102], and self-confidence [99, 100, 102] in identifying and managing IPV/DV sufferers. They were used in settings like Greece, Israel, Canada, and USA. I extracted different items from those tools and combined them to form a questionnaire that suited the Sri Lankan context.

2.5.1 IPV knowledge

I assessed the PHM's IPV knowledge using 16 items. They were prepared under three categories: (1) acts of IPV (6 items), (2) health effects of IPV (4 items), and (3) the IPV prevention laws in Sri Lanka (6 items). For each item, PHMs could respond with a *yes*, *no*, or *don't know*. One mark was given for each correct answer. I calculated the average IPV knowledge score for each PHM by dividing their total knowledge scores by the number of items answered. A higher score indicated better IPV knowledge among PHMs.

2.5.2 Perceived responsibility

I assessed the PHMs' perceived responsibility in assisting IPV sufferers using five items. I assessed: (1) PHMs' responsibility in asking about IPV whenever an injury is noticed, (2) responsibility in asking about IPV when serious child injury is noticed, (3) responsibility in listening to an IPV disclosure, (4) responsibility in telling a sufferer that an abuser's behavior is not acceptable, and (5) the responsibility in telling a sufferer that IPV can adversely affect her/his health. PHMs could indicate their agreement to the statements using a five-point Likert scale that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). I calculated the average perceived responsibility score for each PHM by dividing their total responsibility scores by the number of items answered. A higher score indicated higher perceived responsibility in identifying and managing IPV.

2.5.3 Perceived barriers

I used seven items to asses PHMs' perceived barriers in identifying and managing IPV sufferers. They were: (1) my workload is too heavy, (2) I am afraid to offend a person by asking about IPV, (3) it is difficult to get a person alone, (4) I do not have adequate training to identify or help IPV sufferers, (5) there are no IPV prevention services to refer sufferers, (6) I don't feel I can help a sufferer, and (7) I am more interested in addressing patients' medical problems than their relationships. PHMs could indicate their agreement to the statements using a five-point Likert scale that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). I calculated the average barrier scores for each PHM by dividing their total barrier scores by the number of items answered. A higher score indicated higher perceived barriers for identifying and managing IPV.

2.5.4 Self-confidence

I examined the PHMs' self-confidence in identifying and managing IPV sufferers using eight items. They were: (1) confidence in asking about IPV, (2) confidence in asking about sexual violence, (3) confidence in knowing what to do when a person discloses IPV, (4) confidence in knowing what to do if a person breaks down and cries; (5) confidence in assessing a sufferer's safety, (6) confidence in knowing what to do if a sufferer does not want to leave an abuser, (7) confidence in making an IPV referral, and (8) confidence in knowing what to do when child abuse co-exists with IPV. PHMs could indicate their agreement to the statements using a three-point Likert scale that ranged from 1 *(not confident*), 2 (*somewhat confident*), and 3 (*very confident*). I calculated the average self-confidence scores for each PHM by dividing their total self-confidence scores by the number of items answered. A higher score indicated higher self-confidence in identifying and managing IPV sufferers.

2.5.5 Translation and validation of the study instrument

After developing the questionnaire, I requested two translators to translate the questionnaire into the two official languages used in Sri Lanka (Sinhala and Tamil). I and another translator back translated them into English. Based on the back translations, we made the necessary modifications in the forward-translated questionnaires. For example, the following was an item in the PHMs' perceived responsibility scale: "Telling a person that the violence can adversely affect his/her health". In the original scale [97], this item read as "Telling a patient that a particular relationship is harmful to his/her health". This conveyed a harsh meaning in the forward translation; rather than stressing that IPV is harmful to the person, it stressed that the relationship is harmful to the person. Therefore, I rephrased it to the present form. Further,

because PHMs provide services to healthy people and not patients, I rephrased the term "patient" to "person". These modifications improved the clarity as well as the cultural acceptability of the items.

To examine the content validity, I invited two Sri Lankan university lecturers trained in international IPV prevention to evaluate my questionnaire. Those two evaluators were not involved in designing the PHMs' IPV prevention training program. They evaluated the questionnaire for its clarity, appropriateness for the Sri Lankan context, comprehensiveness, and the ability to assess the efficacy of the training. They assessed whether the level of difficulty was appropriate to examine the intended variables among PHMs. They also reviewed the translated versions of the questionnaires for the proper use of terminology and for clarity. I modified the questionnaires according to the comments.

When designing the questionnaire, I used the following definition of IPV: "violence over wives or husbands by their current or former husbands or wives, in the form of physical, psychological, or sexual violence". The acts of physical violence included hitting, slapping, burning, etc. [1-9]. The acts of psychological violence included shouting, intimidation, humiliation, controlling a partner's behavior, etc. [5-9]. The acts of sexual violence included forced sex, pornography, unwanted sexual acts, etc. [5-9]. Living together without being married and pre-marital or extra-marital relationships are not socially acceptable practices in Sri Lanka [108]. Therefore, I did not include IPV by boyfriends or girlfriends. Moreover, as none of the PHMs identified a husband experiencing IPV from his wife, I only reported the PHMs' practices in identifying and assisting the wives who experienced IPV.

To examine the internal consistency and the reproducibility of the questionnaire, I pre-tested it with 47 PHMs in a different district in Sri Lanka (Nuwara Eliya). I re-tested it in two

weeks; I used a two-week re-test interval to minimize the chances of PHMs' recall of contents from the previous assessment [132-134]. The Cronbach's alpha reliability coefficients were above 0.8 for responsibility, barriers, and self-confidence scales (Table 1). The test-re-test Intraclass Correlation Coefficient (ICC) for IPV knowledge, perceived responsibility, barriers, and self-confidence were 0.94, 0.95, 0.95, and 0.96 respectively. As I calculated the ICC corresponding to the correlation between the test and retest measurements on the same population, I used the two-way mixed-effects model of absolute agreement [134, 135].

Table 1. Internal consistencies of the PHM's perceived responsibility, barriers, and self-confidence scales at the pretest and the pre-intervention survey

Domain	Cronbach's alpha	
	Pretest (*n*=47)	Study (pre-intervention) (*n*=408)
Perceived responsibility	0.89	0.84
Perceived barriers	0.80	0.85
Self-confidence	0.87	0.87

To examine the construct validity of the PHMs' perceived barriers, responsibility, and self-confidence scales, I examined the correlation of the PHMs' IPV knowledge with their perceived barriers, responsibility, and self-confidence scores; for this I used Spearman's rank correlation coefficient [132, 135]. I hypothesized that the PHMs' IPV prevention knowledge will show at least a small positive correlation with their self-confidence and perceived responsibility in assisting IPV sufferers. I expected the perceived barriers to show at least a small negative

correlation with the IPV prevention knowledge. I made these assumptions based on the collective evidence provided by the literature [136-139].

As shown in Table 2, in the pre-test and in the pre-intervention survey, PHMs' IPV prevention knowledge showed a strong negative correlation with their perceived barriers score, and a strong positive correlation with the perceived responsibility score (0.60 – 0.79). The self-confidence score showed moderate positive correlation with the IPV knowledge score (0.40 – 0.59) [132, 135]. This finding agreed with the hypothesis made in this study; health professionals' IPV knowledge positively correlated with their self-confidence and perceived responsibility to assist IPV sufferers, and negatively correlated with their perceived barriers. Hence, the three scales used in my study carried adequate construct validity.

Table 2. The correlation between PHMs' IPV knowledge, perceived responsibility, barriers, and self-confidence scores in the pre-test and the pre-intervention survey

Item	IPV Knowledge	Perceived barriers	Perceived responsibility	Self-confidence
Pretest (n = 47)				
IPV Knowledge	1.00	-0.74	0.56	0.55
Perceived barriers	-0.74	1.00	-0.67	-0.67
Perceived responsibility	0.56	-0.67	1.00	0.74
Self-confidence	0.55	-0.67	0.74	1.00
Study (pre-intervention) (n = 408)				
IPV Knowledge	1.00	-0.66	0.58	0.56

Perceived barriers	-0.66	1.00	-0.64	-0.68
Perceived responsibility	0.58	-0.64	1.00	0.71
Self-confidence	0.56	-0.68	0.71	1.00

2.6 Data collection

I conducted my pre-intervention surveys just before the commencement of each IPV training program. Post-intervention surveys were conducted six months after each pre-intervention survey. I used a six-month follow-up period, because the trans-theoretical model of behavior change suggests that people show changed behavior within six months of a behavior change intervention [140]. To maximize the PHMs' participation for the post-intervention surveys, I conducted the surveys at the PHMs' monthly meetings. PHMs are mandated to participate in the monthly meetings except for illnesses and emergencies [127]. All PHMs completed the questionnaire within 40 minutes. I used ID numbers to match the PHMs' pre- and post-intervention responses.

Furthermore, I observed how the MOH delivered the trainings to the PHMs. The MOH conducted 11 training programs for the 495 PHMs in Kandy (Appendix 13). I randomly selected six of those trainings, and observed them throughout. I observed for the following: (1) whether the trainers adhered to the training manual and delivered the training completely and comprehensively (2) how the PHMs received the training, and (3) whether adequate facilities (venue and equipment) were available for training.

2.7 Data analysis

I used SPSS version 17 statistical software (Chicago, USA) for all of the statistical analyses. Using descriptive statistics, I first summarized the participants' socio-demographic and job characteristics. Using the Wilcoxon signed-rank test, I compared pre- and post-intervention scores for the PHMs' IPV knowledge, perceived barriers, responsibility, and self-confidence. I used the Wilcoxon signed-rank test because all of these variables had non-normal distributions [135]. To assess the efficacy of the training, I examined the changes in the responses to individual items as well as changes in the summary scores. I created scores for each domain by adding the scores for items in the domain and dividing by the number of items answered. Scores for the IPV knowledge scale ranged from 0 to 1, scores for the perceived barriers and responsibility scales ranged from 1 to 5, and scores for the self-confidence scale ranged from 1 to 3.

Using these observed scores, I computed the true scores for each variable; I used the equation "$X_{te} = R_x (X - \bar{X}) + \bar{X}$" for computing the true scores. In this, "X_{te}" was the estimated true score, R_x was the reliability of the scale, X was the observed score, and $\bar{X}$ was the population mean [141]. For each variable, I computed the pre- and post-intervention differences (post-intervention score minus pre-intervention score) of each participant, and showed their frequency distributions (histograms) and cumulative distribution functions (CDFs).

I calculated the Reliable Change Indices (RCIs) for each variable using the equation "$RCI = (\bar{X}_2 - \bar{X}_1) / SE_{diff}$"; in this, $\bar{X}_2$ was the post-intervention mean, $\bar{X}_1$ was the pre-intervention mean and SE_{diff} was the standard error of the difference [142]. If a PHM improved her score exceeding the RCI in a variable, I considered it a reliable improvement.

I computed the minimally important differences (MIDs) for the PHMs' IPV prevention knowledge, perceived responsibility, self-confidence, and barrier scores; MID equals one half a SD of the baseline score. If a PHM improved her score exceeding the MID in a variable, I considered it an important improvement [143].

To identify whether my results could have been affected by the regression to the mean (RTM), first, I prepared scatterplots of the change in PHMs' IPV prevention knowledge, perceived barriers, responsibility, and self-confidence, against their baseline (pre-intervention) measurements [144]. Second, I estimated the percent of regression to the mean (P_{rm}) for each variable using the equation "$P_{rm} = 100\ (1-r)$", in which "r" was the correlation between the pre-intervention and post-intervention measurements of a variable [145]. I also calculated the standardized linear regression coefficients for the changes in PHMs' IPV knowledge, perceived barriers, responsibility, and self-confidence in managing IPV sufferers against their baseline scores, age, work duration, and years of formal education [135].

2.8 Ethical considerations

The Research Ethics Committee of the University of Tokyo, Japan, and the Research Ethics Committee of the University of Peradeniya, Sri Lanka provided ethics approval for this study (appendices 14-15). I obtained permission to conduct the study in Kandy from the Provincial Director of Health Services, Central Province. After reading the information sheet (appendices 16-18), each participant signed an informed consent form (appendices 19-21) prior to the study.

I did not ask PHMs if they had ever experienced IPV. This is because one in three Sri Lankan wives experience IPV; I acknowledged that some of the trained PHMs could be sufferers

of IPV. I explained to the PHMs that they could withdraw their consent for participation at any time, and asked them to contact the research team if they experienced any psychological distress during the study. I planned to refer PHMs to the Medical Officer of Health of their areas if they experienced psychological distress by participating in the study. However, none of the PHMs withdrew from the study or reported psychological distress during or after the study. I was not involved in designing or implementing the PHMs' IPV prevention training and acted as an independent evaluator of the program.

3. Results

3.1 Socio-demographic characteristics of the participants

Table 3 shows the socio-demographic characteristics of PHMs, including their job characteristics. Of all the PHMs included in the study *(n* = 408), 95.1% were field PHMs, 4.2% were estate PHMs, and 0.7% were supervising PHMs. Of all, 85.8% were married, 11.8% were unmarried, and 2.4% were widows; none were divorced or separated at the time of the study. The median age of the 408 PHMs was 43 years (interquartile range [IQR]: 36.5–51 years). The majority of the PHMs (74.3%) had 12 or more years of formal education prior to their enrollment in midwifery schools. PHMs' median work duration was 17 years (IQR: 10–23 years). The work duration as field PHMs was more than 10 years, 5–10 years, and less than 5 years for 63%, 18.6%, and 18.4% of participants, respectively. Some PHMs had worked in hospital settings before commencing work as field PHMs.

Table 3. Socio-demographic characteristics of the participants *(n*=408)

Variable		**N**	**%**
Age	20-30 years	65	15.9
	31-40 years	88	21.6
	>40 years	255	62.5
Marital status	Married	350	85.8
	Unmarried	48	11.8
	Divorced/Separated	0	0.0
	Widowed	10	2.4

Years of formal education	< 10 years (< O/L)	1	0.2
	10 years (O/L)	104	25.5
	12 years (A/L)	293	71.8
	> 12 years (Diploma)	10	2.5
Employment category	Field PHMs	388	95.1
	Estate PHMs	17	4.2
	Supervising PHMs	3	0.7
Work duration	< 5 years	61	15.0
	5-10 years	58	14.2
	>10 years	289	70.8
Work duration as field PHMs	< 5 years	75	18.4
	5-10 years	76	18.6
	>10 years	257	63.0

O/L: Ordinary level; A/L: Advanced level; PHMs: Public health midwives

3.2 The assessment of the pre- and post-intervention differences in PHMs' IPV knowledge, perceived barriers, responsibility, and self-confidence

3.2.1 IPV knowledge

Table 4 shows the PHMs' pre- and post-intervention responses for individual IPV knowledge items under three domains (the acts of IPV, health effects of IPV, and IPV prevention laws). After the intervention, a significantly higher number of PHMs correctly answered the knowledge items on acts and health effects of IPV. Before the training, majority of the PHMs correctly answered only two out of the six items that examined their knowledge on IPV laws.

After the training, the majority of PHMs correctly answered only four out of the six IPV knowledge items.

Table 4. Detailed analysis of PHMs' pre- and post-intervention IPV prevention knowledge *(n*=408)

Variable		Pre-intervention	Post-intervention	*p* value
An act of IPV could be				
Pushing a partner	Yes[#]	367(90.0)	407(99.8)	<0.01
Keeping a partner from seeing friends	Yes[#]	346(84.8)	408(100.0)	<0.01
Not giving money when needed	Yes[#]	335(82.1)	399(97.8)	<0.01
Suspecting a partner for no reason	Yes[#]	339(83.1)	396(97.1)	<0.01
Demanding a partner to seek permission before doing something	Yes[#]	291(71.3)	337(82.6)	<0.01
Persuading a partner to have sexual intercourse	Yes[#]	344(84.3)	399(97.8)	<0.01
Health effects of IPV could be				
Low self-esteem	Yes[#]	290(71.7)	389(95.3)	<0.01
Contusions in the thighs	Yes[#]	252(61.8)	361(88.5)	<0.01
Visiting doctors with multiple somatic complaints	Yes[#]	231(56.6)	364(89.2)	<0.01
Urinary tract infections	Yes#	89(21.8)	276(67.6)	<0.01

IPV laws				
In Sri Lanka, a person can act in courts against partner's emotional violence	Yes[#]	192(47.1)	352(86.3)	<0.01
A person can act against marital rape	No[#]	72(17.6)	172(42.2)	<0.01
A woman should always report to the police before filing an IPV case	No[#]	40(9.8)	214(52.5)	<0.01
In police stations, there is a specific place to receive IPV complaints	Yes[#]	291(71.3)	382(93.6)	<0.01
For IPV, Magistrate court can issue a protection order within two weeks	Yes[#]	58(14.2)	182(44.6)	<0.01
In Sri Lanka, there are supportive services for IPV sufferers	Yes[#]	330(80.9)	404(99.0)	<0.01

Correct answer choice

Table 5 shows a comparison of the PHMs' pre- and post-intervention median total IPV knowledge scores and the median total scores for the three IPV prevention knowledge domains. The Wilcoxon Signed Rank Test revealed a statistically significant increase in PHMs' total IPV knowledge score after the intervention ($p< 0.001$). PHMs' knowledge on acts of IPV, health effects of IPV, and IPV prevention laws also improved significantly ($p< 0.001$)

Table 5. Comparison of PHMs' pre- and post-intervention total knowledge scores *(n*=408)

Variable	Pre-intervention		Post-intervention		Z
	Median	IQR	Median	IQR	
Acts of IPV	0.8	0. 7-1.0	1.0	1.0-1.0	11.55*
Health effects of IPV	0.5	0. 5-0.8	1.0	0.8-1.0	15.09*
Laws against IPV	0.5	0. 3-0.5	0. 7	0.7-0.8	11.40*
Total IPV knowledge	0.6	0.4-0.8	0.9	0.8-0.9	17.36*

*p<0.001

Figure 2 shows the pre- and post-intervention differences (post-intervention score minus pre-intervention score) in PHMs' IPV knowledge in a histogram; the distribution seemed to be symmetrical.

Figure 2. The distribution of the difference in PHMs' pre- and post-intervention total IPV knowledge scores *(n*=408)

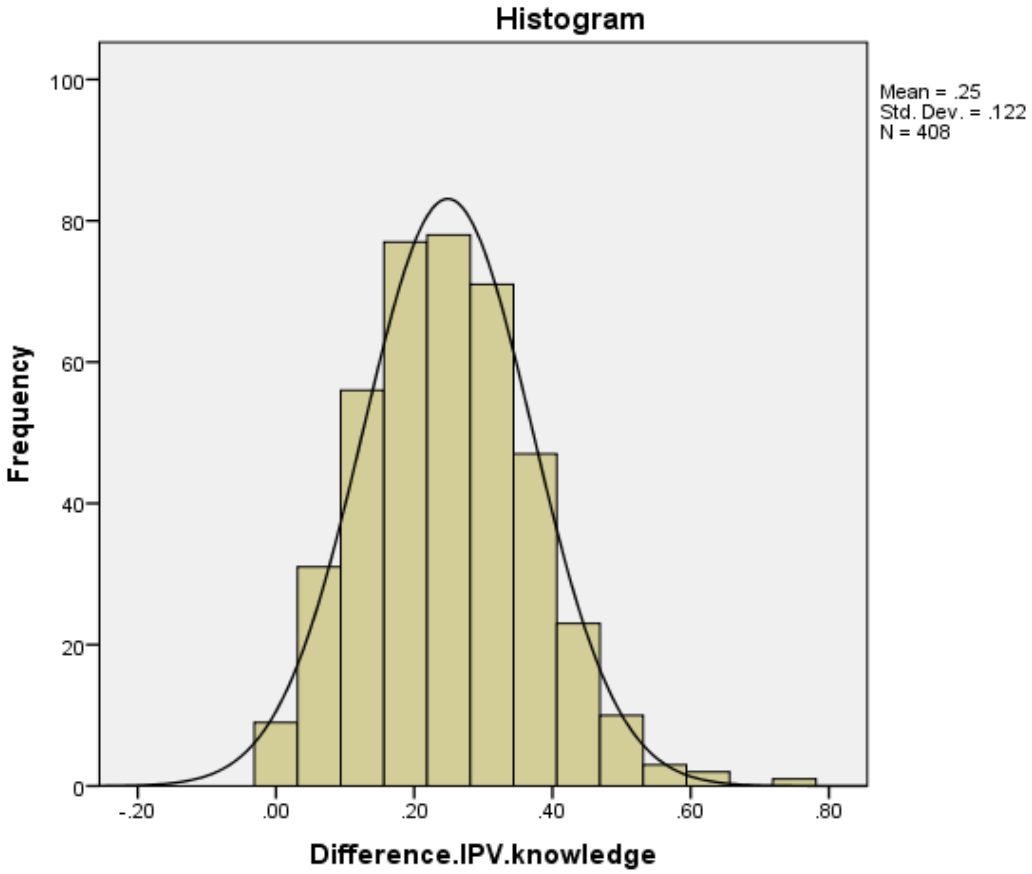


Figure 3 shows the individual differences (post-intervention scores minus pre-intervention scores) in PHMs' IPV knowledge, in relation to the RCI. Of all, 42.4% of the PHMs (*n* = 173) showed a reliable imprrovement in their IPV knowledge score after the intervention, above the RCI.

