INTERNATIONAL
CENTRE FOR
ETHNIC STUDIES

WORLD BANK GROUP

Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-War

Ramila Usoof-Thowfeek

Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-War

Ramila Usoof-Thowfeek

Background Paper 4

Socio-economic Assessment of the Conflict-affected Northern and Eastern Provinces Conducted by the World Bank

Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-War

Colombo, 2018
@ 2018 International Centre for Ethnic Studies and World Bank
2, Kynsey Terrrace, Colombo 08, Sri Lanka
554/6A Peradeniya Rd, Kandy 20000, Sri Lanka

E-Mail: admin@ices.lk
URL: www.ices.lk

ISBN 978-955-580-220-8

This background paper was prepared as an input on the qualitative component of the "Socio-Economic Assessment of the Conflict Affected Northern and Eastern Provinces" conducted by the World Bank in 2017. The findings from this paper were summarized as Background Paper No. 1 to the main report. The qualitative component of the assessment was conducted by the International Centre for Ethnic Studies for the World Bank. The final version of this paper served as inputs to the World Bank publication:

World Bank (2018) Shadows of Conflict in North and East Sri Lanka: Socio-economic Challenges and a Way Forward. International Development in Focus Series. Washington, DC: World Bank.

This report should be cited as:
Usoof-Thowfeek, R. (2018)."Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-War", Background Paper No 4 Prepared by the International Centre for Ethnic Studies as a supplement to the to the Socio-Economic Assessment of the Conflict Affected Northern and Eastern Provinces" conducted by the World Bank. Kandy: International Centre for Ethnic Studies.

This report was made possible with proceeds from the 'State and Peacebuilding Fund'.

Printed by: Horizon Printing (Pvt) Ltd.
Cover :

Background Paper No. 4

Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-War

Ramila Usoof-Thowfeek1

[1] Senior Lecturer, Department of Psychology, University of Peradeniya

Acknowledgements

The author wishes to thank Dr. Anna C. O'Donnell and Dr. M.G.M. Razaak from the World Bank for commissioning ICES to conduct this study, contributing to the design and implementation of the study and making useful comments and suggestions regarding the earlier versions of this report. We must also record the support received from Dr. Mario Gomez, the Executive Director of the International Centre for Ethnic Studies (ICES), Ms. Chalani Lokugamage, Mr. Samarakoon Banda and Ms. Saleeka Pieris of ICES and in implementing this study from January to October, 2017.

This study was part of a larger study conducted by a team of researchers consisting of Prof. K. Tudor Silva (team leader), Kalinga Tudor Silva (ICES and University of Peradeniya), Dr. Dhammika Herath (University of Peradeniya), Dr. Ramila Usoof-Thowfeek (University of Peradeniya), Mr. S. Sivakanthan (University of Jaffna) and Mr. Vikneswaran Kunanayaham (Eastern University of Sri Lanka).

Our dedicated team of field investigators, who contributed greatly towards the successful completion of Focus Group Discussions (FGDs) and documenting the discussions, consisted of the following:

Northern Province

Mr. Kunaraththinam Gowthaman

Ms.Athirai Yoganathan

Ms. Sharmila Shanmuganathan

Ms. Hemilton Mary Nireka

Ms. Arivarasi Muthulingam

Ms. Newton Thevana

Eastern Province

Mr. S. Rishikaran

Mr. K. Thinesh

Ms. Y. Kirushanthini

In organizing our field work and stakeholder meetings in each district in the Northern and Eastern Provinces we received a great deal of assistance and organizational support from a number of persons, including Mr. Sambasivam Sutharsan, Assistant Government Agent in Jaffna and Mr. Kasun Pathiraja from the International Centre for Ethnic Studies and Mr. Suresh from Eastern University of Sri Lanka in Batticaloa. The authors acknowledges with thank the institutional support from Mr. Seenithamby Manoharan, Ms. Nilluka Sriskanthan and other staff in the World Bank Colombo office. Particular mention must be made of intellectual inputs received from Dr. Jeeva Pillai-Essex, Mr. Rangarajah Sivagurunathan and Dr. Minna Thaheer during various stages of the study. Ms. Nikole Joseph Thomas and Ms. Maggie Taylor from University of Pennsylvania and

Lakmali Alwis from ICES and Nikole Joseph from University of Pennsylvania assisted in preparing this publication.

Finally we thanks all those people from the Northern and Eastern provinces who came forward to share their experiences and valuable thoughts during KIIs, FGDs and Stakeholder Meetings.