Figure 3. The individual differences of PHMs' pre- and post-intervention total IPV knowledge scores, in relation to the reliable change index *(n*=408)

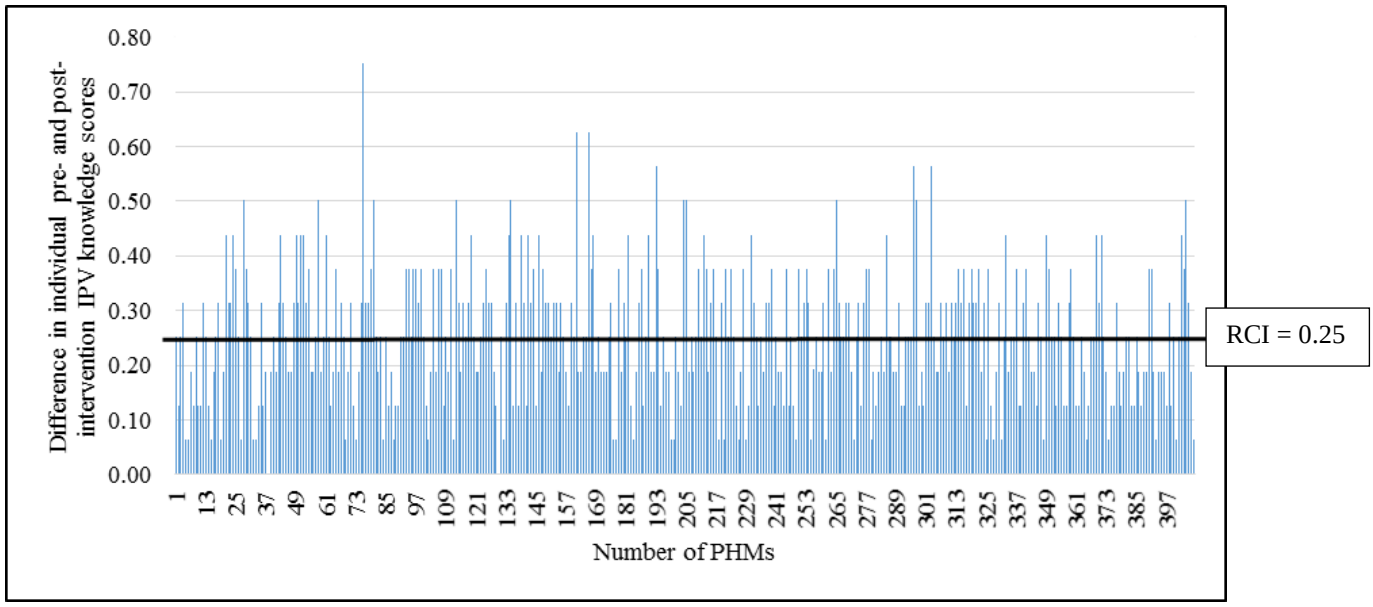
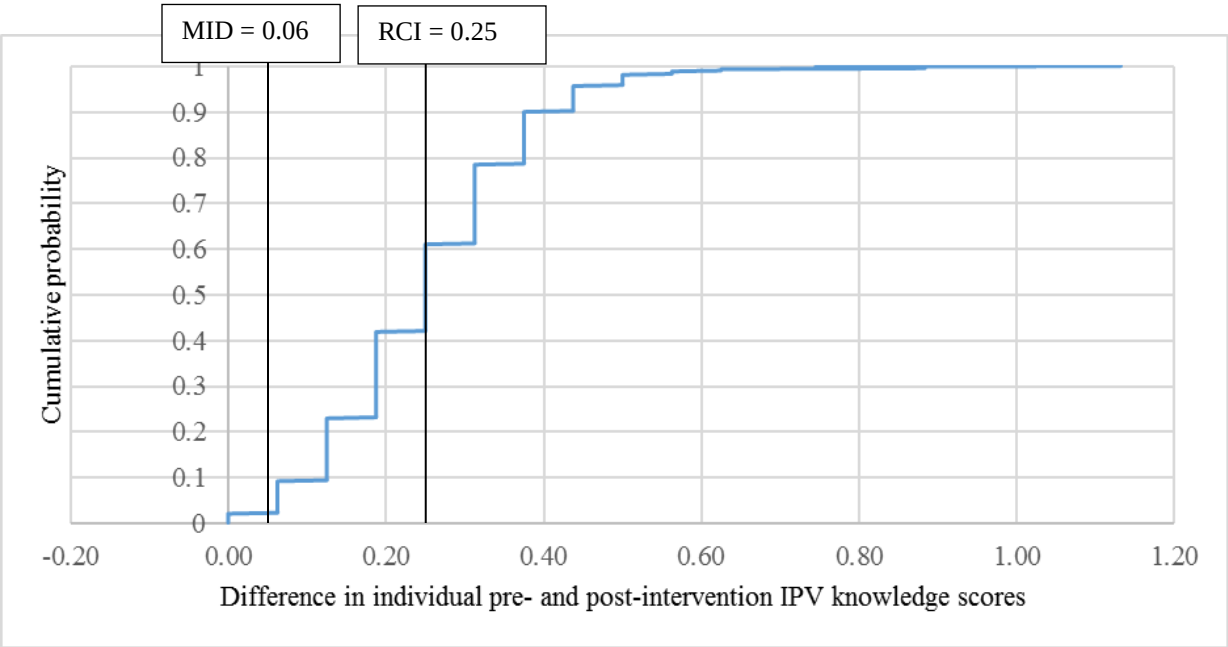


Figure 4 shows the CDF of the difference in PHMs' pre- and post-intervention IPV prevention knowledge. The cumulative probability shows that after the training, 42.4% of the PHMs improved their IPV prevention knowledge score by 0.25 points or more (above the RCI). Of all, 399 PHMs (97.8%) showed an important improvement in their scores, exceeding 0.06 points (MID).

Figure 4. The Cumulative Distribution Function of the difference in PHMs' pre- and post-intervention total IPV knowledge scores (*n*=408)



MID: Minimally Important Difference (0.06); RCI: Reliable Change Index (0.25)

Figure 5 shows a scatterplot of change in PHMs' pre- and post-intervention IPV knowledge scores, against their pre-intervention (baseline) IPV knowledge scores. PHMs who had low baseline scores showed a higher improvement in their IPV knowledge score, while the PHMs who had high baseline scores showed a lesser improvement. With a correlation of 0.25 in PHMs' pre- and post-intervention IPV knowledge scores, the improvement in PHMs' IPV prevention knowledge showed a 75% RTM.

Figure 5. A scatterplot of change in PHMs' pre- and post-intervention total IPV knowledge scores, against their pre-intervention (baseline) IPV knowledge scores *(n*=408)

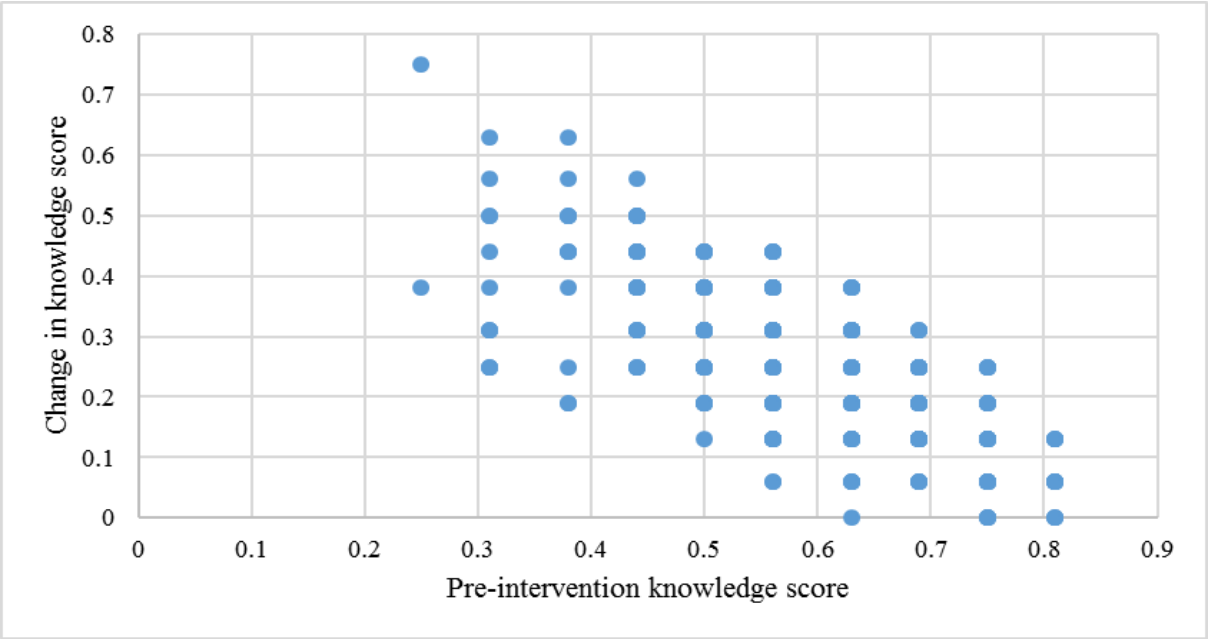


Table 6 shows the adjusted standardized linear regression coefficients for the improvements in PHMs' IPV knowledge, based on their pre-intervention IPV knowledge score, age, education, and work duration. PHMs' pre-intervention IPV knowledge score showed a significant negative association with the improvements in PHMs' IPV knowledge. Age, education, and the work duration did not show such an association.

Table 6. Adjusted regression coefficients for the improvements in PHMs' total IPV prevention knowledge *(n*=408)

Variable	Unstandardized coefficients		Standardized coefficients	95% CI	*p* value
	B	*SE*			
Pre-intervention knowledge score	-0.75	0.04	-0.71	-0.82 – -0.68	<0.001
Age (10 years)	0.00	0.01	0.01	-0.02 – 0.02	0.95
Education (10 years)	-0.04	0.05	-0.03	-0.14 – 0.07	0.50
Work duration (10 years)	0.00	0.01	0.02	-0.02 – 0.03	0.85

3.2.2 Perceived barriers

Table 7 shows a comparison of PHMs' pre- and post-intervention perceived barrier scores. After the intervention, the median total perceived barrier score decreased significantly from 2.4 to 1.1 ($p < 0.001$) [145, 146]. The itemized barrier scores also decreased significantly from the baseline.

Table 7. Comparison of PHMs' pre- and post-intervention perceived barrier scores *(n*=408)

Variable	**Pre-intervention**		**Post-intervention**		**Z-score**	***p* value**
	Median	**IQR**	**Median**	**IQR**		
I do not have enough time to ask about IPV	2.0	1.0-2.0	1.0	1.0-1.0	14.76	<0.001

I am afraid I will offend a sufferer by asking on IPV	2.0	2.0-3.0	2.0	1.0-2.0	10.14	<0.01
It is difficult to get a person alone to ask about violence	2.0	2.0-3.0	1.0	1.0-2.0	14.75	<0.001
I do not have any training to help IPV sufferers	5.0	3.0-5.0	1.0	1.0-1.0	17.80	<0.001
There are no support services to refer sufferers	2.0	2.0-3.0	1.0	1.0-1.0	14.76	<0.001
I don’t feel I can help an IPV sufferer	2.0	2.0-3.0	1.0	1.0-1.0	15.29	<0.001
I am more interested in my patients’ medical problems	2.0	2.0-3.8	1.0	1.0-1.0	15.37	<0.01
Total barrier score	2.4	2.1-3.1	1.1	1.1-1.3	17.52	<0.001

1 = strongly disagree, 5 = strongly agree

Figure 6 shows the difference in PHMs' pre- and post-intervention perceived barrier scores in a histogram; the distribution seemed to be skewed to the left.

Figure 6. The distribution of the difference in PHMs' pre- and post-intervention total perceived barrier scores *(n*=408)

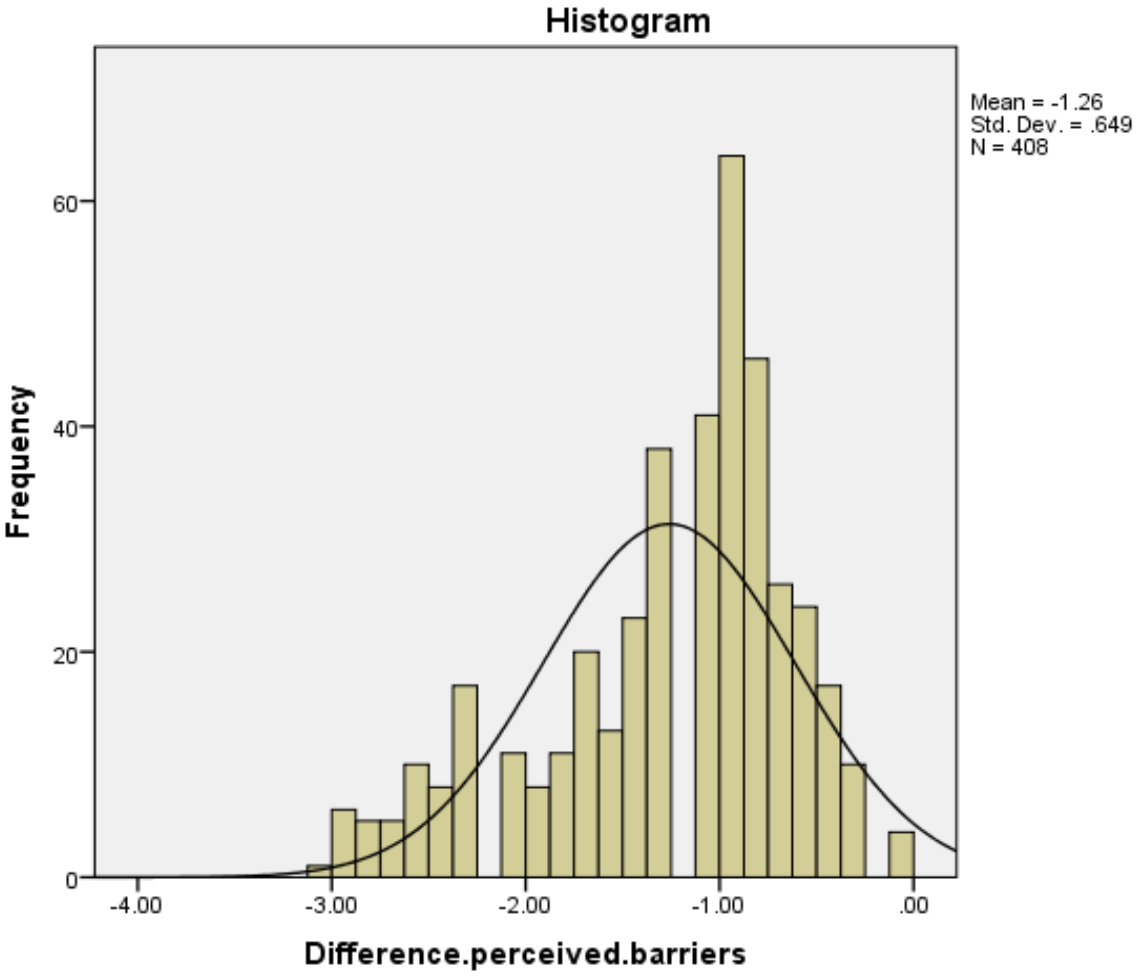


Figure 7 shows the individual differences (post-intervention score minus pre-intervention score) in the PHMs' pre- and post-intervention perceived barrier scores, in relation to the RCI. Of all, 80.1% of the PHMs (*n* = 327) showed a reliable change in their perceived barrier scores after the intervention, above the RCI.

Figure 7. The individual differences of PHMs' pre- and post-intervention total perceived barrier scores, in relation to the reliable change index *(n*=408)

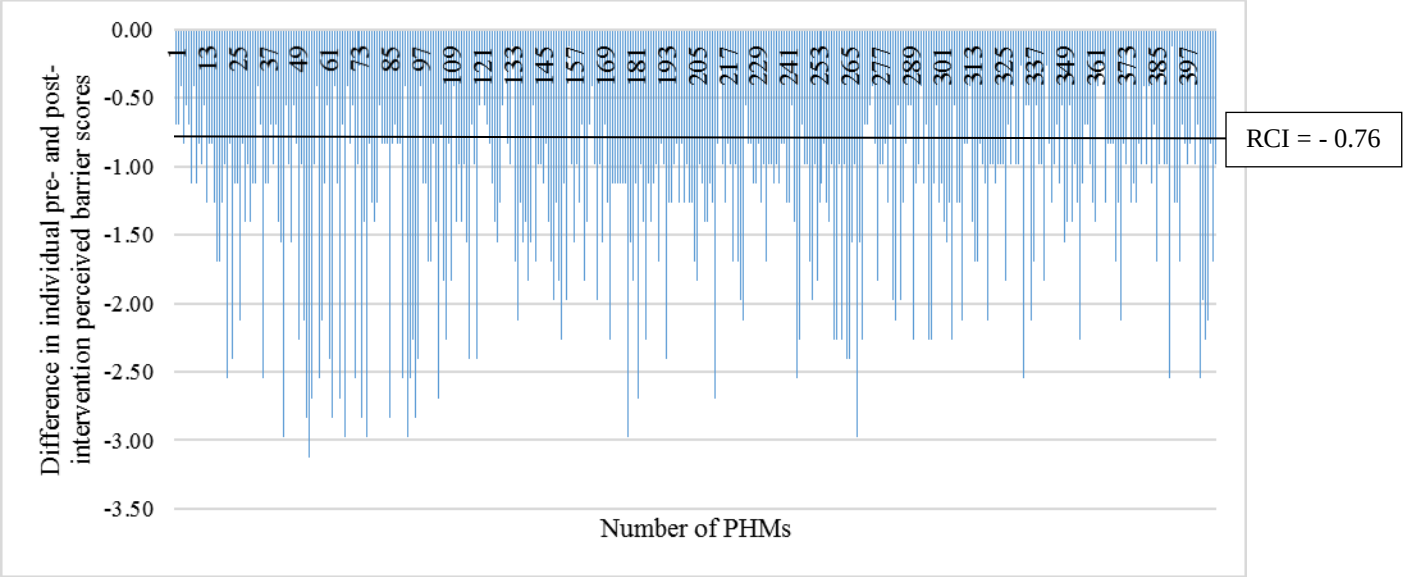
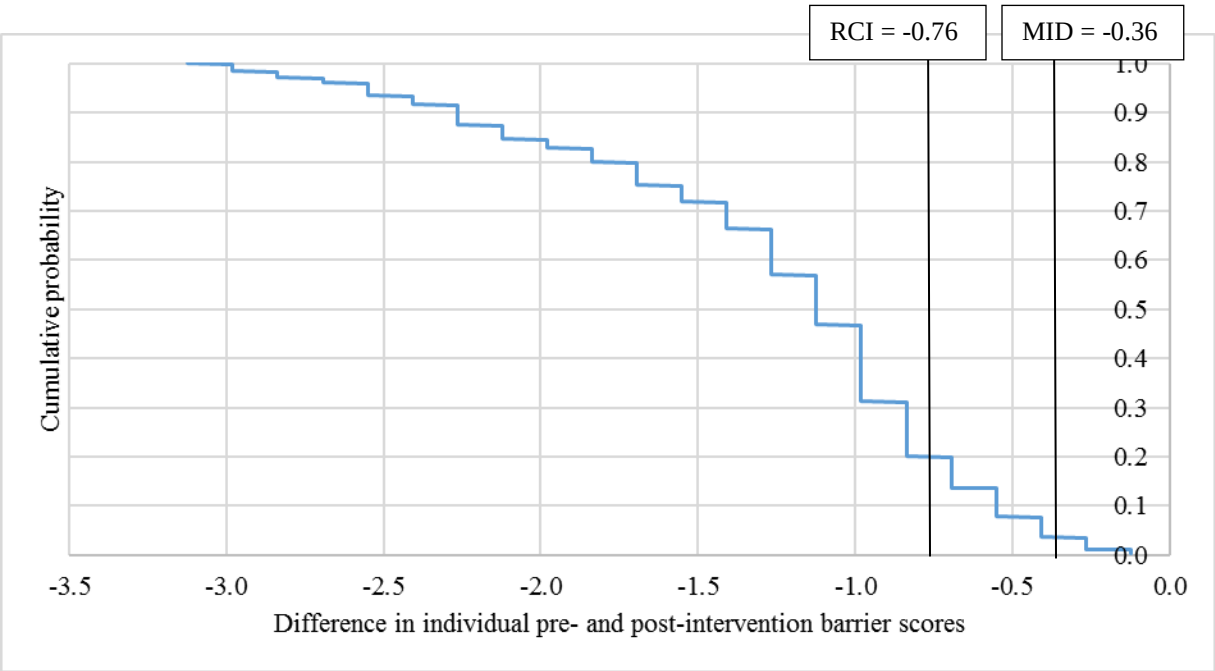


Figure 8 shows the CDF of the difference in PHMs' pre- and post-intervention perceived barrier scores. The cumulative probability shows that after the training, 80.1% of the PHMs improved their perceived barrier score by -0.76 points or more (above the RCI). Of all, 394 PHMs (96.6%) showed an important improvement in their scores, exceeding -0.36 points (MID).

Figure 8. The Cumulative Distribution Function of the difference in PHMs' pre- and post-intervention total perceived barrier scores (*n*=408)



RCI: Reliable Change Index (-0.76); MID: Minimally Important Difference (-0.36)

Figure 9 shows a scatterplot of change in PHMs' pre- and post-intervention perceived barrier scores, against their pre-intervention (baseline) perceived barrier scores. PHMs who had low baseline scores showed a lesser improvement in their perceived barrier score, while the PHMs who had high baseline scores showed a higher improvement. With a correlation of 0.36 in PHMs' pre- and post-intervention perceived barrier scores, the improvement in PHMs' perceived barriers showed a 64% RTM.

Figure 9. A scatterplot of change in PHMs' pre- and post-intervention total perceived barrier scores, against their pre-intervention (baseline) perceived barrier scores *(n*=408)

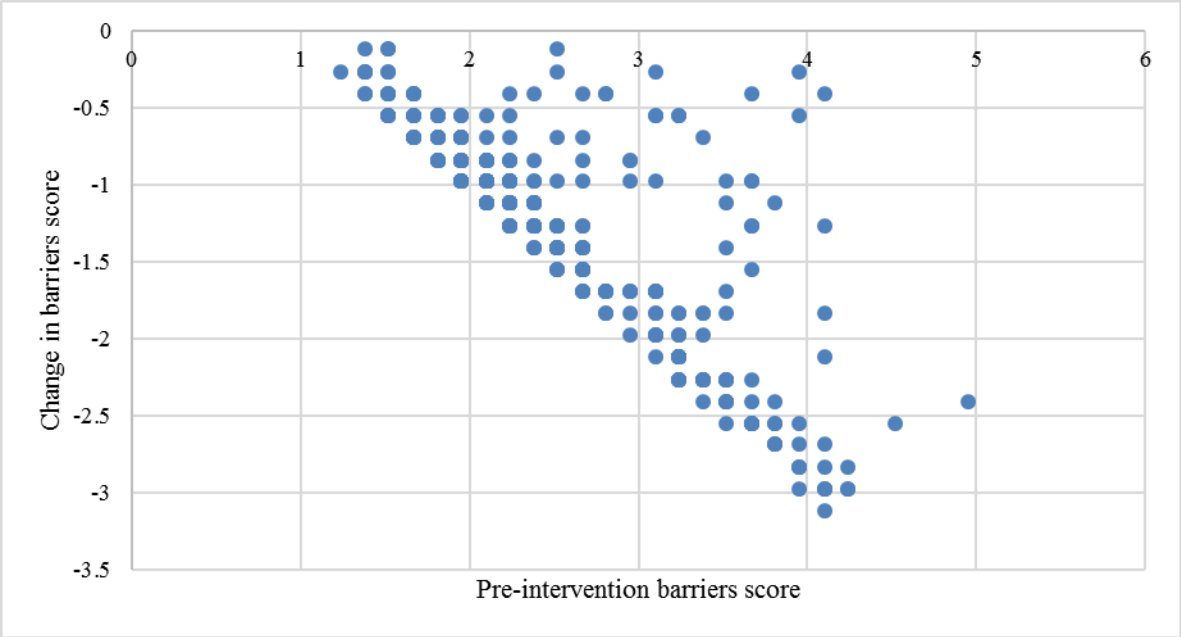


Table 8 shows the adjusted standardized linear regression coefficients for the improvements in PHMs' perceived barriers, based on their pre-intervention perceived barriers score, age, education, and work duration. PHMs' pre-intervention perceived barrier score showed a significant negative association with PHMs' barrier reduction. Age, level of education, or the work duration did not show such an association.

Table 8. Adjusted regression coefficients for the improvements in PHMs' perceived barriers in managing IPV sufferers *(n*=408)

Variable	Unstandardized coefficients		Standardized coefficients	95% CI	*p* value
	B	*SE*			
Pre-intervention barrier score	0.74	0.03	-0.80	-0.79 – -0.68	<0.001
Age (10 years)	0.02	0.05	-0.04	-0.79 – -0.68	0.67
Education (10 years)	0.00	0.02	-0.00	-0.04 – 0.04	0.99
Work duration (10 years)	0.00	0.00	-0.03	-0.01 – 0.00	0.54

3.2.3 Perceived responsibility

Table 9 shows a comparison of the PHMs' pre- and post-intervention perceived responsibility scores. After the intervention, PHMs' median total perceived responsibility scores increased significantly from 3.2 to 4.6 ($p < 0.001$). All of the items of the perceived responsibility scale also showed significant increases in their scores from the baseline.

Table 9. Comparison of PHMs' pre- and post-intervention perceived responsibility scores *(n*=408)

Variable	**Pre-intervention**		**Post-intervention**		**Z-score**	***p* value**
	Median	**IQR**	**Median**	**IQR**		
The responsibility of a public health midwife includes						
Asking about IPV any time	3.0	3.0-4.0	5.0	4.0-5.0	16.62	<0.001

an injury is noticed						
Asking about IPV when notice serious child injury	3.0	3.0-4.0	4.0	4.0-5.0	15.39	<0.001
Listening to an IPV sufferer when abuse is disclosed	3.0	3.0-4.0	5.0	5.0-5.0	15.10	<0.001
Telling a sufferer that IPV is not acceptable	3.0	3.0-4.0	4.0	4.0-5.0	15.64	<0.001
Telling a sufferer that IPV adversely affects her health	3.0	3.0-4.0	5.0	4.0-5.0	16.40	<0.001
Total responsibility score	3.2	2.8-3.9	4.6	4.2-4.8	17.53	<0.001

1 = strongly disagree, 5 = strongly agree

Figure 10 shows the pre- and post-intervention difference (post-intervention score minus pre-intervention score) in PHMs' perceived responsibility scores in a histogram; the distribution seemed to be skewed to the right.

Figure 10. The distribution of the difference in PHMs' pre- and post-intervention total perceived responsibility scores *(n*=408)

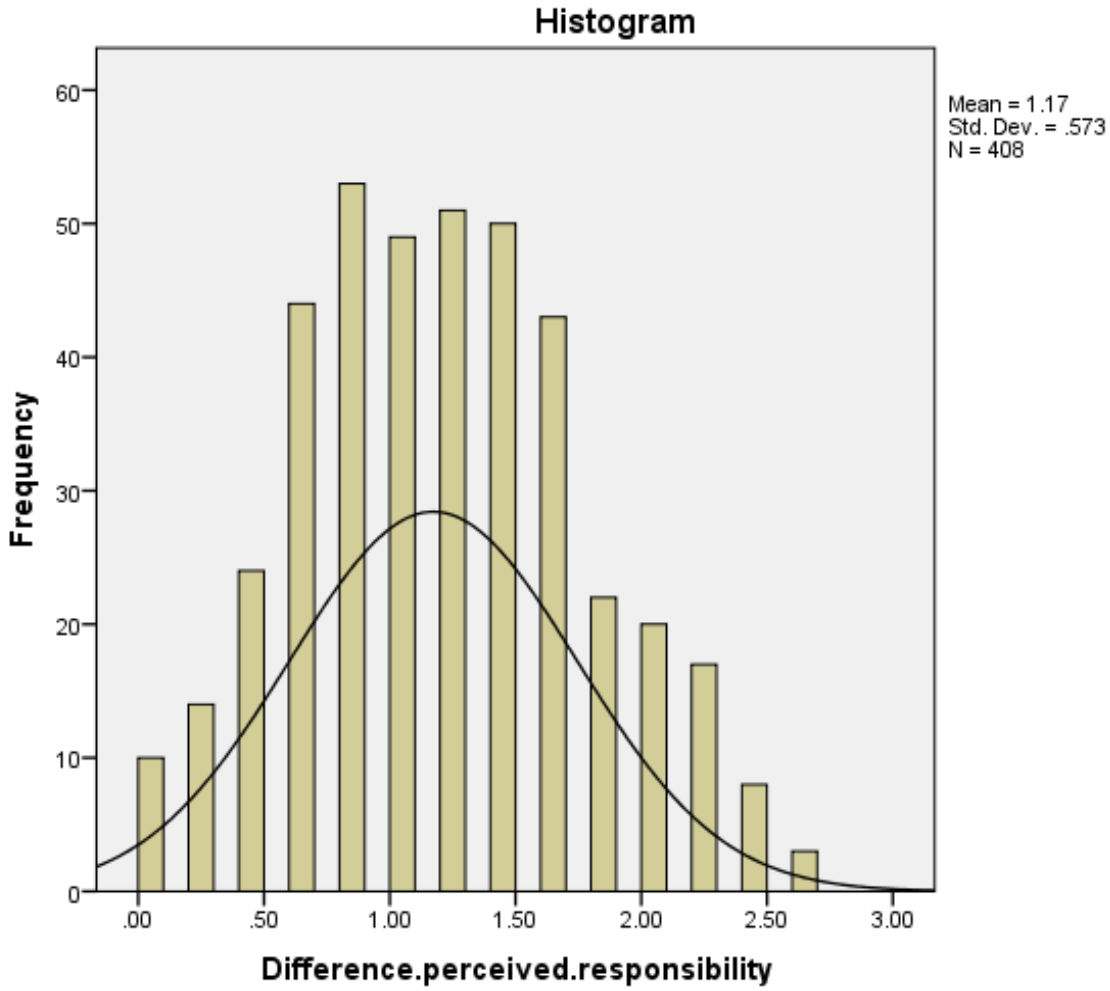


Figure 11 shows the individual differences in PHMs' pre- and post-intervention perceived responsibility scores, in relation to the RCI. Of all, 64.5% of the PHMs (*n* = 263) showed a reliable change in their perceived responsibility score, after the intervention, above 0.82 (RCI).

Figure 11. The individual differences of PHMs' pre- and post-intervention total perceived responsibility scores, in relation to the reliable change index *(n*=408)

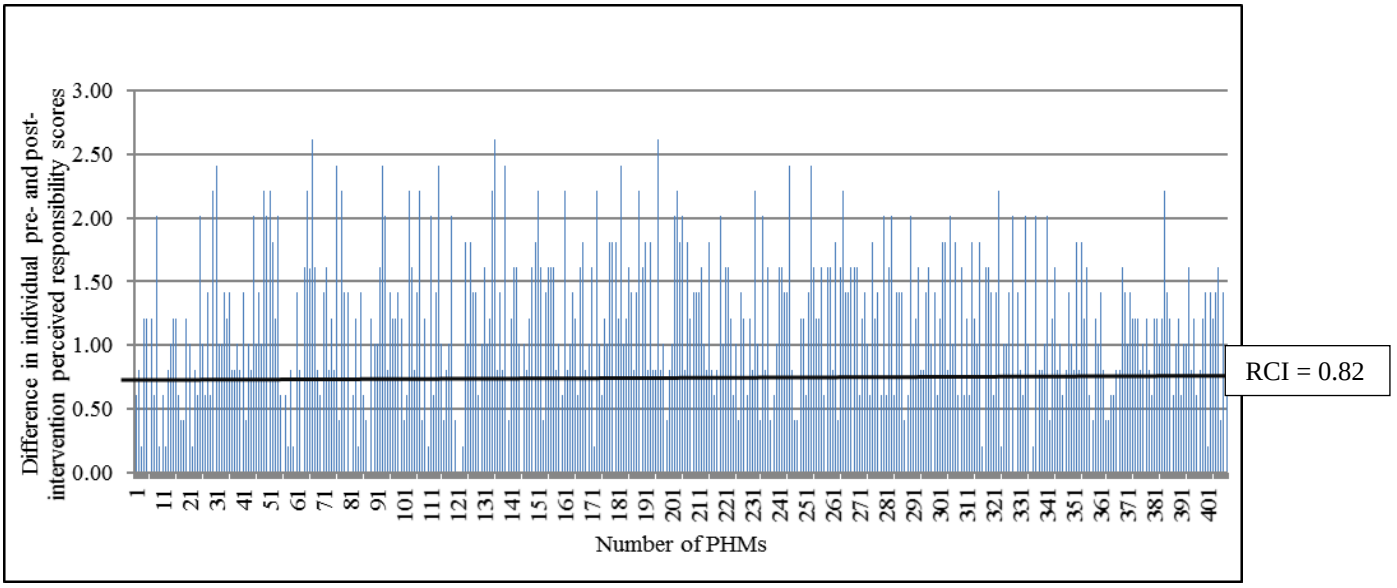
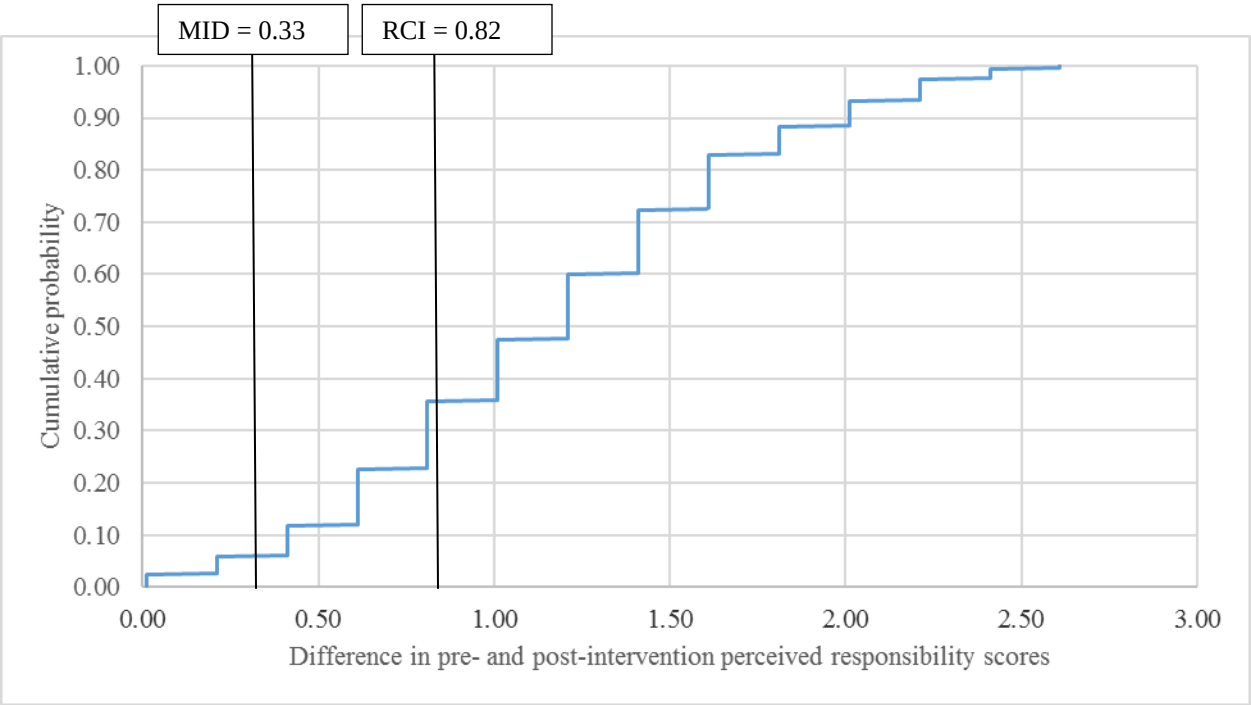


Figure 12 shows the CDF of the difference in PHMs' pre- and post-intervention perceived responsibility scores. The cumulative probability shows that after the training, 64.5% of the PHMs improved their perceived responsibility score by 0.82 points or more (above the RCI). Of all, 384 PHMs (94.1%) showed an important improvement in their scores, exceeding 0.33 points (MID).

Figure 12. The Cumulative Distribution Function of the difference in PHMs' pre- and post-intervention total perceived responsibility scores (*n*=408)



MID: Minimally Important Difference (0.33); RCI: Reliable Change Index (0.82)

Figure 13 shows a scatterplot of the change in PHMs' pre- and post-intervention perceived responsibility scores against their pre-intervention (baseline) perceived responsibility scores. The PHMs who had low baseline scores showed a higher improvement in their perceived responsibility score, while the PHMs who had high baseline scores showed a lesser improvement. With a correlation of 0.54 between PHMs' pre- and post-intervention perceived responsibility scores, the improvement in PHMs' perceived responsibility showed a 46% RTM.

Figure 13. A scatterplot of change in PHMs' pre- and post-intervention total perceived responsibility scores, against their pre-intervention responsibility scores (*n*=408)

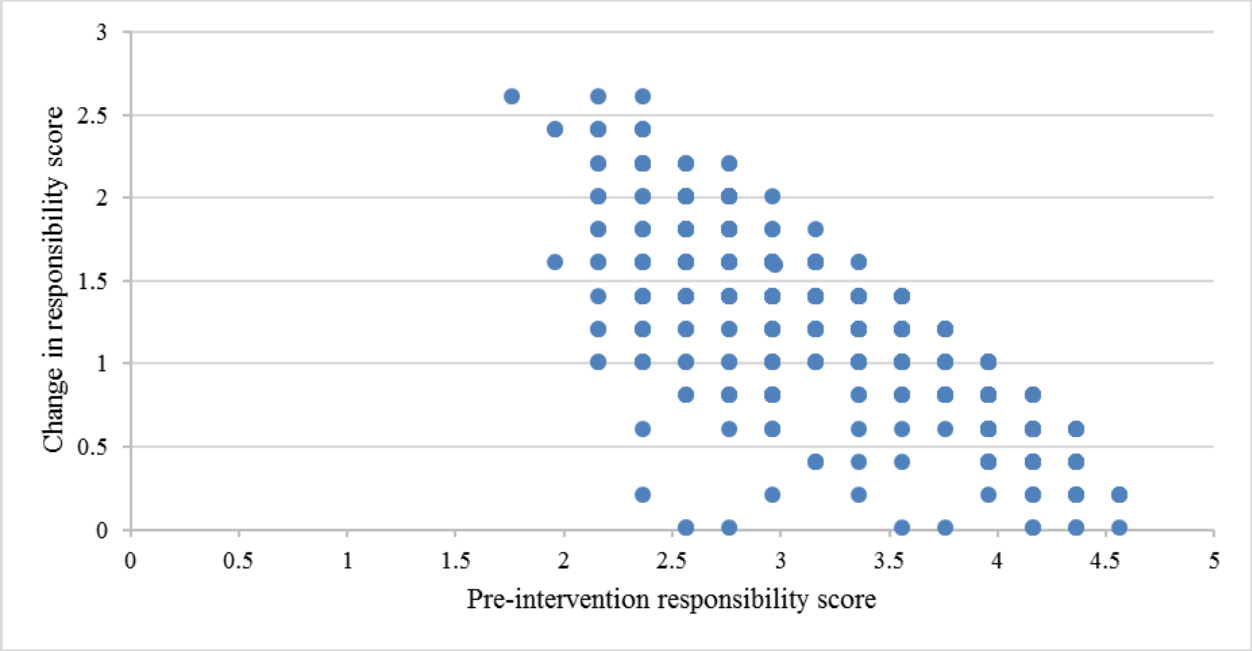


Table 10 shows the adjusted standardized linear regression coefficients for the improvements in PHMs' perceived responsibility scores, based on their pre-intervention responsibility score, age, education, and work duration. PHMs' pre-intervention perceived responsibility score showed a significant negative association with the improvements in their perceived responsibility score. Age, level of education, or the work duration did not show such an association.

Table 10. Adjusted regression coefficients for the improvements in PHMs' perceived responsibility in managing IPV sufferers *(n*=408)

Variable	Unstandardized coefficients		Standardized coefficients	95% CI	*p* value
	B	*SE*			
Pre-intervention responsibility score	-0.64	0.03	-0.74	-0.70 – -0.58	<0.001
Age (10 years)	-0.04	0.05	-0.64	-0.14 – 0.06	0.43
Education (10 years)	-0.23	0.25	-0.04	-0.71 – 0.25	0.89
Work duration (10 years)	0.36	0.06	0.05	-0.08 – 0.15	0.53

3.2.4 Self-confidence

Table 11 shows the comparison of PHMs' pre- and post-intervention self-confidence scores. After the intervention, the PHMs' median total self-confidence score increased significantly from 1.8 to 2.8 ($p < 0.001$). The scores of all the items on the self-confidence scale also showed significant increases from the baseline.

Table 11. Comparison of PHMs' pre- and post-intervention self-confidence scores *(n*=408)

Variable	**Pre-intervention**		**Post-intervention**		**Z-score**	***p* value**
	Median	**IQR**	**Median**	**IQR**		
The current level of self-confidence						
In asking a sufferer whether she has experienced IPV	2.0	1.0-2.0	3.0	3.0-3.0	17.49	<0.001

In taking a history about sexual violence	1.0	1.0-2.0	2.0	2.0-3.0	16.87	<0.001
In knowing what to do if a sufferer discloses IPV	2.0	1.0-2.0	3.0	2.0-3.0	16.66	<0.001
In knowing what to do if a sufferer breaks down/cries	2.0	1.0-2.0	3.0	3.0-3.0	16.96	<0.001
In assessing the safety of an IPV sufferer	2.0	1.0-2.0	3.0	2.0-3.0	19.84	<0.001
In knowing what to do if a sufferer does not want to leave the abuser	2.0	2.0-2.0	3.0	3.0-3.0	16.01	<0.001
About making a referral of an IPV sufferer	2.0	2.0-3.0	3.0	3.0-3.0	14.73	<0.001
Knowing what to do when child abuse is co-existing	2.0	1.0-2.0	3.0	2.0-3.0	15.33	<0.001
Total self-confidence score	1.8	1.4-2.1	2.8	2.6-2.9	17.53	<0.001

1 = not confident, 2 = somewhat confident, 3 = confident

Figure 14 shows the differences (post-intervention score minus pre-intervention score) in the PHMs' pre- and post-intervention self-confidence scores in a histogram; the distribution seemed to be symmetrical.

Figure 14. The distribution of the difference in PHMs' pre- and post-intervention total self-confidence scores *(n*=408)

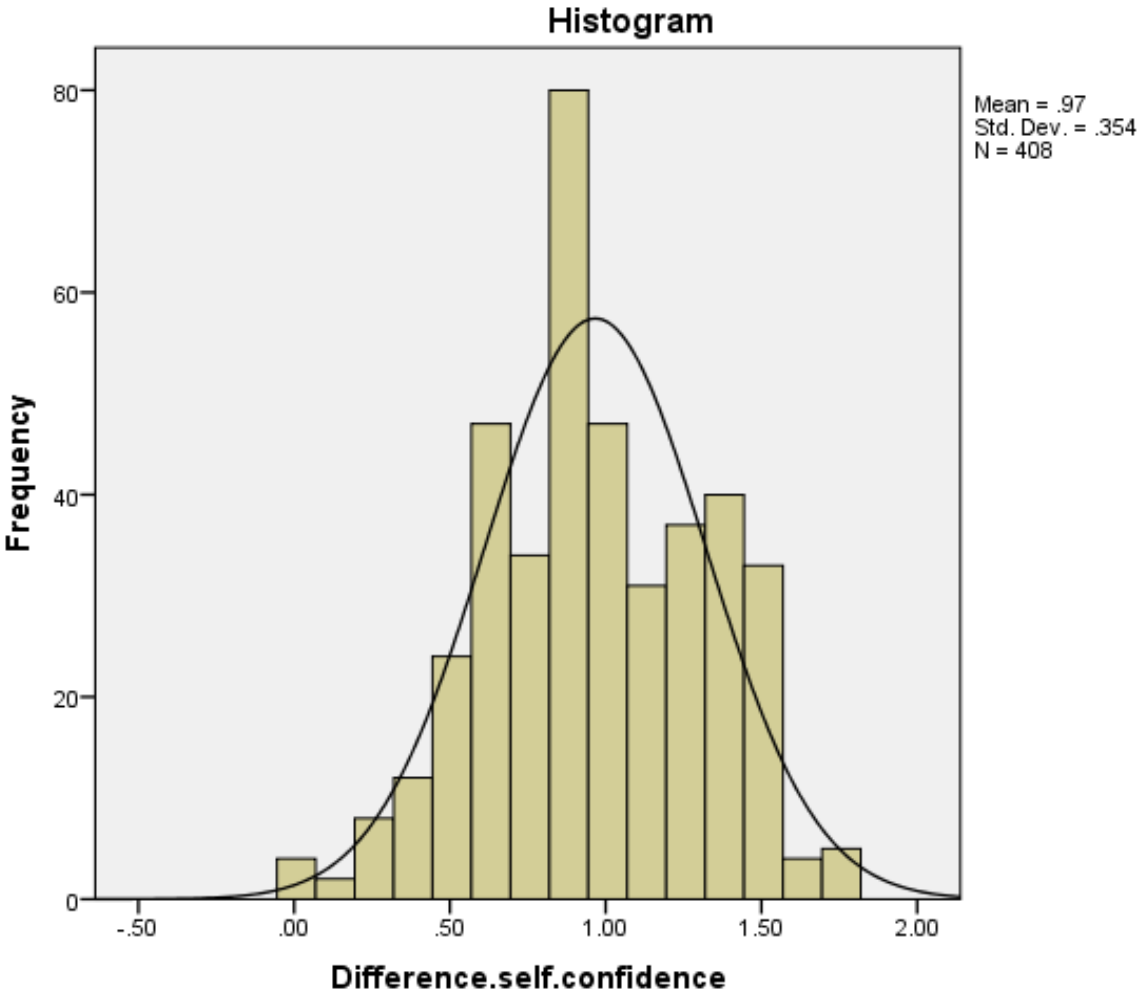


Figure 15 shows the individual differences of PHMs' pre- and post-intervention self-confidence scores, in relation to the RCI. Of all, 93.6% of the PHMs (*n* = 382) showed a reliable change in their self-confidence score after the intervention (above the RCI).