Table of Contents

List of Abbreviations

CHE	Current Health Expenditure
CRADA	Centre for Rehabilitation of Alcoholics and Drug Addicts
DS	Divisional Secretary
FGD	Focus Group Discussion
KII	Key Informant Interview
LTTE	Liberation Tigers of Tamil Eelam
MOE	Ministry of Education
PTSD	Post Traumatic Stress Disorder
WDO	Women's Development Officers

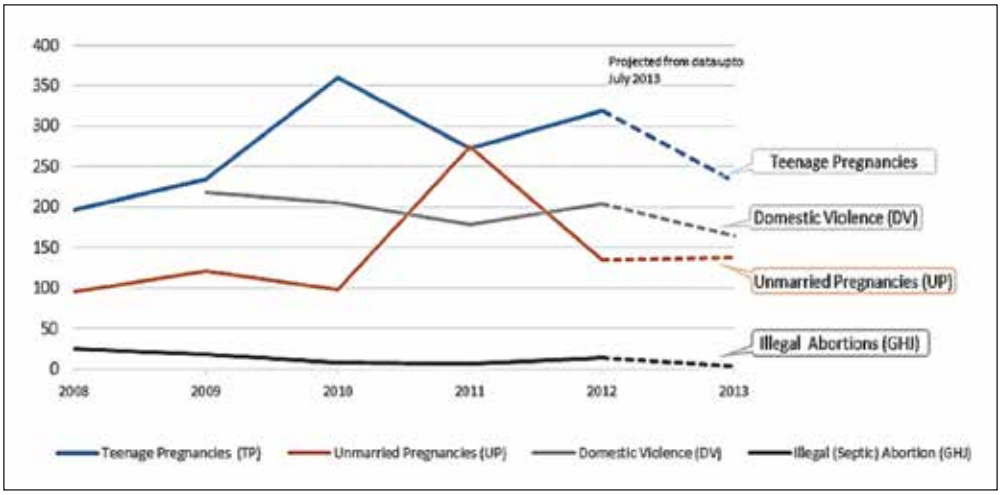
Introduction

Any assessment of the communities in the Northern and Eastern provinces of Sri Lanka will have little value and use if it does not address their psychosocial wellbeing or the lack there of. Being exposed to conflict, violence, and war directly and disproportionately, the populations in these provinces have suffered through almost three decades of psychological distress, social and cultural disintegration, and loss of economic, environmental, and physical resources, which all point to disruptions in the key domains of psychosocial wellbeing. In a survey of such communities immediately after the war, it was reported that these disruptions were pervasive and that little was being done to remedy them (Usoof-Thowfeek, 2011). The findings of this paper suggested that many Internally Displaced Persons in the Mannar and Vavuniya districts who were being resettled were saddled with the burden of resuming their lives and returning them to normalcy with little external support. These grievances were mostly observed in the areas of infrastructure and facilities for shelter, education, healthcare and livelihoods. The greatest insecurities were reported in the realm of financial needs. Additionally, women expressed insecurities around their physical wellbeing given their environments, and also pointed to 'social' insecurity that was connected to gender roles and acceptable behaviours and taboos ascribed to those gender roles; many women feared being ostracized by their communities due to perceived improper behaviour. Social and communal participation was reportedly hindered due to such concerns.

During the C. Sivagnanasundaram Oration in Jaffna in 2013, Daya Somasundaram outlined the state of communities in the Northern province a few years after the end of the war. He described a vicious cycle where socio-cultural disruptions lead to psychological distress, which in turn prevents socio-economic participation. He suggested that data indicated high levels of trauma among all sections of the population, with many suffering from PTSD, anxiety, depression, and somatoform disorders (the manifestation of psychological distress in the form of physical symptoms); much of which was connected to the direct experience of violence, torture, and imprisonment, as well as from living within what he calls a 'repressive ecology.' A repressive ecology is characterized by a lack of security (coupled with generalized terror), and a lack of confidence in institutions and one another. He also

pointed out that living in such a repressive ecology has led to the formation of a mass hysteria and a 'herd response'—exemplified by the 'grease butham'[2] phenomenon and the mass illegal migration by boat from the region[3]. Furthermore, he suggested that the unpredictability, low efficacy, low levels of control of anti-social behaviour, anomie, learned helplessness, and thwarted aspirations can be witnessed through increased levels of alcohol and substance abuse and addiction, child abuse, domestic violence, elder abuse and suicide or attempted suicides. Additionally, he reported that rates of teenage pregnancy and domestic abuse are increasing (Somasundaram, 2013) (see Figure 1). In general, he termed the general social disintegration and collective psychological distress thus experienced as a collective trauma.

Figure 1: Teenage Pregnancies, Unmarried Pregnancies, Domestic Violence and Abortions in Jaffna, 2008-2031



Data gathered by Regional Director of Health Services (RDHS) Jaffna Office reported by Somsundaram, (2013)

While extremely useful, the difficulty with these analyses has been that they have been of a limited geographical scope and are not descriptive of the situation in

[2] The 'grease butham' (Tamil) or the 'grease yaka' (Sinhala) phenomenon gripped the country, especially the North and East but also Southern parts to some degree in the years following the end of the war. Men, naked and covered in grease, were said to have targeted women who they either molested or sexually assaulted or stole from.