Figure 15. The individual differences of PHMs' pre- and post-intervention total self-confidence scores, in relation to the reliable change index *(n*=408)

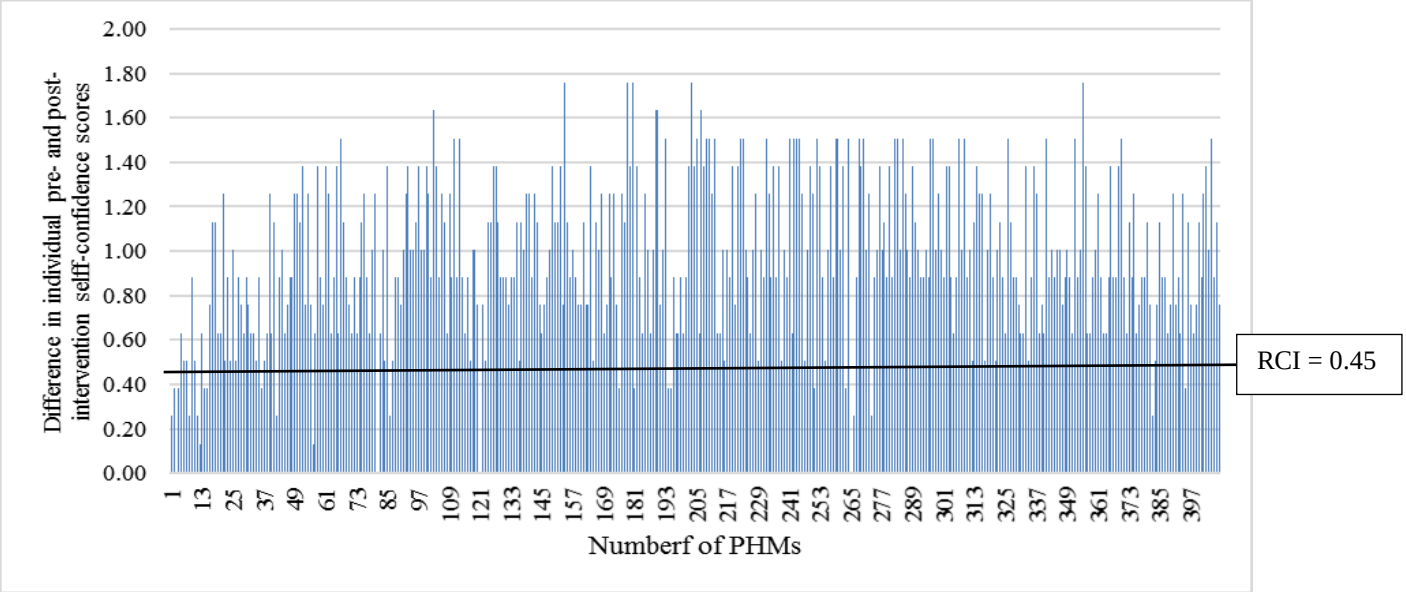
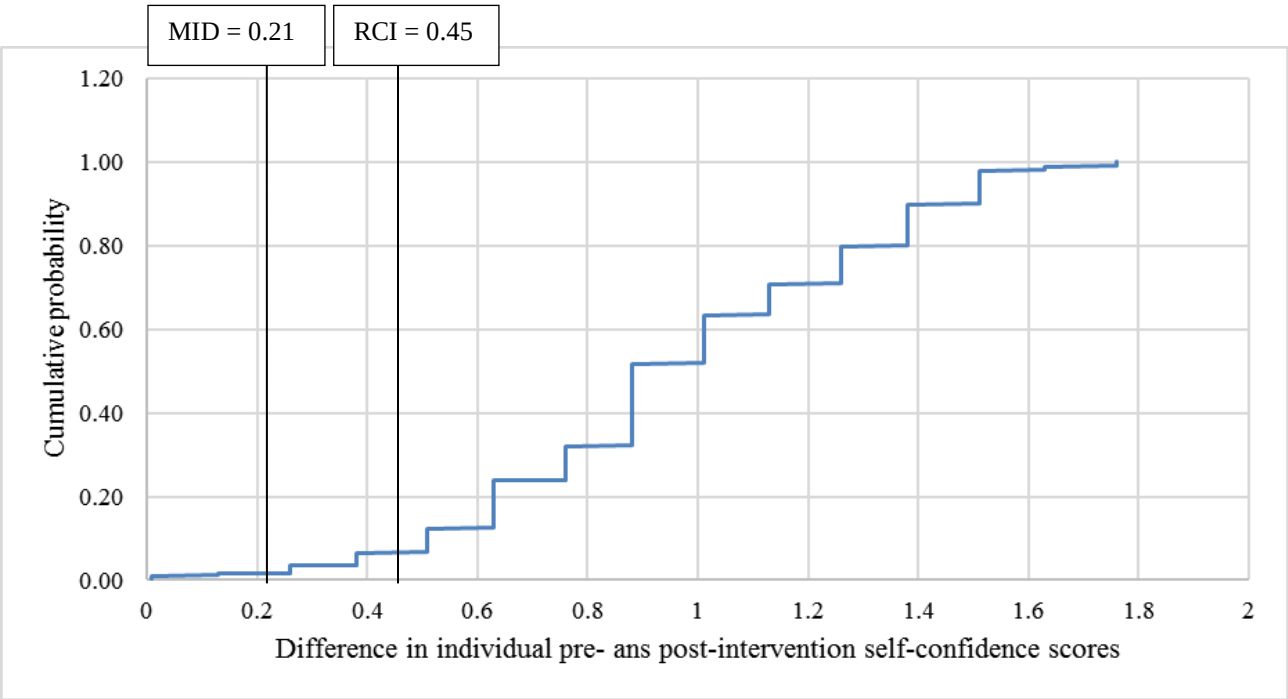


Figure 16 shows the CDF of the difference in PHMs' pre- and post-intervention self-confidence scores. The cumulative probability shows that after the training, 93.6% of the PHMs improved their self-confidence score by 0.45 points or more (above the RCI). Of all, 402 PHMs (98.3%) showed an important improvement in their scores, exceeding 0.21 points (MID).

Figure 16. The Cumulative Distribution Function of the difference in PHMs' pre- and post-intervention total self-confidence scores *(n*=408)



MID: Minimally Important Difference (0.21); RCI: Reliable Change Index (0.45)

Figure 17 shows a scatterplot of the change in PHMs' pre- and post-intervention self-confidence scores against their pre-intervention (baseline) self-confidence scores. The PHMs with low baseline scores as well as the PHMs with high baseline scores showed a similar pattern of improvement in their self-confidence score after the training. With a correlation of 0.57 between PHMs' pre- and post-intervention self-confidence scores, the improvements in PHMs' self-confidence showed 43% RTM.

Figure 17. A scatterplot of change in PHMs' pre- and post-intervention total self-confidence scores, against their pre-intervention self-confidence scores *(n*=408)

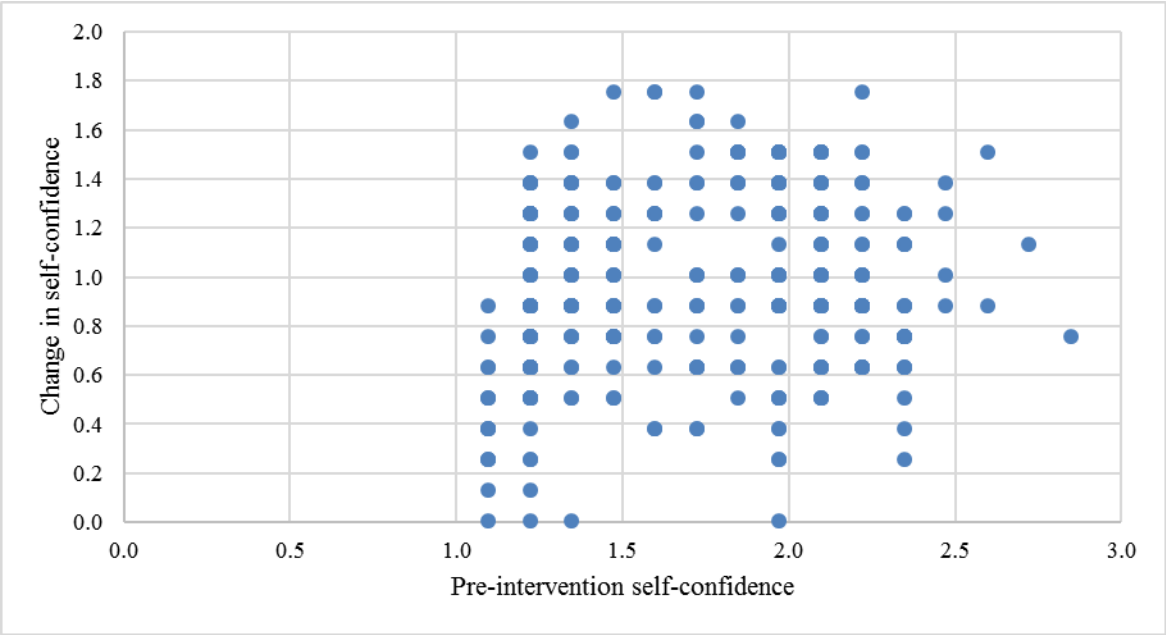


Table 12 shows the adjusted standardized linear regression coefficients for the improvements in PHMs' self-confidence scores, based on their pre-intervention self-confidence score, age, education, and work duration. PHMs' pre-intervention self-confidence score showed a significant negative association with the improvements in their self-confidence after the training. Age, level of education or the work duration did not show such an association.

Table 12. Adjusted regression coefficients for the improvements in PHMs' pre- and post-intervention self-confidence in managing IPV sufferers *(n*=408)

Variable	Unstandardized coefficients		Standardized coefficients	95% CI	*p* value
	B	*SE*			
Pre-intervention self-confidence score	-0.62	0.03	-0.72	-0.68 – -0.56	<0.001
Age (10 years)	0.01	0.03	0.01	-0.06 – 0.07	0.89
Education (years)	-0.08	0.04	0.01	-0.06 – 0.08	0.22
Work duration (years)	0.01	0.04	0.01	-0.07 – 0.08	0.87

3.3 Observations of the PHMs' IPV prevention training program

In total, the MOH held 11 training programs in Kandy. I observed six randomly selected programs throughout. All six training programs were conducted in a similar manner. Training sites were the usual in-service training sites for PHMs, which had the space and equipment to conduct the training. All training programs were delivered by experienced community physicians *(n* = 5).

Of all the 495 PHMs in Kandy, 86% *(n* = 425) received the training. The other 70 PHMs did not attend the training because of personal reasons such as illness [personal communication, Supervising Public Health Nursing Sister (SPHNS) – Central Province, Ministry of Health of Sri Lanka, October, 2010]. PHMs actively participated in the discussions, and provided positive feedback such as "the training is interesting", "training is very relevant to my work", and "we must thank you for providing this important training".

The positive observations of the training were: (1) the MOH provided institutional support for the training, (2) trainers conducted the training completely and comprehensively, in adhereance to the training manual (3) trainers used participatory learning techniques to improve PHMs' practical IPV prevention skills (annex. 6), and (4) PHMs were given adequate time to ask questions on IPV management and get feedback. International IPV prevention training guidelines [22-25, 82, 83] recognize these as strengths of IPV trainings.

Following were the negative observations of the training: (1) all trainers were community physicians and the MOH did not include trainers from other disciplines, such as lawyers, police officers, etc., (2) the PHMs were not provided guidelines, protocols or IPV communication materials which could be used for later reference, and (2) the training did not improve the PHMs' IPV recordkeeping skills and did not provide an IPV recordkeeping format. International IPV prevention training guidelines [22-25, 82,83] suggest these as limitations of IPV trainings.

4. Discussion

The Sri Lankan IPV prevention training for public health midwives was associated with significant improvements in the midvives' total scores in perceived responsibility, barrier reduction, and self-confidence in managing IPV sufferers ($p<0.001$). At the individual level, 64.5% of the PHMs showed reliable improvement in their perceived responsibility, 80.1% showed reliable improvement in barrier reduction, and 93.6% showed improved self-confidence scores above the RCI. Although the PHMs' total IPV knowledge improved significantly from the baseline ($p<0.001$), at the individual level, only 42.4% of the PHMs showed reliable improvements in their IPV knowledge after the training.

These findings are similar to the findings of the previous IPV/DV prevention trainings. None of the previous training programs showed improvements across all domains (the health workers' IPV knowledge, responsibility, self-confidence, barriers, etc.). For example, a 2005 US Continuing Medical Education program improved health workers' *(n* = 284) knowledge, attitudes, empathy, and self-reported assessment behaviors about DV, but did not improve their perceived responsibility to counsel DV sufferers [99]. Another US online IPV prevention training program for community practice physicians in 2006 significantly improved their IPV-related attitudes, beliefs, and self-reported practices, although their IPV knowledge increased only marginally ($p = 0.06$) [100]. In 2010, a two-day intensive IPV prevention training program for Greek general practitioners improved the participants' perceived preparedness and knowledge about IPV, but did not improve their skills in identifying IPV sufferers [102]. Sri Lanka's IPV prevention training was associated with improvements in PHMs' perceived responsibility, barrier reduction, and self-confidence in identifying and managing IPV sufferers,

but not in their IPV prevention knowledge. Appendix 22 presents a comparison between the PHMs' IPV prevention training and five other similar IPV/DV trainings.

Four factors may have contributed to the improvements in PHMs' perceived responsibility, barrier reduction, and self-confidence in managing IPV suffers. The first factor could be the length of the training (four days), and the time allocated to role-playing and case reports. Previous IPV training programs were conducted for less than two days. Only a few programs used role-playing or case reports to improve participants' practical skills. According to a study conducted with a group of medical students at the University of California, the opportunity to practice skills and receive feedback can significantly improve the outcome of DV training programs [99].

Second, the program's culturally sensitive approach might have positively affected its outcome. The PHMs were advised to respect cultural values, encourage harmony betweencouples, and act cautiously if suggesting separation from a violent partner. As many Sri Lankan wives are economically dependent on their husbands [115, 118], PHMs' interventions to assist IPV sufferers could not compromise the sufferer and/or their children's safety or wellbeing; culturally sensitive approaches are more effective than other approaches to address IPV [82, 83].

Third, as PHMs are community health workers, their experience may have improved the program's outcome. As health workers in clinical settings tend to have heavy workloads, they might have little time to discuss IPV with patients and develop a close relationship with sufferers. PHMs, on the other hand, work in the field and have more time with sufferers [106, 128], making it easier for them to inquire about IPV.

Fourth, as the MOH designed and implemented the trainings in adherence to international IPV training guidelines, this, too, mayhave improved the outcome. The training comprehensively covered the important thematic areas on IPV. It suited the Sri Lankan context and matched the PHMs' professional requirements; IPV trainings are more effective when they match the professional requirements of the trainees [22, 83].

Although the training was associated with improvements in PHMs' perceived responsibility, barrier reduction, and self-confidence in managing IPV sufferers, the PHMs' IPV prevention knowledge did not improve in a similar manner. A future study should explore the reasons for this, and suggest possible improvements in future trainings.

The training had a few limitations. For example, MOH used only the community physicians as trainers, and did not include a diverse trainer group. A diverse trainer group that included lawyers, police officers, and social workers could have brought more experience to the training, and improved PHMs' understanding of IPV prevention [22-25, 82, 83]. Furthermore, the training did not provide guidelines, protocols, and IPV communication materials to the PHMs; this can negatively affect IPV identification and management of IPV sufferers [24, 25, 82]. Lastly, the training did not improve the PHMs' IPV recordkeeping skills, and did not provide them with an IPV recordkeeping format. Although further evaluations are necessary, these limitations could have contributed to the inadequate improvements in the PHMs' IPV knowledge. The MOH may address these limitations and improve the training to better train PHMs on IPV prevention.

Sri Lanka is one of the few developing countries to train its community health workers on IPV prevention. The training provides an example to other developing countries, and encourages them to train their community health workers on IPV. The existence of a well-developed

community health care network was an advantage for Sri Lanka's IPV prevention program. Other developing countries might consider training their most common community health workers on IPV prevention. This will allow IPV services to reach the maximum number of IPV sufferers in the community.

It is unlikely that the observed improvements in the PHMs' perceived responsibility, self-confidence, and barrier reduction were caused by their receiving of IPV information from other sources. During the period of this study, no other IPV prevention training programs were conducted for Kandy PHMs. The newspaper media published few case reports on IPV (appendicies 23 and 24), but did not attempt to improve community awareness on IPV prevention. The mass media also did not conduct any IPV prevention campaign during the study period [personal communication, Assistant Director (Media), Ministry of Parliamentary Reforms and Mass Media in Sri Lanka, 22 June, 2016].

This study has three limitations. First, in this study, I did not include a control group to compare with the intervention group. I could have drawn a control group from an adjacent district (Matale and Nuwara Eliya) [111], however, it could have led to information contamination and produced inaccurate results. This is because Kandy PHMs could meet the PHMs in the adjacent districts and share their new IPV prevention knowledge. To prevent information contamination between the intervention and the control groups, I could have used a cluster randomized controlled trial, with a larger sample of PHMs [132]. However, the limited financial resources did not permit me to conduct such a large-scale study.

Second, I did not use a previously validated questionnaire for data collection, and I did not use another validated self-confidence scale to validate PHMs' self-confidence in assisting IPV sufferers. Previous studies in Sri Lanka did not assess any of the variables that were

assessed in my study, with PHMs or any other health workers. However, to confirm the questionnaire's reliability and validity in the Sri Lankan context, I adopted items from previously validated tools in other settings like Israel, Turkey, Canada, and USA [94, 99-103], carefully translated them, and pre-tested with Sri Lankan PHMs prior to the study.

Third, out of all 495 PHMs in Kandy, only 408 (82.4%) participated in this study. This was because I included only the PHMs who received the complete training (over four days) and excluded the PHMs who completed the training partially. The non-participation of 87 PHMs (17.6%) could have led to a truncated selection in this study, and caused the RTM observed in the outcome variables. Because RTM can make natural variation in repeated data look like real change [144], my results need to be interpreted cautiously. A future randomized controlled trial will overcome the participant selection bias, and provide better conclusions on the PHMs' IPV prevention training.

This study has several strengths as well. First, most previous studies on this topic used small sample sizes [97, 100, 102]. In this study, I included all the PHMs in Kandy district to increase the sample size. Second, in this study, dropout rate was minimal. Previous studies had high dropout rates [98, 101]. I avoided postal surveys and used PHMs' monthly meetings to conduct the post-intervention surveys, which minimized the dropout rate. Third, this study evaluated a well-structured [24, 25, 82, 83] and a properly conducted IPV training program. This improved the quality of data reported in this study.

5. Conclusion

In conclusion, the Sri Lankan midwives' pilot intimate partner violence training was associated with improvements in the midwives' perceived responsibility, barrier reduction, and self-confidence in managing partner violence sufferers, among some of the midwives. Midwives partner violence prevention knowledge did not improve in a similar manner. Comprehensive training and participatory learning techniques could have contributed to the observed improvements in the midwives' perceived responsibility, barrier reduction, and self-confidence. Not providing sufferer management protocols to PHMs and not including a diverse trainer group may have contributed to the inadequate improvements in midwives' violence prevention knowledge. The Ministry of Health should address these limitations and bring improvements in IPV prevention training. Independent evaluators may assess the improved training for its efficacy. Future research should also assess the long-term efficacy of partner violence prevention training in improving midwives' partner violence prevention skills. After addressing its limitations, the Ministry of Health may use the training and continue to train its midwives on partner violence prevention.

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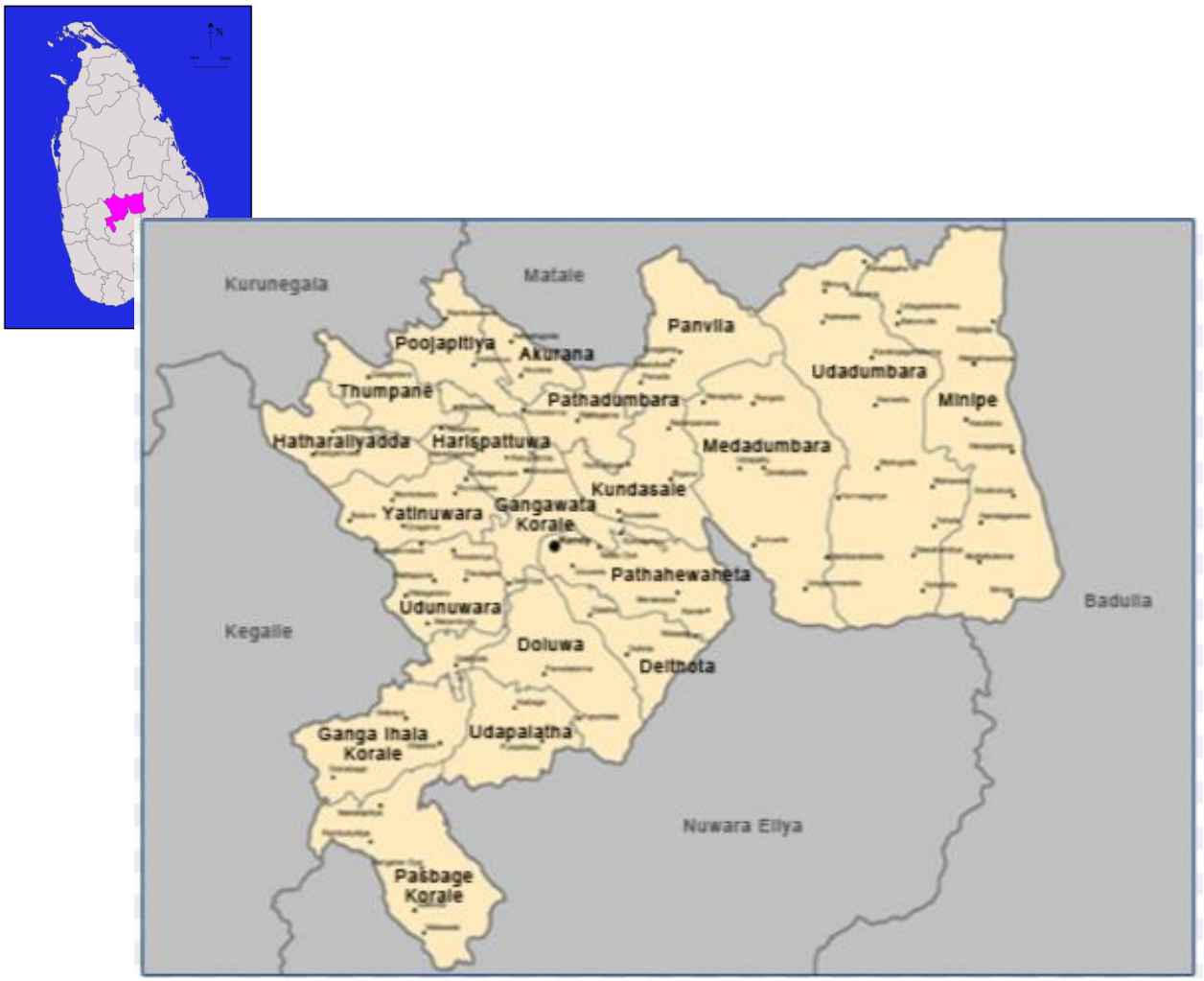
Appendix 1. Map of Sri Lanka indicating the Kandy district within Central province



Appendix 2. Photos indicating PHMs' field work

(Source: Ministry of Health, Sri Lanka web site)