[3] During the 30-year war, it was quite common for Sri Lankans, from the North and East to seek asylum in countries in Europe, North America and Australia. The end of the war did not see an end to this situation. However, it became more common for people to rely on traffickers to get them to these countries. This was often a very dangerous option.

all war-affected communities at a given point in time. Therefore, for the design of interventions and policy formulation, they may be inadequate. The current report makes a comprehensive assessment of the psychosocial context of both the Northern and Eastern provinces, covering many different perspectives derived from all districts. The data for this particular report was collected almost a decade since the end of the war, which appears to be an appropriate juncture to take stock of the situation in these provinces. Thus, in the following report, we examine the present situation in these communities in relation to the aforementioned psychosocial issues. While the scope of this paper is to examine the impact of the war on these communities, it is pertinent to remember that many of the psychosocial responses that are visible within these communities were compounded by the experience of the 2004 Boxing Day tsunami, which caused great devastation and destruction in many places in the East, as well as some places in the North of Sri Lanka.

Methodology

The report is based on data collected using several different methods targeting various milieus and stakeholders within these provinces. A total of 120 key informant interviews (KIIs) with government officials, social service providers attached to the government (including counsellors, Women's Development Officers (WDOs), Child Rights Officers, etc.), community activists, community leaders, members of the business community, mental health professionals and religious leaders served as a basis for analyses. These were further bolstered by focus group discussions (FGDs) held with members of specific groups, including women, youth, the newly resettled, and those engaging in specific livelihoods—such as fisheries and farming. While the FGDs were focused more on the opportunities and challenges faced by the different groups, the conversations often provided information and insights into the psychosocial environment. This was in addition to official documents provided by the government officers who were interviewed. These documents include district statistical handbooks and other secondary sources of data. To better address specific changes affecting communities' psychosocial wellbeing, FGDs were also conducted with former volunteer counsellors trained by the International Centre for Ethnic Studies immediately after the end of war, in the Vavuniya and the Mannar districts. .

Key Findings

The analyses used a disaggregated approach to examine psychosocial distress and growth in these provinces, as well as their significance in relation to community participation in development. Special attention was paid to vulnerable populations within the provinces such as women, children, youth, ex-combatants, disabled, and families of the disappeared. For example, one section focuses on particular psychosocial issues experienced by youth and how it impacts them in other areas such as employment, livelihood participation, and social interactions. This approach helps illustrate how similar factors impact different groups to produce differential responses to development. Ideally, this will provide information that could be the basis of better-targeted interventions.

Psychological Distress and General Emotional Disturbances

According to approximately 60%, of the key informants involved in providing mental health services, who were interviewed the psychological scars of the direct experiences of war are still very much visible among individuals in many communities in the Northern and Eastern Provinces. One consultant psychiatrist who was interviewed pointed out that the psychiatric clinics at the hospital still receive patients who suffer from psychological disorders such as depression, anxiety and Post Traumatic Stress Disorder (PTSD) that are connected to the direct experience of war events. He cited examples of patients who have been visiting the same clinics for over 20 years with little relief. Similarly, a key informant who had been involved in the provision of counselling services in the Northern province, reiterated this point of view, suggesting that much of the depression, anxiety and PTSD that was experienced by individuals have continued to plague the community (see Table 1). For many, these types of psychological disorders can be debilitating, preventing them from engaging in social interactions, holding down a job, and things as simple as having a functional daily routine.

Ex-combatants are specifically vulnerable to the experience of trauma responses, such as PTSD, that are directly related to the combat exposure. Key informants, especially those involved in social welfare service provision, indicated that such

individuals are often unwilling to seek help given a fear of exposing their life histories. Social withdrawal is a key feature of many of these disorders, directly impacting interpersonal interactions, as well as their ability to be involved in work that is connected to any type of income generating activity. When a significant number of individuals are impacted by such disorders in a community, the social and economic impact is considerable. As one key informant explained:

> *"Those who experienced the war are in a daze. They are not able to function normally. They need to be treated. They can't work…many are not willing to come for counselling because of the stigma that is associated with it. They can't function. They can't work. Many of them are addicted to alcohol."*

Previous research reaffirms the finding that non-involvement of communities in economic, development and social endeavours can stem from prolonged exposure to violence and the ensuing psychological distress. Lifton (1967) describes the inability of survivors of the Hiroshima bombings to regain their bearings and function as productive individuals of the community. In particular, he references their inability to engage in day-to-day activities, such as tilling their fields and taking care of their houses and families.