Appendix 3. The cover page of the PHMs' training manual

ගෘහස්ථ හිංසනය වැළැක්වීම සඳහා පවුල් සෞඛ්‍ය සේවිකාවන් පුහුණු කිරීමේ අත්පොත

Public health midwives' training manual for IPV prevention

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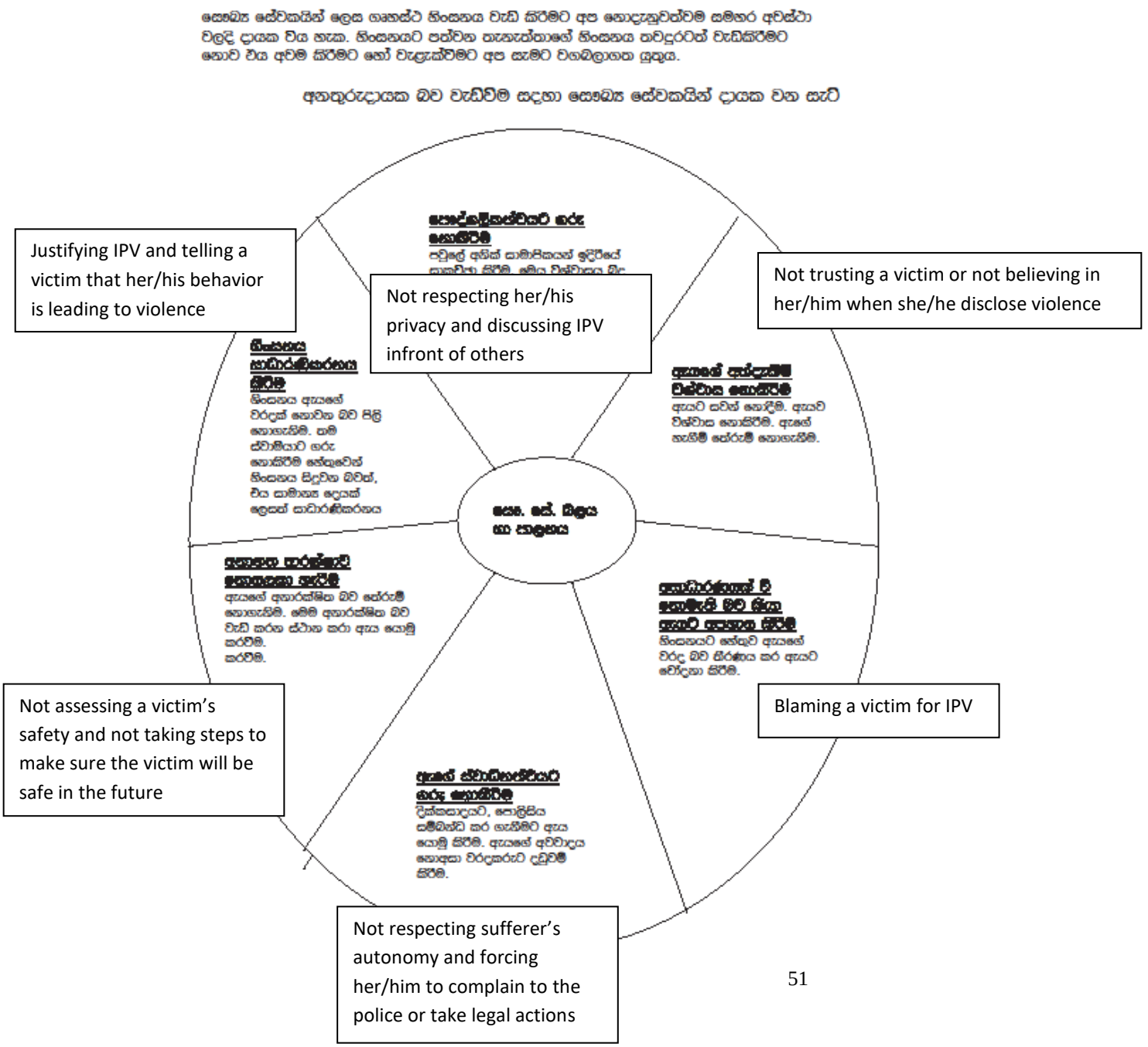
2009

Appendix 4. A figure that trainers used to teach PHMs on how they should address IPV

What we do as health providers might sometimes increase IPV. We have to make sure that we will reduce violence and not increase it. Following are few instances that we should avaoid



Appendix 5. Photos of PHM training

Appendix 6. PHMs' attendance in the training programs

No	Training centers*	Number of PHMs who attended the training			
		Day 1†	Day 2	Day 3	Day 4
1	Kandy (Kandy & Manikhinna)	57	59	65	65
2	Bambaradeniya (Bambaradeniya & Yatinuwara)	50	52	54	54
3	Harispaththuwa (Harispaththuwa & Doluwa)	41	47	47	47
4	Galagedara (Galagedara & Gangaihala)	32	37	39	39
5	Gampola (Gampola & Pasbage)	45	54	55	55
6	Udunuwara (Udunuwara & Gangawatakoralaya)	32	35	37	37
7	Ududumbara (Ududumbara & Akurana)	30	33	33	33
8	Panwila (Panwila & Hasalaka)	29	35	37	37
9	Pathadumbara (Pathadumbara & Menikhinna)	42	48	49	49
10	Galaha (Galaha & Hatharaliyadda)	30	31	33	33
11	Kundasale (Kundasale & Madadumbara)	37	43	46	46

* The office of the Medical Officer of Health
†Participated in the pre-intervention survey

Appendix 7. Agenda of the PHMs' training

Time	Topic	Modes of training
Day 1		
9.00 – 10.30	Gender and sex.	Group activities, Group discussions.
10.45 – 12.45	Gender role attitudes and IPV (understanding IPV/GBV using a theoretical framework).	Power point presentations, Group discussions.
1.30 – 4.00	Men engagement for IPV prevention.	Group discussions, Case reports.
Day 2		
9.00 – 10.00	Definitions of GBV/IPV.	Power point presentations.
10.15 – 12.00	Prevalence and associations of IPV/GBV.	Power point presentations, Small/large group discussions.
1.00 – 3.00	Reproductive health effects of IPV.	Power point presentations, Case discussions.
3.00 – 4.00	Other health effects of IPV.	Power point presentations, Case discussions.
Day 3		
9.00 – 12.00	Legal and other support services for the sufferers of IPV.	Power point presentations.
1.00 – 4.00	Identifying and managing IPV sufferers.	Role playing and case discussions, Group activities.
Day 4		
9.00 – 12.00	Identifying and managing IPV sufferers.	Role playing and case discussions, Group activities.
1.00 – 3.00	PHMs' role in IPV prevention at the community level.	Power point presentations, Group discussions.
3.00 – 4.00	Review and closure.	Group discussions.

Appendix 8. Some case reports used in the PHMs' training

Case report 1

Mala was the second child of a family with five children. Their mother was a housewife, and their father was a government officer. Their age difference was 22 years. Mala's father used to beat her mother daily.

When Mala was 22 years, she got married to a man in the neighboring village, who was 10 years older than her. She gave birth to three children year after year of the marriage, and her life was full of conflicts, disagreements, and arguments with her husband.

Case report 2

Padma is a 45-year-old teacher and a mother of two children. Her children are independent and doing jobs. Padma likes to engage in religious activities and does not like to engage in sexual activities with her husband Ranjith. Ranjith drinks alcohol daily and forces Padma to sex frequently. When Padma refuses sex, he beats her up, and once broke her hand as well.

Case report 3

Malani (24 years) missed her antenatal clinic visit at 32 weeks of pregnancy. When the midwife visited the house, she said she fell near the bathroom and injured her forehead and was unable to come to the clinic.

Appendix 9. Pre-intervention questionnaire (English)

Serial number:	Name of the MOH area:
	PHM area number:

Questionnaire

Thank you for your participation. Please read the information sheet before answering and sign on the consent form.

Please circle the appropriate answer. When necessary, you can circle more than one answer.

Please read the question carefully before answering.

General information:

1. Please indicate your Age. [ ] Years

2. Marital Status
   a. Married
   b. Unmarried
   c. Divorced/separated
   d. Widowed

3. Please indicate the level of your education.
   a. Less than GCE O/L
   b. GCE O/L
   c. GCE A/L
   d. Diploma/ Degree

4. Indicate the type of your employment
   a. Supervising public health midwife
   b. Field public health midwife
   c. Estate public health midwife (trained)
   d. Estate public health midwife (untrained)

5. How long have you been working as a health worker? [ ] years.

6. How long have you been working as a field health worker ☐ years.

Intimate partner violence is as old as mankind and different people have different ideas about it. However, violence by intimate partner has become a topic of discussion in the country in recent past.

7. During the past three months, have you identified at least one person in your working area that experience violence by partner?
   a. Yes.
   b. No

8. During the past three months, have you **newly** identified at least one person in your working area that experience violence by partner?
   a. Yes.
   b. No
9. If you newly identified more than one victim that experience violence by partner, please indicate how many you identified: …….
10. How did you know that/those person/people experience violence by partner? (more than one response allowed)
    a. The person herself/himself told me
    b. A relative/ neighbor told me
    c. A social worker/ volunteer health worker told me
    d. I suspected the violence due to sufferer's behavior/injuries
    e. Other (please specify) ☐

11. After you knew that particular person experience violence by partner, did you talk about their experience of violence with them? (If the answer is no, please go to question 13)
    a. Yes
    b. No
12. After you discussed about the abuse with a sufferer, did you suggest any solution for the problem (more than one response allowed)
    a. I advised the sufferer to be patient and tolerant with the abuser
    b. I advised sufferer to discuss it with family members or friends and seek help
    c. I advised sufferer to complaint to the police
    d. I helped sufferer to complaint to the police
    e. I refered the sufferers to the Medical Officer of Health or an IPV service.
    f. I suggested sufferers to discuss the problem with the abuser, when he is calm
    g. I helped to discuss the problem with the abuser
    h. Other (please specify) ☐

13. If you did not talk about a sufferer's experience of violence with her/him, why?
    a. I believed it's a personal matter
    b. I thought it might humiliate the sufferer
    c. I thought the sufferer will get angry
    d. The sufferer didn't like to talk

e. Other (please specify) ____

14. Have you ever followed up to see what happens to those sufferers that you discussed the violence?
    a. Yes, all of those who I discussed violence
    b. Yes, some of those who I discussed violence
    c. No
15. If you did not follow up IPV sufferers, what was the reason
    a. I didn't have the time to pay another visit with all my work
    b. The sufferer didn't like follow up
    c. Other (please specify) ____

16. During the past three months, have you ever identified men who experience violence from their wives? (If the answer is no, please go to question 18)
    a. Yes.
    b. No
17. If so, how many men did you identify? ……

There can be some practical difficulties for the midwives if they start to involve in detecting violence by husbands and helping the sufferers.

18. Please mark your level of agreement to the following statements

	Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
a. My work load is too much. Therefore, I do not have enough time to ask about partner violence					
b. I am afraid I will offend a person if I ask about partner violence					
c. It is difficult to get a person alone to ask about violence because they are always accompanied by someone					
d. I do not have any training to identify or help the sufferers who experience partner violence					
e. Even though I identify violence, there are no supportive services to help those sufferers					

f. I don't feel like I can help a person who is in an abusive relationship					
g. I am more interested in dealing with my patients' medical problems than their relationships.					

19. Do you generally agree or disagree with following statements?

	Yes	No	Don't know
a. Pushing a partner is a form of partner violence			
b. Trying to keep a partner from seeing friends is a form of partner violence			
c. Not giving a partner money when needed is a form of partner violence			
d. Suspecting a partner for being unfaithful for no reason is a form of partner violence			
e. Demanding a partner to seek permission always before doing something is partner violence			
f. Persuading a partner to have sexual intercourse when she/he does not want to is a form of partner violence			
g. Low self esteem can be a feature of partner violence			
h. Women/men who experience partner violence can have contusions in their thighs			
i. Those who who experience partner violence can visit health facilities frequently with somatic complaints			
j. Those who experience partner violence can get urinary tract infections			

20. In this community and elsewhere, people have different ideas about family and what is acceptable behavior for women and men.

Please indicate if you generally agree or disagree with the following statements.

	Strongly agree	Agree	Somewhat agree	Disagree	Strongly disagree
a. A wife should always obey her husband, even in instances that she disagree with him					
b. A husband being violent over his wife is a family matter. Outsiders should not intervene for that.					
c. As a man, husband should always be able to have the power and control over his wife.					
d. A wife should always agree to have sex with her husband even if she doesn't feel like it.					
e. A wife should seek help from others (family, friends, health workers) if her husband mistreats or abuse her.					

In Sri Lanka, some people say legislations against violent partners are necessary to prevent partner violence. However, some argue such legislations are not necessary in a country like Sri Lanka.

21. According to your opinion, do you think legislations against violent partners are important in Sri Lanka?

a. Very important
b. Somewhat important
c. Not really important

22. According to your knowledge, is there a specific law in Sri Lanka that permits individuals to act against their abusive partners in courts?

a. Yes
b. No (if no, please go to Q 24)

23. If the answer is yes, in what way did you learn about such laws?

a. From media- Television/ Radio/ Newspapers (circle the relevant media)

b. From a friend/relative

c. From a police officer/ legal adviser

d. Other (please specify) [ ]

24. Please indicate your opinion about the following statements.

	Yes	No	Don't know
a. In Sri Lanka a person can act in courts against the acts of psychological abuse by partner			
b. In Sri Lanka a person can act in courts against the acts of sexual abuse by partner			
c. A person should always report to the police and make an entry in the police book before filing a case against partner violence in the courts			
d. In most police stations, there is a specific place to receive the complaints against partner violence			
e. Against a violent partner, a Magistrate court can issue a protection order within two weeks			
f. In Sri Lanka there are supportive services for the sufferers who experience partner violence			

25. Please indicate your opinion to the following statements.

The responsibility of a public health midwife includes

	Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
a. Asking about partner violence any time an injury is noticed, regardless of the stated cause					
b. Asking about partner violence any time a serious child injury is noticed, regardless of the stated cause					
c. Listening to a person when an abuse is disclosed					
d. Telling a person that partner violence is not acceptable, and she/he needs to seek help (from relatives, police, etc).					
e. Telling a person that the abuse can adversely affect her/his health					

26. What is your current level of comfort/ discomfort

	Uncomfortable	Somewhat comfortable	Comfortable
a. In asking a person whether she/he has experienced partner violence			
b. In taking a sexual history and history about sexual violence			
c. In knowing what to do if a person says she/he experiences partner violence			

d. In knowing what to do if the person breaks down and cries			
e. In assessing the safety of a person experiencing partner violence			
f. In knowing what to do if the person does not want to leave the abuser			
g. About making a referral of a person who experience partner violence to MOH or a social worker			
h. In knowing what to do when the child abuse is co-existing			

27. What is your estimate of the percentage of individuals who experience violence by partners in Sri Lanka? ……%

28. Do you think violence by pertners should be considered a health problem in Sri Lanka?
    a. Yes
    b. No

29. Do you think public health midwives should identify and help the sufferers who experience violence by partners?
    a. Yes
    b. No
30. Do you think public health midwives should be given training on how to identify and help the sufferers who experience violence by partners during their initial one and half year midwifery training?
    a. Yes
    b. No

Thank you for your time.

Appendix 10. Post-intervention Questionnaire (English)

Serial number:	Name of the MOH area:
	PHM area number:

Questionnaire

Thank you for your participation. Please read the information sheet before answering and sign on the consent form.

Please circle the appropriate answer. When necessary, you can circle more than one answer.

Please read the question carefully before answering.

General information:

1. Please indicate your Age. [ ] Years

2. Marital Status
   a. Married
   b. Unmarried
   c. Divorced/separated
   d. Widowed

3. Please indicate the level of your education.
   a. Less than GCE O/L
   b. GCE O/L
   c. GCE A/L
   d. Diploma/ Degree

4. Indicate the type of your employment
   a. Supervising public health midwife
   b. Field public health midwife
   c. Estate public health midwife (trained)
   d. Estate public health midwife (untrained)

5. How long have you been working as a health worker? [ ] years.

6. How long have you been working as a field health worker [ ] years.

Intimate partner violence is as old as mankind and different people have different ideas about it. However, violence by intimate partner has become a topic of discussion in the country in recent past.

7. During the past three months, have you identified at least one person in your working area that experience violence by partner?
   a. Yes.
   b. No

8. During the past three months, have you **newly** identified at least one person in your working area that experience violence by partner?
   a. Yes.
   b. No

9. If you newly identified more than one victim that experience violence by partner, please indicate how many you identified: …….

10. How did you know that/those person/people experience violence by partner? (more than one response allowed)
    a. The person herself/himself told me
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11. After you knew that particular person experience violence by partner, did you talk about their experience of violence with them? (If the answer is no, please go to question 13)
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    c. I advised sufferer to complaint to the police
    d. I helped sufferer to complaint to the police

e. I refered the sufferers to the Medical Officer of Health or an IPV service.
f. I suggested sufferers to discuss the problem with the abuser, when he is calm
g. I helped to discuss the problem with the abuser
h. Other (please specify) [ ]

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    d. The sufferer didn't like to talk
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    b. No

17. If so, how many men did you identify? ……

There can be some practical difficulties for the midwives if they start to involve in detecting violence by husbands and helping the sufferers.

18. Please mark your level of agreement to the following statements

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b. I am afraid I will offend a person if I ask about partner violence					

c. It is difficult to get a person alone to ask about violence because they are always accompanied by someone					
d. I do not have any training to identify or help the sufferers who experience partner violence					
e. Even though I identify violence, there are no supportive services to help those sufferers					
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g. I am more interested in dealing with my patients' medical problems than their relationships.					

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e. Demanding a partner to seek permission always before doing something is partner violence			
f. Persuading a partner to have sexual intercourse when she/he does not want to is a form of partner violence			
g. Low self esteem can be a feature of partner violence			
h. Women/men who experience partner violence can have contusions in their thighs			

i. Those who who experience partner violence can visit health facilities frequently with somatic complaints			
j. Those who experience partner violence can get urinary tract infections			

20. In this community and elsewhere, people have different ideas about family and what is acceptable behavior for women and men.

Please indicate if you generally agree or disagree with the following statements.

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d. A wife should always agree to have sex with her husband even if she doesn't feel like it.					
e. A wife should seek help from others (family, friends, health workers) if her husband mistreats or abuse her.					

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21. According to your opinion, do you think legislations against violent partners are important in Sri Lanka?

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f. Somewhat important
g. Not really important

22 According to your knowledge, is there a specific law in Sri Lanka that permits individuals to act against their abusive partners in courts?

a. Yes
b. No (if no, please go to Q 24)

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h. Other (please specify) ____

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c. A person should always report to the police and make an entry in the police book before filing a case against partner violence in the courts			
d. In most police stations, there is a specific place to receive the complaints against partner violence			
e. Against a violent partner, a Magistrate court can issue a protection order within two weeks			
f. In Sri Lanka there are supportive services for the sufferers who experience partner violence			

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	Strongly disagree	Disagree	Somewhat agree	Agree	Strongly agree
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c. Listening to a person when an abuse is disclosed					
d. Telling a person that partner violence is not acceptable, and she/he needs to seek help (from relatives, police, etc).					
e. Telling a person that the abuse can adversely affect her/his health					

26. What is your current level of comfort/ discomfort

	Uncomfortable	Somewhat comfortable	Comfortable
a. In asking a person whether she/he has experienced partner violence			
b. In taking a sexual history and history about sexual violence			
c. In knowing what to do if a person says she/he experiences partner violence			
d. In knowing what to do if the person breaks down and cries			
e. In assessing the safety of a person experiencing partner violence			

f. In knowing what to do if the person does not want to leave the abuser			
g. About making a referral of a person who experience partner violence to MOH or a social worker			
h. In knowing what to do when the child abuse is co-existing			

27. What is your estimate of the percentage of individuals who experience violence by partners in Sri Lanka? ……%

28. Do you think violence by pertners should be considered a health problem in Sri Lanka?
    a. Yes
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29. Do you think public health midwives should identify and help the sufferers who experience violence by partners?
    a. Yes
    b. No
30. Do you think public health midwives should be given training on how to identify and help the sufferers who experience violence by partners during their initial one and half year midwifery training?
    a. Yes
    b. No

Please answer these questions regarding the training program, which you had on intimate partner violence

1. When did you get your training? Date……. Month……. Year…….

2. In your opinion, did the IPV training (received six months ago) improve your IPV services to sufferers in your work area?
   a. Yes
   b. No
   c. Not sure

3. Do you recommend that this training should be delivered to PHMs in other areas of Sri Lanka?
   4. Yes
   5. No
   6. Not sure

7. Please indicate the areas that you think the training program should be improved, and indicate what you want to learn more

……
……..……
……..……
……..……
……

Thank you for your time.

Appendix 11. Post-intervention Questionnaire (Sinhala)

අනු අංකය	ප්‍රාදේශීය. සෞ. සේ. කොට්ඨාශයේ නම:
	ප. සෞ. සේ. කොට්ඨාශයේ අංකය:

පර්යේෂණ ප්‍රශ්නාවලිය

මෙම පර්යේෂණය සඳහා ඔබගේ සහභාගිත්වය පිළිබඳව ස්තුතියි. කරුණාකර පිළිතුරු සැපයීමට පෙර තොරතුරු පත්‍රය කියවා කැමැත්ත ප්‍රකාශ කිරීමේ ආකෘති පත්‍රයට අත්සන් කරන්න.

කරුණාකර සුදුසු පිළිතුර රවුම් කරන්න. අවශ්‍ය අවස්ථාවලදී ඔබට එක් පිළිතුරකට වඩා ලකුණු කළ හැකිය.

1. ඔබගේ වයස සඳහන් කරන්න. අවුරුදු

2. විවාහක/අවිවාහක බව

   a. විවාහකයි

   b. අවිවාහකයි

   c. දික්කසාද වී ඇත/සැමියාගෙන් වෙන් වී ඇත

   d. වැන්දඹු

3. ඔබගේ ඉහළ ම අධ්‍යාපන සුදුසුකම සඳහන් කරන්න.

   a. අ.පො.ස. සාමාන්‍ය පෙළට අඩු

   b. අ.පො.ස. සාමාන්‍ය පෙළ

   c. අ.පො.ස. උසස් පෙළ

   d. ඩිප්ලෝමා/උපාධි

4. ඔබගේ තනතුර සඳහන් කරන්න.

   a. පරිපාලන පවුල් සෞඛ්‍ය සේවා නිලධාරිනි

   b. ක්ෂේත්‍ර පවුල් සෞඛ්‍ය සේවා නිලධාරිනි

   c. වතු පවුල් සෞඛ්‍ය සේවා නිලධාරිනි (පුහුණු)

d. වතු පවුල් සෞඛ්‍ය සේවා නිලධාරිනි (නුපුහුණු)

5. සෞඛ්‍ය සේවයේ ඔබගේ මුළු සේවා කාලය කොපමණද? අවුරුදු ☐

6. එම මුළු සේවා කාලයෙන් කොපමණ කාලයක් ඔබ ක්ෂේත්‍රයේ සේවය කොට තිබෙනවාද? (රෝහල්වල සේවය කළ කාලය හැර)? අවුරුදු ☐

සැමියා හා බිරිඳ අතර වන අඬ දබර මිනිස් ඉතිහාසයේ ආරම්භයේ සිට ම පැවතෙන්නකි. එවන් අඬ දබර පිළිබඳව එක් එක් පුද්ගලයින් විවිධාකාර අදහස් දරයි. කෙසේ වුවත් මෑතක සිට ශ්‍රී ලංකාවේ සහකරුවන්ගෙන් එල්ලවන හිංසනය පිළිබඳව වැඩි කතා බහක් ඇතිවෙමින් පවතියි.

7. ඔබගේ සේවා කාලය තුළ සහකරුවාගේ හිංසනයට ලක්වන එක් අයෙක්වත් අඩුම තරමේ ඔබ හඳුනාගෙන තිබෙනවාද?

a. ඔව්

b. නැත

8. පසුගිය මාස තුනක (3) කාලය තුළ සහකරුවාගේ හිංසනයට ලක්වන එක් අයෙක්වත් ඔබ අලුතින් හඳුනාගෙන තිබෙනවාද?

a. ඔව්

b. නැත

9. සහකරුවාගේ හිංසනයට ලක්වන ඔබ අලුතින් හඳුනාගත් පුද්ගලයින් සංඛ්‍යාව එක් අයෙකුට වඩා වැඩිනම් ඒ කොපමණද?.....

10. එම පුද්ගලයින් සහකරුවන්ගේ හිංසනයට ලක් වූ බව ඔබ දැන ගත්තේ කෙසේද? (වැඩිම අවස්ථා ගණනකදී දැනගත් ආකාරය පමණක් ලකුණු කරන්න)

a. එම පුද්ගලයින් මා සමඟ පැවසුවා

b. එම පුද්ගලයින්ගේ නෑදෑයෙක් හෝ අසල්වැසියෙක් හෝ මිත්‍රයෙක් මා සමඟ පැවසුවා

c. සමාජ සේවකයෙක්/ස්වෙච්ඡා සෞඛ්‍ය සේවකයෙක් මා සමඟ පැවසුවා

d. එම පුද්ගලයා හිංසනයට ලක්වන බව මා විසින් හඳුනා ගත්තා.

e. වෙනත් .....