According to Wickramasinghe (2009), these communities reportedly lived in a context that was strictly controlled by both the Liberation Tigers of Tamil Elam (LTTE) and the Sri Lankan military. Every aspect of their daily lives, from their movements, to what goods they had access to, to where they lived, were decided by someone else (Wickramasinghe, 2009). Additionally, in many cases, this tightly controlled environment also discouraged emotional expression. For example, many were not allowed to grieve their dead (Somasundaram, 2007). Those who have family members and loved ones missing, were left unable to grieve adequately (Derges, 2009). Such emotional repression can either lead to a disordered state known as Alexithymia (the inability to express felt emotion) or emotional anaesthesia (emotional numbing) that makes an individual incapable of expressing positive emotion (Bryan, Cukrowicz, West, & Marrow, 2010). Both responses negatively impact the formation of interpersonal relationships, especially intimate relationships, and hinder social interaction. According to key informants, this means

that individuals are unable to connect emotionally with each other, and that the most intimate relationships, like those between parents and children and between spouses, have become merely transactional. According to a key informant,

> *"During the war, violence suppressed and repressed emotional expression. Depression and anxiety and resentment came out in sexual violence, child abuse…" He went on to say that, "Society is uncomfortable with feelings. They experience frustrations and helplessness because of things like the lack of employment. But everything is bottled up. They don't express these feelings."*

The significance of such emotional numbing is that it can form a basis for the intergenerational transmission of the effects of conflict. For example, the emotional unavailability of parents and caregivers results in the stunted emotional development of the young. As they reach adulthood, they are unable to be fully emotionally functional human beings (Somasundaram, 2007). Table 1 shows the levels of emotional disturbances among children.

The ecology in which these communities have lived has also impacted levels of community trust. According to key informants who were involved in social activism, both the LTTE and the military used members of the community in different capacities in their war strategies, and this inculcated a sense of distrust between neighbours and even family members. These key informants reported that this distrust is still prevalent among communities, which has led directly to the disintegration of the communal fabric. Thus, both the emotional numbing and the destruction of communal trust have led to the expression of a collective trauma, where not only the individual is psychologically traumatized, but where communal institutions become disintegrated, leading to the dysfunction of entire communities. One key informant explained the lack of trust as such:

> *"People have lost trust in each other. We have to reach out to the people who have lost trust…The lack of trust affected intimate relationships. Now what people have are sexual and social interactions…These are superficially led lives."*

Key informants, especially those involved in providing services, felt that the communal distrust experienced by these communities has a disproportional impact on certain sections of the community, particularly with ex-combatants and women . Ex-combatants during the war, aside from how and why they joined, enjoyed certain privileges. However, as communities adjust to life after conflict, they are viewed as being capable of violence and as being dangerous. Thus, they are often ostracised from communities, preventing them from fully integrating and participating socio-economically. As one key informant in a public sector administrative position pointed out, though they are given training as part of their rehabilitation process, many are not hired because they are not trusted. Many of these ex-combatants are youth and middle-aged individuals who are fully capable of engaging in productive livelihood generating activities. While there have been attempts to help such individuals start self-employment ventures, the majority of them failed, most likely due to the lack of stable social networks that would allow them to successfully engage in income generation. A key informant summarized the predicament of ex-combatants in the following manner, "People don't trust ex-combatants. They are seen as violent-prone. They are not given jobs. They are ostracized by society." While this is mostly true of former LTTE cadres, in Sinhala communities, as explained by focus group participants, former combatants—especially those involved in the Civil Defence Force—were seen as capable of harm, though not as pervasively as in the case of ex-LTTE cadres. During FGDs, many Sinhala ex-combatants were seen as being morally weak, as preying on young women and tempting women into clandestine relationships. One FGD participant said:

> *"The presence of military camps and having many of our communities join the CDF was detrimental to our communities. Many women fell into trouble because of them. Some parents sent their young girls away for protection during the conflict."*

*Table 1: Distribution of Patients with Psychological Distress in Sri Lanka by District and Type of Disorder, 2015**

Regional Director of Health Services (RDHS) Area	Population (000)	Psychiatrists	Alcohol related Disorders	Substance Abuse Related Disorders	Mood Disorders	Neurotic, Stress Somatoform Disorders	Behavioral and Emotional Disorders in Children
Western							
Colombo	2735	17	1033	403	3084	279	665
Gampaha	2348	4	1250	190	1665	219	531
Kalutara	1250	3	447	16	352	119	266
Central							
Kandy	1418	5	1082	28	2398	266	196
Matale	502	2	319	5	530	62	98
Nuwara Eliya	740	2	186	4	275	75	139
Southern							
Galle	1091	2	240	5	839	80	120
Matara	837	2	340	9	473	113	219
Hambantota	628	2	64	15	27	25	356
Northern							
Jaffna	**597**	**1**	**218**	**19**	**272**	**113**	**127**
Killinochchi	**120**	**0**	**118**	**56**	**99**	**17**	**44**
Mullaitivu	**104**	**1**	**10**	**1**	**71**	**6**	**50**
Vauniya	**179**	**1**	**38**	**5**	**223**	**72**	**46**
Mannar	**94**	**1**	**17**	**12**	**3**	**55**	**69**
Eastern							
Batticaloa	**541**	**0**	**377**	**11**	**106**	**96**	**135**
Ampara	**677**	**1**	**57**	**4**	**224**	**19**	**31**
Trinomalee	**397**	**1**	**47**	**16**	**202**	**224**	**94**