11. යම් පුද්ගලයෙකු සිය සහකරුවාගේ හිංසනයට ලක්වන බව දැනගත් පසු ඒ පිළිබඳව ඔබ එම පුද්ගලයා සමඟ කතා කළාද?

a. ඔව්

b. නැත (පිළිතුරු නැත නම් ප්‍රශ්න අංක 13 වෙත යන්න)

12. වින්දිතයෙකු සමඟ සහකරුවාගේ හිංසනය පිළිබඳව කතා කිරීමෙන් පසුව ඔබ ඒ පිළිබඳව ගත් ක්‍රියා මාර්ගය කුමක්ද? (අවශ්‍ය නම් එක් පිළිතුරකට වඩා තෝරාගත හැක)

a. සහකරුවාගේ වධ හිංසා උපේක්ෂාවෙන් විඳ දරාගෙන ඉවසීමෙන් කටයුතු කරන ලෙස උපදෙස් දුන්නා.

b. එම පුද්ගලයා මුහුණ දෙන හිංසනය පිළිබඳව පවුලේ සාමාජිකයන් සහ හිතවතුන් සමඟ සාකච්ඡා කරන ලෙස කියා සිටියා.

c. එම හිංසනය පිළිබඳව පොලීසියට පැමිණිලි කරන ලෙස කියා සිටියා.

d. පොලීසියට පැමිණිලි කිරීමට මා වින්දිතයාට උපකාර කළා.

e. එම පුද්ගලයා සෞඛ්‍ය සේවා නිලධාරී හො පොලීසියට හෝ වෙනත් උපකාරක මධ්‍යස්ථානයකට යොමු කළා.

f. වින්දිතයාට එම ගැටලුව හිංසකයා සමග ඉවසීමෙන් සාකච්ඡා කරන ලෙස කියා සිටියා.

g. වින්දිතයාට එම ගැටලුව හිංසකයා සමග සාකච්ඡා කිරීමට උපකාර කළා.

h. වෙනත් …….

13. සහකරුවන්ගේ හිංසනයට ලක්වන පුද්ගලයින් සමඟ එම අත්දැකීම පිළිබඳව ඔබ කතා නොකළා නම් එසේ කළේ,

a. එය පෞද්ගලික ප්‍රශ්නයක් ලෙස මා සිතූ නිසා

b. එසේ විමසීම එම පුද්ගලයින්ට කරන අපහාසයක් ලෙස මා සිතූ නිසා

c. එම පුද්ගලයින් කෝප වේ යැයි මා සිතූ නිසා

d. එම පුද්ගලයින් ඒ පිළිබඳව කතා කිරීමට අකමැති වූ නිසා

e. වෙනත් …….

14. සහකරුවාගේ හිංසනයට ලක්වන බවට හඳුනාගෙන සාකච්ඡා කළ පුද්ගලයින් පිළිබඳව ඔබ කෙදිනක හෝ පසුවිපරම් කොට තිබෙනවාද?

a. ඔව් ඒ සියළුම දෙනා

b. ඔව් ඒ ඇතැමෙක්

c. නැත

15. සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයින් පිළිබඳව ඔබ පසුවිපරම් නොකලේනම් ඒ කුමන හේතුවක් නිසාද?

a. කාර්යබහුල නිසා මට ඒ සඳහා වේලාවක් නොතිබුණු නිසා

b. වින්දිතයා ඊට අකමැති නිසා

c. වෙනත් .....

16. පසුගිය මාස තුනක (3) කාලය තුළ බිරිඳගේ හිංසනයට ලක්වන සැමියන් එක් අයෙක්වත් ඔබ හඳුනාගෙන තිබෙනවාද? (පිළිතුරු නැත නම් ප්‍රශ්න අංක 18 වෙත යන්න)

a. ඔව්

b. නැත

17. ඔව් නම් ඒ කොපමණද?.....

සහකරුගේ හිංසනයට ලක්වන පුද්ගලයින් හඳුනා ගැනීමට හා ඔවුන්ට උපකාර කිරීමට උත්සාහ කිරීමේදී පවුල් සෞඛ්‍ය සේවා නිලධාරිනීන් හට යම් යම් ප්‍රායෝගික අපහසුතා ඇතිවිය හැකිය.

18. පහත සඳහන් වගන්ති පිළිබඳව ඔබගේ අදහස් දක්වන්න. (ඒ යන්නෙන් අදහස් වන්නේ සහකරුගේ හිංසනයයි)

	කොහෙත්ම එකඟ නොවේ	එකඟ නොවේ	තරමක් එකඟයි	එකඟයි	ඉතා එකඟයි
a. අධික කාර්ය බහුලත්වය නිසා මට ඒ පිළිබඳව ඇසීමට කාලයක් වෙන් කිරීමට හැකියාවක් නැත					
b. ඒ පිළිබඳව ඇසීමෙන් පුද්ගලයින් අපහසුතාවයට පත් වේ යැයි මට බියක් පවතී					
c. ඒ පිළිබඳව විමසීමට පුද්ගලයින් හා තනිව කතා කිරීමට අවස්ථාවක් ඇති කර ගැනීමට ඉතා අපහසුය.					
d. එම පුද්ගලයින් හඳුනා ගැනීමට හෝ ඔවුනට උපකාර කිරීමට මා කිසිදු පුහුණුවක් ලබා නැත					

e. මා එම පුද්ගලයින් හඳුනාගත්තත්, ඔවුන්ට උපකාර කිරීමට උපකාර සේවාවන් නැත					
f. මා එම පුද්ගලයින් හඳුනාගත්තත් ඔවුන්ට උපකාර කිරීමේ හැකියාවක් මට ඇතැයි මට නොසිතේ					
g. මා සේවය සපයන පුද්ගලයින්ගේ විවාහ ජීවිතයේ ගැටළුවලට මැදි වෙනවාට වඩා ඔවුන්ගේ සෞඛ්‍ය ගැටලු වලට අවධානය යොමු කිරීමට මම කැමතිය					

19. පහත සඳහන් ප්‍රකාශ සමග ඔබ එකග වෙනවාද?

	ඔව්	නැත	නොදනී
a. සහකරු තල්ලු කර දැමීම සහකරුවාට කරන හිංසනයකි			
b. සහකරුගේ යහළු යෙහෙලියන් හමුවීම වැළැක්වීම හිංසනයකි			
c. සහකරුගේ අවශ්‍යතා සඳහා මුදල් ලබා නොදීම හිංසනයකි			
d. සහකරු පිළිබඳව නිරපරාදේ සැකකිරීම හිංසනයකි			
e. සහකරු කරන/කියන සියළු දෑට අවසර ගැනීමට කීම හිංසනයකි			
f. ලිංගිකව හැසිරීමට අකමැති වූ අවස්ථාවල බලහත්කාරයෙන් ලිංගිකව හැසිරීම හිංසනයකි			
g. තමා පිළිබඳ අවතක්සේරුව හිංසනයේ ලක්ෂණයකි			
h. හිංසනයට ලක්වන පුද්ගලයින්ගේ කලවාවල තැලුම් දක්නට ලැබේ			
i. හිංසනයට ලක්වන පුද්ගලයින් විවිධ රෝගාබාධ පිළිබඳ පැමිණිලි කරමින් නිතර වෛද්‍යවරුන් මුණ ගැසේ			
j. හිංසනයට ලක්වන පුද්ගලයින්හට නිතර මුත්‍රා ආසාදන ඇතිවේ			

20. විවිධ සමාජවල පවුල සහ කාන්තාවන් හා පිරිමින්ගේ හැසිරීම් පිළිබඳ විවිධ ආකල්ප ඇත. මීළඟට සඳහන් කරන ප්‍රකාශ පිළිබඳ ඔබේ අදහස් කුමක්ද?

	ඉතා එකඟයි	එකඟයි	තරමක් එකඟයි	එකඟ නොවේ	කොහෙත්ම එකඟ නොවේ
a. හොඳ බිරිඳක් සැමවිටම සැමියාට අවනත වේ. (තමන් අකමැති දෙයකදී වුවත්)					
b. සැමියෙක් බිරිඳට අඩන්තේට්ටම් කිරීම පවුලේ ප්‍රශ්නයක් වන අතර පිටස්තරයන් ඊට මැදිහත් විය යුතුය නැත.					
c. පිරිමියෙකු ලෙස සැමියාට සැමවිටම පවුලේ බලතල සහ බිරිඳගේ පාලනය තිබිය යුතුය.					
d. තමා අකමැති වුවත් සැමියාගේ ලිංගික අවශ්‍යතාවලට බිරිඳ සැමවිටම එකඟ විය යුතුය					
e. සැමියාගේ තමන්ට හිංසා සහ අපයෝජනය කරයිනම් බිරිඳ සැමවිටම පවුලේ අය මිතුරන් සෞඛ්‍ය සේවකයින් සමග සාකච්ඡා කළ යුතුය					

සහකරුවන්ගේ හිංසනයට ලක්වන පුද්ගලයින්ගේ යහපත සඳහා ශ්‍රී ලංකා රජය විසින් එවන් හිංසාකාරී ක්‍රියාවන්ට එරෙහිව නීති ප්‍රතිපාදන ඇති කිරීම වැදගත් බව ඇතැමුන් පවසන අතර එවැනි නීති ප්‍රතිපාදන ශ්‍රී ලංකාව වැනි රටකට අනවශ්‍ය බව තවත් සමහරුන්ගේ මතයයි.

21. ඔබගේ දැනුමට අනුව හිංසාකාරී සහකරුවන්ට එරෙහි නීති ශ්‍රී ලංකාවට වැදගත්ද?

a. ඔව් ඉතා වැදගත්

b. ඔව් තරමක් වැදගත්

c. කිසිසේත්ම නැත

22. ඔබගේ දැනුමට අනුව ශ්‍රී ලංකාවේ සහකරුවාගේ හිංසනයට ලක්වන කාන්තාවන් සඳහා විශේෂිත වූ නීති ප්‍රතිපාදන තිබේද?

a. ඔව්

b. නැත (පිළිතුරු නැත නම් ප්‍රශ්න අංක 24 වෙත යන්න)

23. පිළිතුර 'ඔව්' නම්, ඔබ ඒ පිළිබඳව දැන ගත්තේ කෙසේද?

a. මාධ්‍ය මගින් - රූපවාහිනිය/ගුවන් විදුලිය/පුවත්පත් (අදාළ මාධ්‍ය ලකුණු කරන්න)

b. හිත මිතුරන්/නැදෑයන් මඟින්

c. පොලිස් නිලධාරියෙක්/නීති ක්ෂේත්‍රයේ නිලධාරියෙක් මඟින්

d. වෙනත් (ලියා දක්වන්න).....

24. පහත සඳහන් වගන්ති පිළිබඳව ඔබගේ අදහස් දක්වන්න.

	ඔව්	නැත	නොදනී
a. ශ්‍රී ලංකාවේ පුද්ගලයෙකුට සිය සහකරු විසින් සිදු කරනු ලබන මානසික වධ හිංසාවලට එරෙහිව උසාවියේ පැමිණිලි කර නීති ක්‍රියාමාර්ග ගත හැක.			
b. . ශ්‍රී ලංකාවේ පුද්ගලයෙකුට සිය සහකරු විසින් සිදු කරනු ලබන ලිංගික වධ හිංසාවලට එරෙහිව උසාවියේ පැමිණිලි කර නීති ක්‍රියාමාර්ග ගත හැකිය.			
c. ශ්‍රී ලංකාවේ පුද්ගලයෙකුට සිය සහකරු විසින් සිදු කරනු ලබන වධ හිංසාවලට එරෙහිව උසාවියේ නඩුවක් ගොනු කිරීමට පෙර පොලීසියට පැමිණිලි කර තිබිය යුතුය.			
d. ශ්‍රී ලංකාවේ ප්‍රධාන පොලීසිවල ගෘහස්ථ හිංසනයන්ට විරුද්ධව පැමිණිලි භාර ගැනීම සඳහා විශේෂිතවූ ස්ථානයක් ඇත			
e. මහේස්ත්‍රාත් අධිකරණයක් මගින් හිංසාකාරී සහකරුවෙකුට එරෙහිව ආරක්ෂක නියෝගයක් සති දෙකක් තුළ නිකුත්කළ හැක			
f. ශ්‍රී ලංකාවේ සහකරුවන්ගේ හිංසනයට ලක්වන පුද්ගලයින් හට උපකාර කිරීම සඳහාඋපකාරක මධ්‍යස්ථාන ඇත			

25. පහත සඳහන් වගන්ති පිළිබඳව ඔබගේ අදහස් දක්වන්න.

පවුල් සෞඛ්‍ය සේවා නිලධාරිනියක සතු වගකීමකි,

	කොහෙත්ම එකඟ නොවේ	එකඟ නොවේ	තරමක් එකඟයි	එකඟයි	ඉතා එකඟයි
a. පුද්ගලයෙකු තැලීම්, සීරීම් හෝ තුවාල සහිතව සිටිනවා දුටු සෑම විටකම එම තුවාල සඳහා දක්වන හේතුව කුමක් වුවත් සහකරුවාගේ හිංසනයට ලක්වීදැයි එම පුද්ගලයාගෙන් විමසීම					
b. යම් පුද්ගලයෙකුගේ දරුවකු තැලීම්, සීරීම් හෝ තුවාල සහිතව සිටිනවා දුටු සෑම විටකම එම තුවාල සඳහා දක්වන හේතුව කුමක් වුවත් සහකරුවාගේ හිංසනයට ලක්වේදැයි එම පුද්ගලයාගෙන් විමසීම					
c. සහකරු විසින් සිදුකරන ලද හිංසනයක් පිළිබඳව යමෙක් විස්තර කරන කල එයට සවන් දීම.					
d. හිංසනයට ලක්වන කාන්තාවක් හමුවූ විට ඇගේ සැමියාගේ හිංසාකාරී ක්‍රියා කලාපය ඉවසා දරා සිටිය යුත්තක් නොවන බවත් එවන් අවස්ථාවක ඔහු හෝ ඇය උදව් (නෑදෑ හිතමිතුරන්ගේ සහ පොලීසියේ) සහය පැතිය යුතු බව පැවසීම.					
e. සහකරුවාගේ හිංසාකාරී ක්‍රියා කලාපයන් ඔහු හෝ ඇයගේ විවිධ රෝගාබාධ සඳහා හේතුවන බව පැවසීම.					

26. පහත වගන්තිවලින් දැක්වෙන ක්‍රියාකාරකම් කිරීම ඔබට පහසුද අපහසුද යන්න දක්වන්න.

	පහසුය	තරමක් පහසුය	අපහසුය

a. සහකරුවාගේ හිංසනයට ලක්වේදැයි විමසීම			
b. සහකරුවාගෙන්ලිංගික හිරිහැර සිදුවන්නේ ද යන්න පිළිබඳව ප්‍රශ්න ඇසීම			
c. යම් පුද්ගලයෙකු සහකරුවාගේ හිංසනයට ලක්වන්නේ යැයි පැවසූ විට කුමක් කළ යුතු දැයි තීරණය කිරීම			
d. සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයෙකු ඒ පිළිබඳව විමසූ විට හඬා වැටෙන්නේ නම් ඒ අවස්ථාවේදී කුමක් කළ යුතු දැයි සිතා ගැනීම			
e. සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයෙකුගේ ජීවිත ආරක්ෂාව පිළිබඳ තක්සේරු කිරීම			
f. සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයෙකු සිය සහකරුවාගෙන් වෙන් වීමට අකමැති අවස්ථාවලදී කුමක් කළ යුතු දැයි තීරණය කිරීම			
g. සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයෙකු පොලීසියට හෝ වෙනත් උපකාරක මධ්‍යස්ථානයකට යොමු කිරීම			
h. සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයෙකුගේ දරුවන්ද හිංසනයට ලක්වන අවස්ථාවක කුමක් කළ යුතු දැයි තීරණය කිරීම.			

27. ඔබගේ අදහස පරිදි ශ්‍රී ලංකාවේ විවාහක පුද්ගලයින්ගෙන් කොපමණ ප්‍රතිශතයක් සිය සහකරුවාගේ හිංසනයට ලක් වේද?

සියයට..... ක් (.....%)

28. ඔබගේ අදහස පරිදි ශ්‍රී ලංකාවේ පුද්ගලයින් වෙත සිය සහකරුවන්ගෙන් එල්ල වන ශාරීරික, මානසික හා ලිංගික හිංසනය ප්‍රජා සෞඛ්‍ය ගැටළුවක් ලෙස සැළකීම වැදගත්ද?

a. ඔව්

b. නැත

29. ඔබගේ අදහස පරිදි සහකරුවන්ගේ හිංසනයට ලක්වන පුද්ගලයින් හඳුනාගෙන ඔවුන්ට උපකාර කිරීම පවුල් සෞඛ්‍ය සේවා නිලධාරිනියකගේ රාජකාරියේ කොටසක් ලෙස ඇතුළත් කිරීම වැදගත්ද?

a. ඔව්

b. නැත

30. ඔබගේ අදහස පරිදි සහකරුවාගේ හිංසනයට ලක්වන පුද්ගලයින් හඳුනාගෙන ඔවුන්ට උපකාර කිරීම සඳහා පවුල් සෞඛ්‍ය සේවා නිලධාරිනියන්ට පුහුණුවක් ලබා දීම වැදගත්ද?

a. ඔව්
b. නැත

සහකරුගේ හිංසනය පිළිබඳව ඔබ ලැබූ මෙම පුහුණුව පිළිබඳව අසා ඇති පහත ප්‍රශ්න වලට පිළිතුරු සපයන්න

1. ඔබ මෙම පුහුණුව ලැබුවේ කවදාද ? දිනය..... වර්ෂය..... මාසය.....

2. මාස හයකට පෙර ඔබ ලැබූ පුහුණුව සහකරුගේ හිංසනයට පත්වූ කාන්තාවන්ට උපකාරකිරීමට ඔබට වැදගත් වූවාද?

a. ඔව්
b. නැත
c. විශ්වාස නැත

3. ඔබ මෙම පුහුණුව අනෙකුත් පළාත්වල පවුල් සෞඛ්‍ය සේවා නිළධාරීණින්ට නිර්දේශ කරනවාද?

a. ඔව්
b. නැත
c. විශ්වාස නැත

4. ඔබගේ අදහස පරිදි මෙම පුහුණුවට ඇතුළත් වූවා නම් හොඳයි යැයි සිතෙන යම් දෙයක් හෝ ඔබ තවදුරටත් ඉගෙන ගත යුතු යැයි සිතන යම් විෂය පථයක් වේද?

.....
.....
.....
.....
.....

ඔබගේ සහභාගිත්වයට ස්තුතියි

Appendix 12. Post-intervention Questionnaire (Tamil)

முன் தலையீட்டு கேள்வித்தாள் (தமிழ்) MOH பகுதியின் பெயர்

வரிசை இலக்கம் PHM பகுதி இலக்கம்

கேள்வித்தாள்

உங்களுடைய பங்குபற்றுதலுக்கு நன்றி. தயவு செய்து கேள்விகளுக்கு பதிலளிப்பதற்கு முன்னரும், அறிக்கையில் கையொப்பம் இடுவதற்கு முன்னரும் தகவல் தாளை நன்றாக வாசிக்கவும்.

சரியான பதில்களுக்கு வட்டம் இடவும். தேவையேற்படின் ஒன்றுக்கு மேற்பட்ட பதில்களுக்கு வட்டம் இடமுடியும். தயவு செய்து பதிலளிப்பதற்கு முன்னர் கேள்விகளை நன்றாக வாசிக்கவும்.

பொதுத் தகவல்.

1. உங்களது வயதைக் குறிப்பிடவும் ..... ஆண்டுவாரியாக
2. திருமண நிலை
    - (அ) திருமணம்
    - (ஆ) திருமணமாகாதவர்
    - (இ) விவாகரத்து / பிரிந்து வாழ்பவர்
    - (ஈ) விதவை
3. உங்களது கல்வி நிலையை குறிப்பிடவும்
    - (அ) கல்விப் பொதுத் தராதர சாதாரண தரத்திலும் குறைவு.
    - (ஆ) கல்விப் பொதுத் தராதர சாதாரண தரம்.
    - (இ) கல்விப் பொதுத் தராதர உயர் தரம்.
    - (ஈ) டிப்ளோமா / பட்டதாரி
4. உங்களது தொழில் தொடர்பானவை:
    - (அ) பொது சுகாதார மருத்துவிச்சி மேற்பார்வையாளர்
    - (ஆ) பொது சுகாதார மருத்துவிச்சி
    - (இ) பயிற்றப்பட்ட வீடு பொது சுகாதார மருத்துவிச்சி
    - (ஈ) பயிற்றப்படாத வீடு பொது சுகாதார மருத்துவிச்சி
5. நீங்கள் சுகாதாரப் பணியாளராக சேவையாற்றும் காலம்..... ஆண்டுகள்
6. நீங்கள் சுகாதாரத் துறையில் எவ்வளவு காலமாக வெளிக்கள உத்தியோகத்தராக பணியாற்றி வருகின்றீர்கள்..... ஆண்டுகள்

கணவர் மூலம் பெண்களுக்கு எதிராக மேற்கொள்ளப்படும் வன்முறைகள் தொடர்பில் அந்தக்காலம் முதல் பல்வேறு மனிதர்களால் பல்வேறு கருத்துக்கள் அவ்வப்போது முனைவைக்கப்பட்டுக் கொண்டிருந்தாலும் கூட அண்மைக்காலங்களில் நாட்டின் பிரதான விவாதத்திற்கு உள்ளாகும் விடயமாக இது மாறிவிட்டது.

7. கடந்த மூன்று மாதங்களில், உங்கள் பணிப்பகுதியில் வாழ்க்கைத் துணைவரால் வன்முறையை அனுபவித்த ஒருவரை அடையாளம் கண்டுள்ளீர்களா?

(அ) ஆம்.

(ஆ) இல்லை

8. கடந்த மூன்று மாதங்களில், உங்களது பணிப்பகுதியில் வாழ்க்கைத் துணைவரால் வன்முறைக்குள்ளாக்கப்பட்ட குறைந்தது ஒரு நபரையாவது புதிதாக அடையாளம் கண்டுள்ளீர்களா?

(அ) ஆம்.

(ஆ) இல்லை

9. வாழ்க்கைத் துணைவர்களால் வன்முறைகளை எதிர்கொண்டவர்கள் என உங்களால் அடையாளம் காணப்பட்ட ஒன்றுக்கு மேற்பட்டவர்கள் உள்ளார்கள் எனில் அந்த அனுபவங்களை சந்தித்தவர்கள் எத்தனை பேர் என குறிப்பிட முடியுமா?