North Western							
Kurunegala	1658	4	707	55	1922	72	209
Puttlam	790	2	289	8	170	40	97
North Central							
Anuradhapura	893	0	166	29	858	158	498
Polonnaruwa	419	1	260	21	385	27	225
Uva							
Badulla	844	2	180	115	446	67	182
Moneragala	472	1	57	8	286	69	122
Sabaragamuwa							
Ratnapura	1127	3	398	35	279	44	125
Kegalle	861	1	341	19	315	80	33

Source: Data from Annual Health Bulletin, 2015

Fear and Generalized Anxiety

While the fear of living in a war zone is understandable, eight years or more after the war ended, communities are still on edge. Whereas a significant part of this fear is connected to the present social and political ground realities, part of it is also reflective of the long-term anxiety experienced during the protracted war. The general fight-or-flight reaction that human beings experience in situations of fear and anxiety—if experienced for a prolonged duration—becomes a 'normal' response to almost every experience. This is generally known as generalised anxiety, characterised by an unreasonable fear response to mundane stimuli. Findings from both the KIIs and FGDs describe such fear felt by communities, with vulnerable subgroups experiencing a heightened sense of generalised anxiety. Fear was often spoken of in relation to women. One key informant explained the fear that is felt by communities in saying:

> *"Women are especially fearful. They don't find it safe to go out at night. The continuous presence of the military is one reason." He also went on to say that, "...there are gangs operating in this area. Young men who have nothing to do are joining these gangs. Now this is also a main route for bringing in drugs."*

In addition, presence of the military was commonly cited as fear inducing factors experienced by women in the Northern Province. These fears were seen as disproportionately affecting war widows and women headed households. In general, patriarchal social norms present in these communities require that men serve as guardians and protectors for women. In the absence of such a figure, women are excluded from social spaces and from opportunities that are available to others which in turn perpetuate their suffering and deprivation. During FGDs conducted with women, fear was also reflected in more common place ways. For instance, in an FGD conducted with a group of women in a Sinhala village in the Eastern province, the fear of wild elephant attacks, and the fear of being harassed and attacked at night by certain men in the community was brought up. Their daily confrontations with fear were highlighted barriers to certain employment opportunities and why certain livelihoods were not viable options for these women. One FGD participant said:

> *"There are no lights on these streets. We can't walk alone on these streets after dark. Men can do something to us. It is not safe…The elephants are all over the place. Last afternoon when I was working in the kitchen, one had come very close to where I was. Luckily it didn't do anything. We told the authorities to build an elephant fence. They built one but it didn't last."*

Living in constant fear can often lead to a generalized anxiety that impacts the daily functioning of an individual. This is characterised by an unreasonable constant fear that is pervasive in every aspect of one's daily life, and a state of constant hyper-vigilance that leads to social and psychological dysfunction. Thus, while the fear of being attacked may reasonably keep a woman away from employment or a livelihood activity that makes her return home after dark, a woman suffering from generalized anxiety will also be anxious and fearful in more ordinary situations in their daily lives. For example, if being offered assistance to start up a home based self-employment venture, they may be prevented from expecting this support, due to unfounded anxieties and fears that they continuously experience. For example, Sheheen (1983) found that generalized anxiety disorder impacts the quality of life of individuals by affecting family and social functioning, global functioning, and most pertinent to our purposes—work functioning (Sheehan, 1983). Thus, suffering from generalized anxiety effectively prevents a person from engaging in productive forms of employment and livelihoods. Furthermore, fear does not only seem to be experienced at the individual level. Many discuss fear as being a collective experience—a fear psychosis that grips the whole community. Somasundaram (2013) believes that this communal and collective fear led to mass hysteria around the phenomenon of the 'grease butham'—a man believed to be covered in grease, who attacked women who were out or were lured out during the night. This phenomenon curtailed movement of the local population to great extent. While not a significant discourse at the present moment, the phenomenon is ingrained in the community psyche, with many key informants alluding to it while describing the social context of the region.

As evidence from the KIIs and FGDs point to, ex-combatants who live in these communities are also feared. Ex-combatants reportedly live in fear due to the heavy military presence in the area and the belief that they are constantly under

surveillance. Though ex-combatants have been rehabilitated, they are still closely monitored by the security forces due to the widespread belief that they still pose a threat to society. This may not only prevent these ex-combatants from maintaining normal social interactions, which serve as a protective factor against psychological distress, but it may also prevent their economic participation, as fear dissuades employers from hiring such individuals. A key informant explained the situation in the following manner:

> *"Though they have gone through rehabilitation, there is a belief in the community that they are being followed. We don't know. But people don't want to have anything to do with them. They can bring trouble. If they are being followed, if people get involved with them, they will also be checked."*

Alcohol Abuse and Addiction

The majority of key informants and participants in FGDs with women, flagged alcohol abuse and addiction as grave concerns in communities in the North and East. Most believed that the rates of alcohol consumption in these areas were much higher than in other parts of the country. Data provided by the 2015 Health Bulletin, published by the Ministry of Health, and based on an island-wide representative survey conducted by the Department of Census and Statistics, shows that this perception is not inaccurate.

Table 2: District-wise Rates of Alcohol Consumption and Availability in Sri Lanka, 2015

District	Percentage of Alcoholics[1] (% of cases detected in a public health screening)	Amount of Alcohol Consumed (litres)[3]	Amount of Alcohol Consumed per Person (litres)	Number of Outlets[2]	Number of Outlets by Population Served
Ampara	**12.34**	**5813854**	**8.5**	**43**	**15162**
Anuradhapura	8.69	8374387	9.3	92	9391
Badulla	10.21	9445210	11.2	127	6440
Batticaloa	**7.09**	**5208234**	**9.6**	**54**	**9777**
Colombo	6.55	31176055	13.1	597	3903
Galle	4.43	11353254	10.4	202	5277
Gampaha	7.78	24592132	10.4	407	5676
Hambantota	5.33	5998714	9.5	55	10946

Jaffna	**7.72**	**3420426**	**5.7**	**61**	**9590**
Kalutara	8.95	11120278	8.9	120	10208
Kandy	4.64	16340108	11.5	200	6905
Kegalle	0.25	5744495	6.6	87	9690
Killinochchi	**11.19**	**537911**	**4.5**	**12**	**9500**
Kurunegala	5.56	13188388	8	137	11854
Mannar	**9.72**	**1552670**	**16.5**	**11**	**9091**
Matale	3.41	6865796	13.7	94	5170
Matara	4.18	8559452	10.2	95	8600
Monaragala	9.05	4843251	10.2	64	7078
Mullaitivu	**10.88**	**Not available**	**---**	**Not available**	**---**
Nuwara Eliya	18.08	14658831	19.8	198	3611
Polonnaruwa	3.81	4031070	9.6	47	8681
Puttlam	6.96	6281828	7.9	89	8596
Ratnapura	9.12	11182624	9.9	108	10111
Trincomalee	**4.96**	**3339153**	**8.4**	**67**	**5686**
Vavuniya	**14.71**	**2548741**	**14.2**	**25**	**6920**
Average (Sri Lanka)	6.95	-----	10.3	---	

[1] *These statistics are derived from the Annual Health Bulletin, 2015. It shows the percentage of cases detected in a public health screening.*

[2] *Outlet statistics are derived from the Performance Report, 2015 of the Excise Department of Sri Lanka.*

[3] *Also derived from the Performance Report, 2015 of the Excise Department of Sri Lanka. Illicit alcohol amounts are not covered in this data.*

These statistics clearly show that the rates of consumption in areas surveyed for the current report were mostly higher than the national average. The screening also identified higher numbers of those exhibiting signs of alcoholism in these areas as compared to the national average. Different sections of these communities ascribe different reasons for the pervasive use of alcohol. Key informants who were involved in providing mental health services believe that this is a direct response to the experience of psychological trauma that is common amongst these populations. As one informant described:

> *"People have gone through terrible experiences. They want to numb the fear and the anger that they feel. So they drink. Drinking leads to other problems. Child abuse and incest are high in these communities. If you investigate why this happens, it is because people are drinking. Their morals are breaking down."*

The actual level of alcohol consumption in the affected areas may be considerably higher, as illicit alcohol consumption may not be adequately recorded in this data. For instance, outlets of illicit alcohol are not included in the data from official sources.

A significant body of research has shown that there is a high correlation between the experience of traumatic events and alcohol consumption (Volpicelli, Balaraman, Hahn, Wallace, & Bux, 1999). One of the explanations for this is that alcohol has endorphin boosting properties. Endorphins form a class of neurotransmitters that prevent the negative impacts of either emotional or physical pain. When an individual experiences a trauma, endorphins work to protect the individual, which leads to an endorphin depletion and withdrawal, reflected in symptoms such as depression, irritability and anxiety. Alcohol can remedy this. Once a habit is established, it becomes difficult for a person to function without alcohol, leading addiction. Therefore, given the constant trauma experienced by these communities, it is not surprising that such communities are also susceptible to higher levels of alcohol consumption (Volpicelli, Balaraman, Hahn, Wallace & Bux, 1999; Green, Beckham, Youssef, & Elbogen, 2014). Alcohol was also widely discussed as a form of self-medication for the physical pain that is suffered as a part of hard labour by key informants as well as focus group participants of both genders.

However, this does not explain why alcohol abuse is a phenomenon largely affecting the male population. Many key informants as well as focus groups participants talked of a well-established pattern of alcohol abuse among men, but women who drink were seen as an exception and an anomaly. This is further supported by data from Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm and Gmel, (2009) shown below in Table 3.