10. தனது வாழ்க்கைத் துணைவரால் குறித்த நபர் அல்லது மக்கள் வன்முறையை அனுபவிக்கின்றனர் என உங்களுக்கு எவ்வாறு தெரியவந்தது எனக் குறிப்பிடுவீர்களா? (ஒன்றுக்கு மேற்பட்ட பதிலை எதிர்பாக்கின்றோம்)

(அ) அந்த நபர் தானாக / சுயமாக என்னிடம் கூறினார்

(ஆ) அவரது உறவினர் / அவரைத் தெரிந்த அயலவர் என்னிடம் கூறினார்

(இ) ஒரு சமூக சேவகர்/தன்னார்வ சுகாதார பணியாளர் என்னிடம் கூறினார்

(ஈ) வன்முறையால் பாதிக்கப்பட்டவரின் செயற்பாடு/ காயங்கள் என்பவை எனக்கு சந்தேகத்தை ஏற்படுத்தின.

11. நீங்கள் குறிப்பிட்ட நபர் தனது வாழ்க்கைத் துணைவரினால் வன்முறைக்கு உள்ளாக்கப்பட்டவர் என தெரிந்த பின்னர் அந்த அனுபவம் தொடர்பில் குறிப்பிட்ட நபரிடம் அதற்குப் பின்னர் பேசவில்லையா? (உங்களது பதில் இல்லை எனில் 13 ஆவது கேள்விக்கு நேரடியாகச் செல்லலாம்)

(அ) ஆம்

(ஆ) இல்லை

12. துன்புறுத்தலுக்குள்ளாக்கப்பட்ட நபருடன் தொடர்ந்தும் உரையாடலில் ஈடுபட்டிருந்த போது அவருக்கு நேர்ந்த அந்த முறைகேடு தொடர்பான பிரச்சினைக்கு தங்களால்

பரிந்துரை ஏதாவது வழங்கப்பட்டதா?

(ஒன்றுக்கு மேற்பட்ட பதில் எதிர்பார்க்கப்படுகிறது)

(அ) இந்த விடயம் தொடர்பில் சகிப்புத்தன்மையுடன் இருக்குமாறு பாதிக்கப்பட்வருக்கு சில ஆலோசனைகளை வழங்கினேன். ஏனெனில், அவருக்கு இதுகுறித்து எதுவும் செய்யமுடியாது என்பதனால்.

(ஆ) பாதிக்கப்பட்டவர் இது தொடர்பில் அவரது குடும்ப உறுப்பினர்கள் அல்லது நண்பர்களுடன் நான் கலந்துரையாடினேன்.

(இ) பாதிக்கப்பட்டவரை இது தொடர்பில் பொலிஸில் முறைப்பாடு ஒன்றை செய்யுமாறு நான் ஆலோசனை வழங்கினேன்

(ஈ) பாதிக்கப்பட்டவர் பொலிஸில் முறைப்பாடு செய்வதற்கு நான் உதவி புரிந்தேன்.

(உ) பாதிக்கப்பட்டவரை எனது சுகாதார மேலதிகாரியின் உதவிக்காக அழைத்துச் சென்றேன்.

(ஊ) பாதிக்கப்பட்டவரை துஷ்பிரயோகத்தில் ஈடுபட்டவருடன் கலந்துரையாடுமாறு பரிந்துரைத்தேன்.

(எ) பாதிக்கப்பட்டவரை துஷ்பிரயோகத்தில் ஈடுபட்டவருடன் கலந்துரையாடுவதற்கு உதவி புரிந்தேன்.

13. வன்முறை தொடர்பான அனுபவங்கள் பற்றி பாதிக்கப்பட்ட அவளுடன்/ அவருடன் நீங்கள் ஏன் கதைக்கவில்லை?

(அ) அது அவரது தனிப்பட்ட விடயம் என நான் நினைத்தேன்

(ஆ) அதுபற்றி கதைப்பது பாதிக்கப்பட்டவரை அவமதிக்கும் என்று நான் நினைத்தேன்

(இ) அது பற்றி கதைத்தால் பாதிக்கப்பட்டவருக்கு கோபம் வரும் என நான் நினைத்தேன்

(ஈ) பாதிக்கப்பட்டவர் அது தொடர்பில் எதுவும் பேச விரும்பவில்லை.

14. நீ வன்முறை விவாதிக்கப்படும் என்று அந்த பாதிக்கப்பட்டவர்களுக்கு என்ன நடக்கிறது என்று பார்க்க தொடர்ந்து?

(அ) ஆமாம்இ நான் வன்முறை பற்றி அந்த அனைத்து
(ஆ) ஆமாம்இ நான் வன்முறை பற்றி சிலர்
(இ) இல்லை

15. நீங்கள் வன்முறை தொடர்பில் கலந்துரையாடிய பாதிக்கப்பட்டவர்களுக்கு என்ன நடக்கிறது என அறிய அவர்களை பின்தொடர்ந்து சென்றீர்களா?

(அ) ஆம், வன்முறை தொடர்பில் நான் அனைவரிடமும் கலந்துரையாடினேன்.

(ஆ) ஆம், வன்முறை தொடர்பில் நான் சிலரிடமே கலந்துரையாடினேன்.

(இ) இல்லை

16. இந்தப் பணியின் போது தங்களது மனைவியை வன்முறைக்குள்ளாக்கிய ண்களை அடையாளம் கண்டீர்களா?

(அ) ஆம்.

(ஆ) இல்லை

17. அப்படியானால், நீங்கள் எத்தனை ஆண்களை அடையாளம் கண்டுள்ளீர்கள்? .....

18. பாதிக்கப்பட்டவர்கள் தொடர்பில் வன்முறைகளை கண்டறிதல் மற்றும் அவர்களுக்கு உதவிகளை புரிவதனால் மருத்துவிச்சிகள் சில நடைமுறைச் சிக்கல்களை எதிர்நோக்குகின்றனர்.

பின்வரும் கூற்றுக்களுடன் உடன்படுமிடத்து தயவு செய்து அந்தக் கூற்றுக்களின் நிலைகளுக்கு புள்ளி வழங்குக.

	கடுமையான இணக்கமின்மை	இணக்கமின்மை	ஏதாவது ஒரு வகையில் இணக்கம்	இணக்கம்	கடுமையான இணக்கம்
(அ) எனக்கு வேலைச்சுமை கடுமையாக உள்ளதனால் துணைவர் வன்முறை தொடர்பில் கேட்பதற்கு போதுமான நேரமில்லை.					
(ஆ) துணைவர் வன்முறை தொடர்பில் கேட்குமிடத்து அது அவரை புண்படுத்தும் என நான் பயப்படுகின்றேன்.					
(இ) அவர்கள் எப்போதும் யாருடனாவது சேர்ந்தே இருப்பதனால் துணைவர					
(ஈ) துணைவரின் வன்முறையால் பாதிக்கப்பட்டவரை அடையாளம் காண்பதில் அல்லது உதவுவதில் எனக்கு போதிய அனுபவமோ பயிற்சியோ இல்லை.					

(உ) துணைவரின் வன்முறையால் பாதிக்கப்பட்டவரை அடையாளம்					
(ஊ) துஷ்பிரயோக உறவைக் கொண்டுள்ள ஒருவருக்கு உதவ முடியும் என நான் உணரவில்லை.					
(எ) அவர்களது உறவினர்களை விட நான் எனது நோயாளியினுடைய					

19. பின்வரும் பொ ாதுவான கூற்றுக்களுடன் நீங்கள் இணங்குகிறீர்களா? இணங்கவில்லையா?

	ஆம்	இல்லை	தெரியாது
(அ) துணைவர் ஒருவர் தனது வாழக்கைத் துணைவருக்கு அழுத்தத்தைக் கொடுப்பதே அவர் வன்முறையில் ஈடுபடக் காரணமாகும்.			
(ஆ) துணைவர் ஒருவர் தனது வாழ்க்கைத் துணைவரை நண்பன் ஒருவன் பழகவிடாமல் சந்திக்கவிடாமல் தடுப்பதே அவர் வன்முறையில் ஈடுபடக் காரணம்			
(இ) துணைவருக்கு பணம் தேவைப்படும்போது அதனை வழங்க மறுப்பதே அவர் வன்முறையில் ஈடுபடக் காரணம்.			
(ஈ) துணைவரை எந்தவொரு காரணமும் இன்றி சந்தேகப்படுவதே அவர் வன்முறையில் ஈடுபடக் காரணம்.			
(உ) துணைவர் எந்தவொரு காரியத்தை செய்யவேண்டுமானாலும் அனுமதி கோர நிர்ப்பந்திக்கப்படுவதே அவர் வன்முறையில் ஈடுபடக் காரணம்.			
(ஊ) துணைவர் விரும்பாத நேரத்தில் அவரை பாலியலுக்கு நிர்ப்பந்திப்பதே அவர் வன்முறையில் ஈடுபடக் காரணம்.			
(எ) துணைவரின் தாழ்வுமனப்பான்மையே அவர் வன்முறையில் ஈடுபடக் காரணம்.			
(ஏ) துணைவரின் வன்முறையை அனுபவித்த பெண்கள்/ஆண்கள்தமது தொடைகளில் காயங்களைக்			

கொண்டிருக்கக் கூடும்.			
(ஐ) துணைவர் வன்முறையை அனுபவிப்பவர்கள் உடல் சார்ந்த பிரச்சினைகளுடன் சுகாதார நிலையங்களுக்கு விஜயம் செய்யக்கூடும்.			
(ஒ) துணைவர் வன்முறைக்குள்ளானவர்களின் சிறுநீர்ப் பாதை தொற்றுநோய்க்குள்ளாகக்கூடும்.			

20. இன்றைய சமுதாய மக்கள் மற்றும் பிற இடங்களில் குடும்பப் பெண்கள், ஆண்களின் நடத்தை பற்றி பல்வேறு கருத்துக்கள் நிலவுகின்றன.

பின்வரும் பொதுவான அறிக்கைகள் தொடர்பில் தங்களுக்கு இணக்கப்பாடு உண்டா இணக்கப்பாடு இல்லையா என்பதை குறிப்பிடவும்.

இலங்கை மக்களில் ஒரு பகுதியினர் வன்முறை புரிகின்ற கணவன்மார்களுக்கு எதிராக சட்டங்கள் தேவை என கூறுகின்றனர். எனினும் சிலர் இலங்கை போன்ற நாடுகளுக்கு இதுமாதிரியான சட்டம் அவசியம் இல்லை என வாதிடுகின்றனர்.

	கடுமையான இணக்கம்	இணக்கம்	சற்றே இணக்கம்	இணக்கமின்மை	கடுமையான இணக்கமின்மை
(அ) ஒரு மனைவி கணவருடன் இணக்கப்பாடில்லை என்றாலும் கூட எப்போதும் அவருக்கு கீழ்படிந்தே நடக்க வேண்டும்.					
(ஆ) கணவன் மனைவி மீது மேலாதிக்க வன்முறையை பிரயோகித்தல் அதில்					
(இ) ஒரு ஆணாக கணவன் எப்போதும் தனது மனைவிமீது கட்டுபாடுகள					
(உ) ஒரு மனைவி எப்பொழுதும் இணங்கியே தனது கணவருடன் உடலுறவில்					
(ஊ) ஒரு மனைவி தனது கணவரால் துன்புறுத்தலுக்கோ அல்லது					

21. உங்களின் கருத்துப்படி கணவன்மாரின் வன்முறைக்கெதிரான சட்டம் இலங்கைக்கு அவசியம் என கருதுகின்றீர்களா?

மிகவும் முக்கியம்

ஓரளவு முக்கியம்

முக்கியம் இல்லை

22. உங்களது அறிவுக்கெட்டியவரை, பெண்களுக்கு எதிராக துன்புறுத்தல்களை புரிந்த கணவன்மார்கள் தொடர்பில் முறையிட இலங்கை நீதிமன்றங்களில் பிரத்தியேக சட்டம் உள்ளதா?

(அ) ஆம்

(ஆ) இல்லை (உங்களது பதில் இல்லை எனில் நேரடியாக 24ஆவது கேள்விக்குச் செல்க)

23. பதில் ஆம் எனில், இதுபோன்ற சட்டங்கள் பற்றி நீங்கள் எந்தெந்த வழியில் அறிந்துகொண்டீர்கள்?

(அ) ஊடகங்களிலிருந்து- தொலைக்காட்சி/வானொலி/ பத்திரிகைகள் (நெருங்கிய ஊடகத்துக்கு வட்டமிடுக)

(ஆ) நண்பர்கள்/ உறவினர்களிடமிருந்து

(இ) பொலிஸ் அதிகாரி/ சட்ட ஆலோசகரிடமிருந்து

(ஈ) வேறு, (ஏதாவது வழியில் எனில் தயவு செய்து அதனை குறிப்பிடுக)

24. பின்வரும் அறிக்கைகள் தொடர்பில் உங்களது கருத்தைக் குறிப்பிடுக.

	ஆம்	இல்லை	தெரியாது
(அ) இலங்கையில் ஒரு நபர் தனது துணைவரை உளவியல் ரீதியான முறைகேட்டுக்கு உட்படுத்தினால் அந்த செயற்பாட்டுக்கு எதிராக நீதிமன்றங்களுக்கு செல்லலாம்.			
(ஆ) இலங்கையில் ஒரு நபர் தனது துணைவரினால் பாலியல் துஷ்பிரயோகத்துக்கு உட்படும்போது நீதிமன்றங்களுக்கு செல்லலாம்.			
(இ) ஒரு பெண் தனது துணைவரினால் வன்முறைக்காளாக நேரிடும்போது அது தொடர்பில் முதலில் பொலிஸாரிடம் முறையிட்டு புத்தகத்தில் பதிந்த பின்னரே நீதிமன்றங்களில் வழக்குத் தாக்கல் செய்ய முடியும்.			
(ஈ) பெரும்பாலான பொலிஸ் நிலையங்களில் தனது பங்காளியினால் வன்முறைக்குள்ளானமை தொடர்பில் புகார் தெரிவிக்க ஒரு தனி இடம் இருக்கின்றது.			

(உ) வன்முறை புரிந்தவருக்கு எதிராக நீதிவான் நீதிமன்றம் இரண்டு வாரங்களுக்குள் அழைப்பாணை உத்தரவு வழங்க முடியும்.			
(ஊ) இலங்கையில் துணைவரின் வன்முறையால் பாதிக்கப்பட்டவர்களுக்காக உதவிச் சேவைகள் உள்ளன.			

25. தயவு செய்து பின்வரும் கூற்றுக்களுக்கு உங்களது கருத்துக்களை பதிவிடுங்கள்:

பொதுமக்களுக்கான பொறுப்புக்கூறலில் ஒரு மருத்துவிச்சிக்கும் பங்கு உண்டு.

	கடுமையாக இணங்கவில்லை	இணங்கவில்லை	இணக்கம்	இணக்கம	கடுமையான இணக்கம்
(அ) காரணத்தை கவனத்தில் கொள்ளாமல் எந்த ஒரு நேரத்திலும் துணைவரின் ன்முறையினால் காயம் அடைந்ததை அவதானித்தேன்.					
(ஆ) காரணத்தை கவனத்தில் கொள்ளாமல் எந்த ஒரு நேரத்திலும் துணைவரின் வன்முறையினால் ஒரு குழந்தை தீவிரமாக காயமடைந்ததை அவதானித்தேன்.					
(இ) நான் எப்போதுமே துஷ்பிரயோகத்திற்கு உட்படுத்தப்படவில்லை என்று ஒரு நபர் சொல்வதை கேள்வியுற்றேன்.					
(ஈ) பங்குதாரின் வன்முறையினால் பாதிக்கப்பட்ட அவள்/அவர் (பொலிஸார், சொந்தங்கள், ஏனவைர்களிடமிருந்து) உதவியை நாடவேண்டும் என்பதை அனுமதிக்க முடியாது என்று கூறுவது ஏற்கத்தக்கதல்ல.					
(உ) ஒரு நபர் கூறுகிறார் துஷ்பிரயோகம் அவள்/அவரின் ஆரோக்கியத்தில் தாக்கத்தை ஏற்படுத்தும்.					
(ஊ) தவறாக மோசமான அவளை பாதிக்கும் என்று ஒரு நபர் சொல்லும் / அவரது உடல்					

26. தற்போதைய நிலையில் உங்களுக்கு ஏற்புடைய்/ ஏற்புடையதற்றவை என நீங்கள் எதை கருதுகின்றீர்கள்?

	ஏற்புடைய தல்ல	ஓரளவு ஏற்புடையது	ஏற்புடை யது
(அ) ஒரு நபர், துணைவரின் வன்முறை தொடர்பான அனுபவம் பற்றி அவள்/ அவனிடம் கேட்கும்போது.			
(ஆ) பாலியல் வன்முறை மற்றும் பாலியல் வராலாறு பற்றி கதைக்க எடுக்கும்போது.			
(இ) துணைவரினால் வன்முறை அனுபவிக்கின்றேன் என்று தெரிந்தும் என்ன செய்ய முடியும் என அவள்/ அவன் கூறும்போது.			
(ஈ) ஒரு நபர் என்ன செய்கின்றேன் என தெரிந்துகொண்டே கீழே விழுந்து அழும்போது			
(உ) துணைவரினால் வன்முறை அனுபவிக்கும் நபரின் பாதுகாப்பை மதிப்பீடு செய்யும் போது.			
(ஊ) துஷ்பிரயோத்திற்கு ஆளானவர் எல்லை மீறுகின்றவரை விட்டு வெளியேற வேண்டும். இல்லையேல் அதுபற்றி தெரிந்தும் என்ன செய்வது			
(எ) எந்த ஒரு நபரும் தனது துணைவரினால் வன்முறையை அனுபவிக்கின்றார் என தெரிந்தால் அது தொடர்பில் சுகாதார மருத்துவ பரிசோதகரிடமோ அல்லது சமூக சேவையாளரிடமோ குறிப்பிட முடியும்.			
(ஏ) சிறுவர் முறைகேட்டை தவிர்ப்பது எவ்வாறு என எப்போதாவது தெரிந்து கொள்ளும்போது.			

27. உங்களது மதிப்பீட்டின்படி இலங்கையில் எத்தனை சதவீதமான பெண்கள் கணவன்மார்களினால் வன்முறையை அனுபவிக்கின்றனர்? .....மூ

28. கணவன்மார்களினால் தொடரும் வன்முறையானது இலங்கையில் ஒரு சுகாதரப் பிரச்சினையாக உருவெடுக்குமென நீங்கள் நினைக்கின்றீர்களா?

(அ) ஆம்

(ஆ) இல்லை

29. கணவர்களின் வன்முறையினால் பாதிப்புக்குள்ளானவர்களை அடையாளம் கண்டு குடும்பநல உத்தியோகத்தர்கள் அவர்களுக்கு உதவ வேண்டும் என நீங்கள் நினைக்கின்றீர்களா?

(அ) ஆம்

(ஆ) இல்லை

30. குடும்பநல உத்தியோகத்தர்களுக்கு வழங்கப்படுகின்ற ஒன்றரை வருட பணிப் பயிற்சியின் ஆரம்ப காலத்தில் கணவர்களினால் வன்முறையை அனுபவிக்கும் பாதிக்கப்பட்டவர்களை இலகுவாக அடையாளம் காண உதவும் பயிற்சி வழங்கப்பட வேண்டும் என்று நினைக்கின்றீர்களா?

(அ) ஆம்

(ஆ) இல்லை

வன்முறையில் ஈடுபடும் துணைவர் தொடர்பான பயிற்சித்திட்ட நிகழ்வு தொடர்பாக கேட்கப்படும் கேள்விகளுக்கு தயவு செய்து பதிலளிக்கவும்.

1. பயிற்சியில் எப்போது இணைந்துகொள்கிறீர்கள்? திகதி ..... மாதம் ..... ஆண்டு ....

2. உங்கள் கருத்து, (ஆறு மாதங்களுக்கு முன்பு பெற்றார்) IPV பயிற்சி உங்கள் வேலை பகுதியில் பாதிக்கப்பட்டவர்களுக்கு உங்கள் IPV சேவைகளை மேம்படுத்த?

(அ) ஆமாம்

(ஆ) இல்லை

(இ) நிச்சயமாக இல்லை

3. இந்த பயிற்சி இலங்கையின் ஏனைய பகுதிகளில் PHMs வழங்கப்படும் என்று பரிந்துரைக்கிறோம்?

(அ) ஆமாம்

(ஆ) இல்லை

(இ) நிச்சயமாக இல்லை

4. தயவு செய்து கல்வி திட்டம் மேம்படுத்தப்பட வேண்டும் என்று நீங்கள் குறிப்பிடும் பகுதிகளை பற்றி தெரிந்து கொள்ள மேலதிகமாக என்ன செய்ய வேண்டும் என குறிப்பிடுங்கள்.

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உங்கள் பொன்னான நேரத்திற்கு நன்றி

Appendix 13. The time frames of the pre-intervention and post-intervention surveys

No	Dates of the IPV training	Oberved or not	Pre-intervention survey date	Post-intervention survey date
1	10 – 13 August 2009	Observed	10 August 2009	17 February 2010
2	24 - 27 August 2009	Not observed	24 August 2009	24 February 2010
3	7 – 10 September 2009	Not observed	7 September 2009	3 March 2010
4	21 - 24 September 2009	Observed	21 September 2009	17 March 2010
5	5 – 8 October 2009	Observed	5 October 2009	7 April 2010
6	19 – 22 October 2009	Not observed	19 October 2009	28 April 2010
7	9 – 12 November 2009	Observed	9 November 2009	5 May 2010
8	23 – 26 November 2009	Not observed	23 November 2009	19 May 2010
9	11 – 14 January 2010	Not observed	11 January 2010	21 July 2010
10	8 – 11 February 2010	Observed	8 February 2010	18 August 2010
11	8 – 11 March 2010	Observed	8 March 2010	8 September 2010

Appendix 14. Ethical approval from the University of Tokyo

様式第２号

倫　理　委　員　会
審　査　結　果　報　告　書

平成２１年１月２６日

申請者
国際地域保健学
教授
神馬　征峰　殿

大学院医学系研究科・医学部
倫理委員会
委員長　赤林　朗　印

受付番号　2419

研究課題　配偶者暴力に関する教育プログラムの開発とその知識・態度および行動への効果

研究者　神馬征峰、SILVA Achini Chinthika、PUDEL Krishna C、DHARMARATHNA、大塚恵子、野本まりの

上記研究計画を平成２１年１月２６日の委員会で審査し下記のとおり判定しました。
ここに通知致します。

判定

○承認する。
条件付きで承認する。
変更を勧告する。
承認しない。
該当しない。

条件あるいは変更勧告の理由（細則第３条第２項）

Appendix 15. Ethical approval from University of Peradeniya, Sri Lanka

Faculty of Medicine
Peradeniya

ETHICAL CLEARANCE CERTIFICATE

This is to certify that the Committee on Research and Ethical Review,
Faculty of Medicine, University Peradeniya
received
the research proposal on

"The effectiveness of an education program to improve public health midwives' identification and support for victims of intimate partner violence in Kandy, Sri Lanka"

submitted by

Dr. A.C Silva
of

Faculty of Medicine, University of Peradeniya
on
24th April 2009

The Committee is satisfied that the said study has taken into consideration all ethical aspects in its implementation and granted Ethical Clearance at it's meeting held on
10th August 2009

Prof. W.I Amarasinghe
Dean
Faculty of Medicine

Prof. R Sivakanesan
Chairperson
Committee on Research
& Ethical Review

Date: 10.08.2009

Appendix 16. Information sheet (English)

Study Information for Participants

Study title: The effectiveness of an education program to improve midwives' detection of and interventions against intimate partner violence in Kandy, Sri Lanka.