Table 3: Male to Female Ratios of Alcohol Consumption in Sri Lanka in 2009

Age group	Life time abstainers	Current drinkers	Former drinkers
18 - 34	0.31	7.46	0.59
35 - 49	0.17	8.55	0.50
50 - 65	0.18	10.61	0.61
Total	0.22	8.37	0.58

Source: Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm and Gmel, (2009)

One FGD participant summarized the gender dimension to alcohol use as such:

> *"Both men and women do the same work. When we finish, men go off to drink, women don't get a break. We have to come home and do the household work. We have to prepare their meals. If the meals are not ready when they get home, they will hit us. They say they drink because they are tired. Don't we feel tired?"*

This was a sentiment echoed by many female focus groups participants in different settings. For many men, consuming alcohol is also a social event that they partake in with their friends. Communal interaction is also an important source of support and a coping mechanism for women, as evidenced by the fact that in the majority of communities, women suggested that they were active in Women's Development Societies and other women's organizations. However, given the strong cultural taboo against women indulging in alcohol, these social interactions do not feature sharing alcohol. Therefore, the common denominator for both men and women in terms of coping, is communal support and interaction. In the case of men, alcohol is only auxiliary to the process, however it is misidentified as the key to the positive feelings that are felt after such a communal interaction. This is supported by a body of research looking at the social lubricant aspect of alcohol consumption (Fairbairn & Sayette, 2014).

In addition to this, other key informants, as well as focus group participants, suggested socio-cultural factors that perpetuate increased alcohol consumption and addiction. One key informant suggested that gender norms, together with the inclusion of alcohol in the most mundane of activities, also perpetuate abuse and addiction. According to him, alcohol is used as a mode of payment for fishermen and for other types of wage labourers:

> *"Alcohol is a common part of life here. If a mudalali (boat owner) wants to pay those working on his boat, he will ask them to come to the tavern. They are given the money there. So people will buy the alcohol, immediately. Even when people have to pay for those who work on their land, they use alcohol. If the amount is 1500 rupees, they will give 1000 rupees in cash and two cans of beer for the rest. The system is there to promote drinking."*

Many key informants, as well as FGD participants, suggested that the increased availability of alcohol—both legal and illegal— contributes to increased abuse and addiction. They explained that while under the LTTE, alcohol was tightly controlled. With the end of the war, more liquor licences were being issued, leading to increased availability. However, looking at Table 1, there does not appear to be a direct correlation between the number of outlets and the alcohol consumption rate. However, it is likely that this is due to the fact that the availability of moonshine (kassippu) and un-distilled toddy is not taken into account in this data, and that these types of alcohol account for most of what is consumed.

By all accounts, alcohol can lead to both individual and communal dysfunction. Several key informants suggested that alcohol addiction was generally connected to individual level dysfunction, such as the inability to hold down a job, the inability to have normal interpersonal interactions, and the disintegration of intimate relationships—especially the breakup of families. Additionally, alcohol abuse and addiction can take a heavy toll on the overall social fabric. As one key informant explained, alcohol abuse and addiction was generally a factor in the child abuse and child neglect cases that they have witnessed, as well as in domestic violence cases and other forms of aggression and violence. In an FGD with a group of women, respondents explained how it impacted the socio-economic wellbeing of the family:

> *"Ninety-nine percent of the men in this community drink. It is not possible to find a man who does not drink in our community. This is the reason for a lot of problems in our families."*

The female FGD participants explained how despite having done the same or a similar volume of work, men earn more. However, spending large amounts of this money on alcohol perpetuated poverty in their households. In their view, alcohol was also directly associated with domestic violence. Often, these women noted that they were assaulted for pointing out shortcomings in their households. Once their money was spent on alcohol, the women were required to handover any money that they had earned (usually half of what the men earned) to their husbands. This left the women feeling disempowered and frustrated.

Unfortunately, despite high rates of alcohol abuse and addiction, the number of facilities to provide services and treatment to affected individuals is extremely limited and sparse. According to the 2015 Health Bulletin, two hospital based alcohol rehabilitation units were available in the Northern Province, while one such centre was located in the Eastern province. In addition to these units, there are a handful of privately run units in the provinces. Two such organizations that provide specialized services in these two provinces are Alcoholics Anonymous, which provides specialized services for addicts and has a branch in Jaffna, and the Centre for Rehabilitation of Alcoholics and Drug Addicts (CRADA) in Mannar. Officials from the two organizations, as well as one activist, complained that with the presence of many NGOs and funding for the region dwindling or having being completely withdrawn, such institutions have found it difficult to sustain their activities. Key informants in the public health system also suggested that while the psychiatric units do have the know-how to handle addiction, they rarely have enough resources to dedicate themselves solely to addiction treatment and in-patient care. The NGOs also complained that they often find it extremely difficult to conduct prevention programs which are key to successfully dealing with increased rates of abuse and addiction due to financial constraints and the lack of enthusiasm and participation in communities.