Principle investigator: Achini Silva (the University of Tokyo).

Thank you for your participation in this study. In this study, we would like to give you a questionnaire to be answered by your self. We don't ask your name in this questionnaire. So, your identity will not be disclosed.

The objectives of this study are:

1. To examine the knowledge, attitudes and practices of public health midwives on intimate partner violence.
2. To test the effectiveness of an intimate partner violence education program for public health midwives.

If you agree to proceed with the study, we will give you the questionnaire. We will ask some questions about you and your job. Also, we will ask some questions to examine your knowledge, attitudes and practices towards intimate partner violence. What we learn from you will help us to prevent intimate partner violence in Sri Lanka. That will help to improve the quality of life of many Sri Lankan women.

Your participation for this study is entirely voluntary and you may refuse to answer any question if you choose or may withdraw your consent to participate at any time without penalty. The confidentiality of the completed questionnaires will be fully assured. Collected data will be handled by the principal researcher (Achini Silva) and the completed questionnaires will be kept in a locked cabinet at University of Tokyo. No body has the access to them except the principal researcher and the supervising staff of the Department of International community health, Graduate school of medicine, University of Tokyo, Japan.

You may ask any question about the study at this time and if you have further questions about this study, please do not hesitate to contact;

Dr. Achini Silva, Department of International Community Medicine, Graduate School of Medicine, University of Tokyo. 0081-3-5841-3322, achini@m.u-tokyo.ac.jp.

Dr Nilani Fernando, Deputy Provincial Director of Health services Office, Kandy, Central Province. 077-253-3618, nilani1954@yahoo.co.nz.

Prof. Masamine Jimba, Department of International Community Medicine, Graduate School of Medicine, University of Tokyo, 0081-3-5841-3422, mjimba@m.u-tokyo.ac.jp.

Appendix 17. Information sheet (Sinhala)

අධ්‍යයනය පිළිබඳ විස්තර පත්‍රිකාව

මාතෘකාව : කාන්තා හිංසනය පිළිබඳව පවුල් සෞඛ්‍ය සේවා නිලධාරිනියන්ගේ දැනුම හා ආකල්ප පිළිබඳ අධ්‍යයනය

පර්යේෂකයාගේ නම : වෛද්‍ය අචිනි සිල්වා (තෝකියෝ විශ්ව විද්‍යාලය)

මෙම අධ්‍යයනය සඳහා ඔබගේ සහභාගිත්වය පිළිබඳව ස්තුතියි. මෙම අධ්‍යයනයේදී අපි ඔබට සම්පූර්ණ කිරීම සඳහා ප්‍රශ්න පත්‍රයක් ලබා දෙන්නෙමු. එහිදී අපි ඔබගේ නම අසන්නේ නැත. එබැවින් ඔබගේ පිළිතුරු පත්‍රය මගින් ඔබ කවුදැයි හඳුනාගැනීමේ හැකියාවක් අපට නැත.

මෙම අධ්‍යයනයේ අරමුණු වන්නේ,

1. ශ්‍රී ලාංකික කාන්තාවන් සිය සැමියන් වෙතින් අත්විඳින හිංසනය පිළිබඳව පවුල් සෞඛ්‍ය සේවා නිලධාරිනියන්ගේ දැනුම හා ආකල්ප අධ්‍යයනය කිරීම.

2. එම අධ්‍යයනයෙන් ලබන දැනුම ශ්‍රී ලාංකික කාන්තාවන් සිය සැමියන් වෙතින් අත්විඳින හිංසනය පිළිබඳව පවුල් සෞඛ්‍ය සේවා නිලධාරිනියන්ගේ දැනුම හා ආකල්ප වර්ධනයට යොදා ගැනීම.

මෙම අධ්‍යයනයේදී අපි ඔබ හා ඔබගේ රැකියාව පිළිබඳව විමසන්නෙමු. එමෙන් ම කාන්තාවන් සිය සැමියන් වෙතින් අත්විඳින හිංසනය පිළිබඳව ඔබගේ දැනුම හා ආකල්ප පිළිබඳව අධ්‍යයනය සඳහා ප්‍රශ්න කිහිපයක් අසන්නෙමු. ඔබගේ පිළිතුරු මඟින් අපි සැමියන්ගේ හිංසනයට ලක්වන කාන්තාවන් පිළිබඳව ශ්‍රී ලංකාවේ පවුල් සෞඛ්‍ය සේවා නිලධාරිනියන්ගේ දැනුම හා ආකල්ප පිළිබඳව දළ අදහසක් ලබා ගැනීමට බලාපොරොත්තු වන්නෙමු.

මෙම අධ්‍යයනය සඳහා සහභාගි වීමට අපි ඔබට කිසිදු බල කිරීමක් නොකරන්නෙමු. සැමියන්ගේ හිංසනයට ලක්වන ශ්‍රී ලාංකික කාන්තාවන්ගේ යහපත උදෙසා මෙම අධ්‍යයනයට සහභාගි වීමෙන් ඔබ අපට සහයෝගය දෙතැයි අපි බලාපොරොත්තු වෙමු.

ඔබ සපයන සියළු තොරතුරුවල රහස්‍ය බව සුරැකීමට අපි පොරොන්දු වෙමු. මෙම ප්‍රශ්නාවලියේ ඕනෑම ප්‍රශ්නයකට පිළිතුරු නොදී සිටීමේ අයිතිය ඔබ සතුවේ. මෙම අධ්‍යයනය ගැන කිසියම් ගැටළුවක් ඔබට ඇති වුවහොත් මේ අවස්ථාවේදී හෝ පසු අවස්ථාවක පහත සඳහන් අය වෙතින් විමසා සිටිය හැකිය.

Dr. Achini Silva, Department of International Community Medicine, Graduate School of Medicine, University of Tokyo. 0081-3-5841-3322, achini@m.u-tokyo.ac.jp.

Dr Nilani Fernando, Deputy Provincial Director of Health services Office, Kandy, Central Province. 077-253-3618, nilani1954@yahoo.co.nz.

Prof. Masamine Jimba, Department of International Community Medicine, Graduate School of Medicine, University of Tokyo, 0081-3-5841-3422, mjimba@m.u-tokyo.ac.jp.

Appendix 18. Information sheet (Tamil)

பங்கேற்பாளர்களுக்கான ஆய்வு தகவல்

ஆய்வு தலைப்பு: தாதிகள் எதிர்நோக்கும் நெருக்கமான துணையாளர்களின் வன்முறைகளுக்கு எதிரான கண்டறிதல்களையும் தலையீடுகளையும் விருத்தி செய்வதற்கான கல்வி திட்டத்திறன்.

முதன்மை ஆய்வாளர்: அச்சினி சில்வா (டோக்கியோ பல்கலைக்கழகம்)

இந்த ஆய்வில் உங்களது பங்களிப்புக்கு நான் எனது நன்றியை தெரிவித்துக் கொள்கிறேன். இந்த ஆய்வில் நீங்கள் சுயமாக பதிலளிப்பதற்கான கேள்வித்தாள் உங்களுக்கு வழங்கப்படும். கேள்வித்தாளில் உங்களது பெயர் கேட்கப்பட மாட்டாது. ஆகவே உங்களது அடையாளங்கள் வெளிப்படுத்தப்பட மாட்டாது.

இந்த ஆய்வின் நோக்கங்களாவன:

1. நெருங்கிய துணையாளர்களின் வன்முறை தொடர்பாக பொது சுகாதார தாதிமார்களின் அறிவு, நடத்தை மற்றும் நடைமுறை என்பவற்றை பரீட்சித்தல்.
2. பொதுச் சுகாதார தாதிமார்களுக்கான நெருங்கிள துணையாளர்களின் வன்முறை தொடர்பான கல்வித்திட்டத்திறனை பரீட்சித்தல்.

இதனை நீங்கள் தொடர விரும்பினால் நாங்கள் உங்களுக்கான கேள்வித்தாளை தருவோம். உங்களையும் மற்றும் உங்களது தொழில் பற்றியதுமான சில கேள்விகளை நாங்களே கேட்போம். மேலும் நெருக்கமானதுணையாளர்களின் வன்முறை தொடர்பாக உங்களது அறிவு, நடத்தை மற்றும் நடைமுறைகளை பரீட்சிக்கவும் நாங்கள் சில கேள்விகள் கேட்போம். உங்களிடம் இருந்து நாம் அறியும் தகவல்கள் இலங்கையில் நெருங்கிள துணையாளர்களின் வன்முறைகளுக்கு எதிரான நடவடிக்கைகளை மேற்கொள்ள உதவும். அந்நடவடிக்கைகள் அநேகமான இலங்கை மாதர்களின் வாழ்வின் தரத்தை விருத்தி செய்ய உதவும்.

இந்த ஆய்வில் உங்களது பங்களிப்பானது முற்று முழுதாய் சுய விருப்பத்தின் அடிப்படையிலானது. மேலும் நீங்கள் தெரிவு செய்யும் கேள்விகளுக்கு பதிலளிக்க மறுக்கவும், நீங்கள் விரும்பிய நேரத்தில் இந்த ஆயிவின் பங்களிப்பிலிருந்து எவ்வித தண்டணைகளுமின்றி மீளப்பெற முடியும். பூரணப்படுத்தப்பட்ட கேள்வித்தாளின் நம்பகத்தன்மை முழுமையாக பாதுகாக்கப்படும். சேகரிக்கப்பட்ட தகவல்கள் அனைத்தும் முதன்மை ஆய்வாளரினால் (Dr.Achini Silva) கையாளப்படும். பூரணப்படுத்தப்பட்ட கேள்வித்தாள்கள் டோக்கியோ பல்களைக்கழகத்தின் பூட்டப்பட்ட அலுமாரிகளில் வைக்கப்படும். தன்மை ஆய்வாளர், ஜப்பானின் டோக்கியோ பல்களைக்கழகத்தின் சர்வதேச சுகாதார மற்றும் மருத்துவ பட்டதாரி பாடசாலை மேற்பார்வையாளர்கள் தவிர்த்து வேறெவர்க்கும் அவற்றுக்கான அணுகல் கிடையாது.

இந்த நேரத்தில் இந்த ஆய்வு தொடர்பான எவிவத கேள்விகளையும் கேட்க முடியும், மலும் இந்த ஆய்வு தொடர்பான கேள்விகள் இருந்தால் நீங்கள் தயக்கமின்றி தொடர்பு கொள்வதற்கான தகவல்கள்.

Dr. Achini Silva, Department of International Community Medicine, Graduate School of Medicine, University of Tokyo. 0081-3-5841-3322, achini@m.u-tokyo.ac.jp.

Dr Nilani Fernando, Deputy Provincial Director of Health services Office, Kandy, Central Province. 077-253-3618, nilani1954@yahoo.co.nz.

Prof. Masamine Jimba, Department of International Community Medicine, Graduate School of Medicine, University of Tokyo, 0081-3-5841-3422, mjimba@m.u-tokyo.ac.jp.

Appendix 19. Informed consent (English)

Informed Consent Form for Participants

Study title: The effectiveness of an education program to improve midwives' detection of and interventions against intimate partner violence in Kandy, Sri Lanka

Principle investigator: Achini Silva (the University of Tokyo)

The Director, Graduate School of Medicine,

The University of Tokyo.

Dear Sir,

I, _____ after reading and having had the contents of this study explained to me, understand what is expected of me as a participant and agree to participate in the study.

I understand:

1. The purpose and procedures of the study
2. The content of the questionnaire
3. How to deal with questions that I feel uncomfortable in answering
4. What to do if I wish to withdraw from the research after initial agreement
5. That any information I provide will be destroyed at the end of the study.

I understand that my participation is entirely voluntary and that I may refuse to answer any question if I choose, or may withdraw my consent to participate at any time without penalty or without in any

way affecting the health care I receive. I understand that the information collected will be treated in a confidential manner that I will not be identified in the reporting of the results.

Signature / Name: _____

Date: _____

Address: _____

_____

I, the researcher, certify that I have explained to participant the content and procedures of the study according to the attached to information page. I have covered all points listed on the consent form above.

I will protect the confidentiality of the participant.

Signature / Name: _____

Date: _____

Appendix 20. Informed consents (Sinhala)

කැමැත්ත ප්‍රකාශ කිරීමේ පත්‍රිකාව

මාතෘකාව : කාන්තා හිංසනය පිළිබඳව පවුල් සෞඛ්‍ය සේවා නිලධාරිනියන්ගේ දැනුම හා ආකල්ප පිළිබඳ අධ්‍යයනය

පර්යේෂකයාගේ නම : වෛද්‍ය අචිනි සිල්වා (ටෝකියෝ විශ්ව විද්‍යාලය)

මහත්මයාණෙනි,

..... වන මම මෙම අධ්‍යයනයේ තොරතුරු පත්‍රිකාව කියවා හොඳින් තේරුම් ගත්තෙමි.

මෙහිදී,

1. මෙම අධ්‍යයනයේ අරමුණ

2. ප්‍රශ්නාවලියේ අඩංගු විය හැකි කරුණු

3. පිළිතුරු දීමට අපහසු ප්‍රශ්න මඟ හැරිය හැකි බව

4. මාගේ පිළිතුරු පත්‍රයෙන් මා කවුදැයි හඳුනා ගත නොහැකි බව

5. මෙම අධ්‍යයනය අවසානයේදී පර්යේෂණ කණ්ඩායම විසින් මා සපයනබ සියළු පිළිතුරු විනාශ කර දමන බව මම දනිමි.

මෙම අධ්‍යයනයට මම මගේ කැමැත්තෙන් සහභාගි වෙමි. මා සපයන විස්තරවල සුරක්ෂිත භාවය පිළිබඳව මම සෑහීමකට පත් වෙමි.

නම/අත්සන :.....

දිනය :.....

ලිපිනය :.....

අධ්‍යයනයේ ප්‍රධාන පර්යේෂකයා වන මම මෙම අධ්‍යයනයට සහභාගි වන මෙම පවුල් සෞඛ්‍ය සේවා නිලධාරිනියට අධ්‍යයනයට අදාළ සියළු තොරතුරු සැපයූවෙමි. ඇයගේ ප්‍රශ්න පත්‍රයේ අඩංගු විස්තරවල සුරක්ෂිත භාවය සුරකිමි.

නම/අත්සන :.....

දිනය :.....

Appendix 21. Informed consents (Tamil)

பங்கேற்பாளர்கள் அறிவிக்க ஒப்புதல் படிவம்

ஆய்வின் தலைப்பு: இலங்கையின் கண்டி பிரதேசத்தில் தாதியர்களின் கல்வித்திட்டத்தை கொள்கையளவில் மேம்படுத்தல் மற்றும் அதனுடன் தொடர்புடைய வன்முறைகளுக்கு எதிரான தலையீடுகளை கண்டறிந்து தவிர்த்தல்.

ஆய்வாளர் : அச்சினி சில்வா (டோக்கியோ பல்கலைக்கழகம்)

இயக்குநர், மருத்துவம் படிப்பு பள்ளி,

டோக்கியோ பல்கலைக்கழகம் .

அன்புடையீர்,

நான்..... படித்த
இந்த ஆய்வு உள்ளடக்கங்களை எனக்கு விளக்கினார் இருந்தது பின்னர் , ஒரு பங்கு என்னை
எதிர்பார்க்கப்படுகிறது மற்றும் ஆய்வு பங்கேற்க ஒப்பு என்ன புரிந்து .

நான் புரிந்துகொள்கிறேன் :

1 நோக்கம் மற்றும் ஆய்வு நடைமுறைகள்

2 கேள்வித்தாளை உள்ளடக்கம்

நான் பதில் கஷ்டமாக என்று கேள்விகள் சமாளிக்க எப்படி 3

4 நான் ஆரம்ப உடன்பாடு பிறகு ஆராய்ச்சி இருந்து விலக்கி விரும்பினால் என்ன செய்ய வேண்டும்

5 நான் வழங்க எந்த தகவலை ஆய்வு முடிவில் அழிந்து விடும்என்று.

நான் என் பங்களிப்பு முற்றிலும் தன்னார்வ என்று புரிந்து நான் தேர்வு செய்தால் நான் எந்த கேள்விக்கு பதிலளிக்க மறுக்கலாம் என்று , அல்லது நான் பெறும் சுகாதார பாதிக்கும் எந்த வழியில் தண்டனை இல்லாமல் அல்லது இல்லாமல் எந்த நேரத்திலும் பங்கேற்க என் ஒப்புதலை திரும்ப கூடும். நான் சேகரித்த தகவல்களை நான் முடிவுகளை வெளியிடுவது அடையாளம் முடியாது என்று ஒரு இரகசிய முறையில் சிகிச்சை என்று புரிந்துகொள்கிறேன்.

கையொப்பம் / பெயர் :.....

தேதி :.....

முகவரி :.....

நான் , ஆராய்ச்சியாளர் , நான் பங்கு உள்ளடக்கம் மற்றும் தகவல் பக்கம் இணைக்கப்பட்ட படி ஆய்வு நடைமுறைகள் விளக்கினார் என்று சான்றளிக்க . நான் மேலே ஒப்புதல் படிவத்தில் பட்டியலிடப்பட்ட அனைத்து புள்ளிகள் விவாதிக்கப்படுகின்றன.
நான் பங்கு இரகசியத்தன்மை பாதுகாக்கும்.

கையொப்பம் / பெயர் :…….

தேதி :……...

Appendix 22. A comparison of PHMs' IPV training program with other recently published IPV/DV training programs.

Reference	Participants and setting	Intervention	Evaluation	Findings	Limitations
Jayatilleke et al. (2015).	Public health midwives in Sri Lanka (n=408).	A four day training that included lectures, group discussions, role playing and case report discussion.	Pre- and post-intervention design. Used a self-administrative questionnaire for evaluation.	At 6 month's post intervention, there were improvements in PHMs' perceived barriers, responsibility, and self-confidence in addressing IPV. PHMs' IPV knowledge did not improve among majority	Training did not provide written protocols, guidelines, IPV record keeping formats, or communication materials to PHMs Training did not include a diverse trainer geroup
Feder (2011).	General practices in two urban primary care trusts in UK (n=48).	Two multi-disciplinary training sessions on IPV (each 2 hour long) for clinicians in the general practices	Cluster randomized controlled trial with 48 general practices divided in to 24 intervention practices and 24 control practices.	Over one year, Intervention practices identified 641 sufferers and recorded 223 referrals. Control practices identified only 236 sufferers and recorded 12 referrals.	Did not assess clinicians' individual practices. Did not asses improvements in clinicians' IPV

			Assessed number of sufferers identified and referred over 12 months. Used document review		knowledge, barriers, etc.
Papadakaki (2010).	Primary care physicians in a Greece prefecture (n=40).	Two day intensive IPV education program. Physicians provided with information on IPV, and involved in skill building exercises to identify, asses, document abuse and refer sufferers for services.	Pre- and 6 month's post-test design with 40 physicians, divided in to 26 intervention group physicians and 14 controls. Assesed physicians perceived IPV knowledge, preparedness to assist sufferers, and self-reported detection of cases using a self-administrative questionnaire	Intervention group had significantly better perceived IPV knowledge and perceived preparedness.	No significant difference in Self-reported detection of IPV sufferers among cases and controls
Shefet (2007).	Physicians in inpatient and outpatient settings of Israeli MOH (n=74)	Eight-hour workshop. Educated physicians using statistics,	Pre- and 6 month's post-intervention survey using a self-administrative questionnaire.	Physicians' IPV knowledge and skills to screen sufferers increased significantly.	Of the 150 physicians trained, only 74 physicians participated in both pre- and post-

		literature, and case reports.		Barriers for screening decreased significantly	intervention surveys.
Short (2006).	Primary care physicians in community-based medical offices in Arizona and Missouri	Online IPV education program	Pre- and 6 month's post-intervention survey with 23 intervention group physicians and 29 controls. Evaluated using an online questionnaire	Physicians' IPV related attitudes, beliefs, and self-reported practices improved significantly.	Physicians' IPV knowledge improved, but the change only significant at p = 0.06.
Debra (2004).	Community midwives in UK (n=79)	One day DV training program. Trained PHMs with case discussions. Provided guidelines for screening and information on supportive services	Pre- and six month's post-intervention using a self-administrative questionnaire.	Midwives' DV knowledge, efficacy beliefs, and positive attitudes towards enquiry on IPV increased significantly. Screening for DV increase by 30% (from 50% to 80%)	Presence of family members and lack of time mentioned as barriers to screen.

Appendix 23. IPV articles published in Sri Lankan newspapers between 01.08.2009 and 30.09.2010

Year	Month	Newspapers per month	Number of IPV articles in each newspaper*			
			Divaina	Lakbima	Silumina	Lankadeepa
2009	August	20	1	2	0	0
	September	16	1	1	0	0
	October	16	0	1	0	0
	November	20	1	2	0	0
	December	16	0	0	0	0
2010	January	20	1	2	0	0
	February	16	0	0	0	0
	March	16	1	1	0	0
	April	16	0	0	0	0
	June	16	1	2	0	0
	July	16	0	2	0	0
	August	20	1	1	0	0
	September	16	1	1	0	0
	Total					

*All were case reports on IPV, and highlighted women as the responsible party for triggering IPV

Appendix 24. Some examples of newspaper articles

පෙම්වතාගේ අනියම් බිරිඳ
ගැබ්බර පෙම්වතිය මරා දමයි

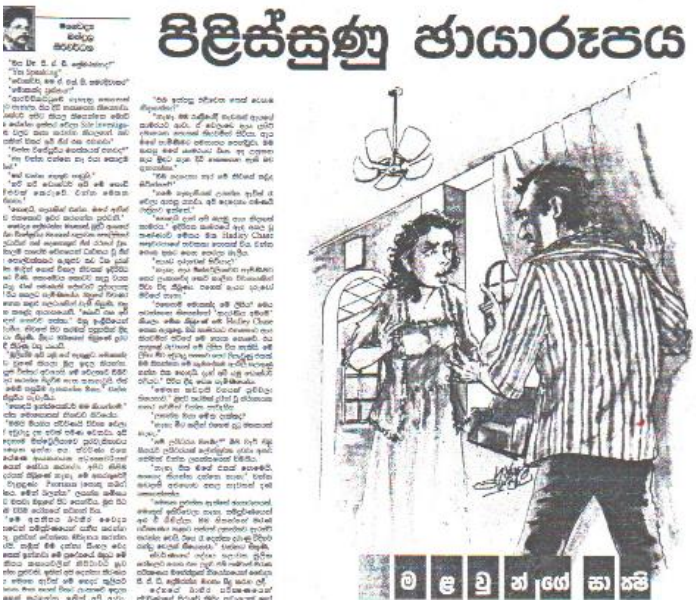
The ex-wife kills the ex-husband's girlfriend

The story highlights the fault of the ex-wife, but does not discuss the root causes for the incidence. (14.03.2010)

කසාද ජීවිතය රැකගන්නට
නිරෝෂන් පෙම්වතිය මරා පුළුස්සයි

To protect his family life, Niroshan kills his girl friend

The story justifies the act of killing as an attempt to protect the killer's family life. (29.11.2009)



පිළිස්සුණු ඡායාරූපය

The burnt photo

(evidence from dead)

The story explains that a husband has killed his wife because of her extramarital affair. It highlights the fault of the wife, but not the husband. (23.05.2010)