While alcohol has been taking a firm grip in the Northern and Eastern provinces, service providers, as well as focus group participants and other key informants complained of the new challenge of substance abuse and addiction. They identified both familiar substances, such as heroin and *kerala ganja,* and newer substances—most of which are synthetic drugs that are being imported into the country. Many respondents suggested that this was an issue that affected youth in these communities. Key informants suggested that living in a repressive environment, where young people especially are viewed suspiciously by the authorities, and with extremely limited opportunities for employment, education and recreation, substance abuse was viewed as a coping mechanism, albeit an extremely harmful one. The introduction of drugs in the area was explained as such:

"There are drugs coming into this area. This is one of the main routes for Kerala ganja being brought into the country from India. Now there are also other drugs that are being imported. You can't even say that they are drugs. They look like sweets. There is one that you can keep under your tongue and it gives you a high. A lot of young people are getting caught up in the trend."

Suicide

As in the case of alcohol abuse and addiction, there was considerable consensus among both key informants, as well as FGD participants, that suicide is a key psychosocial concern among the populations in the Northern and Eastern provinces. Unfortunately, data on the actual numbers of suicides are not readily available for all districts under investigation. Therefore, it is difficult to fully examine these claims.

Table 4: Crude Suicide Rates in Sri Lanka, by District-1955 to 2011

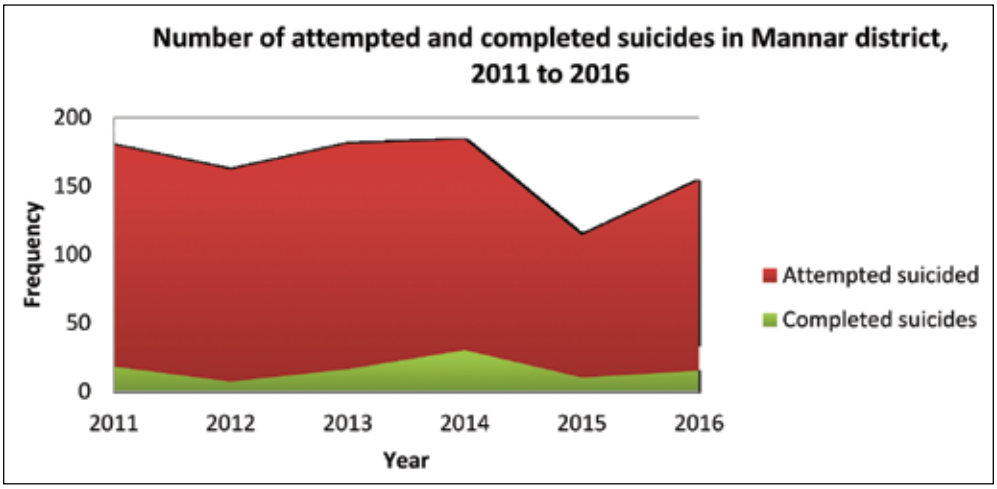
	Suicide rate per 100,000			
District	**1955**	**1972**	**1980**	**2011**
Ampara	**5.7**	**12.0**	**26.5**	**15.4**
Anuradhapura	3.8	24.4	48.4	24.2
Badulla	6.7	24.2	37.8	21.6
Batticaloa	**5.7**	**25.4**	**39.9**	**23.7**
Colombo	6.7	13.3	13.7	11.5
Galle	7.8	14.1	18.6	17.1
Gampaha	6.7	13.3	9.8	11.2
Hambantota	7.5	18.0	53.6	21.3
Jaffna	**13.1**	**32.9**	**27.4**	**24.5**
Kalutara	9.8	12.9	11.7	17.1
Kandy	5.1	23.9	25.8	15.6
Kegalle	4.9	19.9	23.0	12.5
Kilinochchi	**13.1**	**32.9**	**27.4**	**27.3**
Kurunegala	4.8	36.7	58.9	24.3
Mannar	**4.3**	**24.1**	**25.1**	**17.1**
Matale	11.0	29.2	36.2	23.3
Matara	2.7	9.8	23.0	21.0
Moneragala	6.7	19.0	28.4	25.7

Mullaitivu	**17.9**	**63.9**	**89.3**	**28.2**
Nuwara Eliya	7.0	24.3	44.3	17.0
Polonnaruwa	3.8	28.3	50.2	24.1
Puttalam	7.3	25.0	30.7	30.6
Ratnapura	8.9	21.3	24.0	22.6
Trincomalee	**8.7**	**18.3**	**21.6**	**16.3**
Vavuniya	**17.9**	**63.9**	**84.1**	**15.7**

Source: (Knipe, Padmanathan, Muthuwatta, Metcalfe, & Gunnell, 2017)

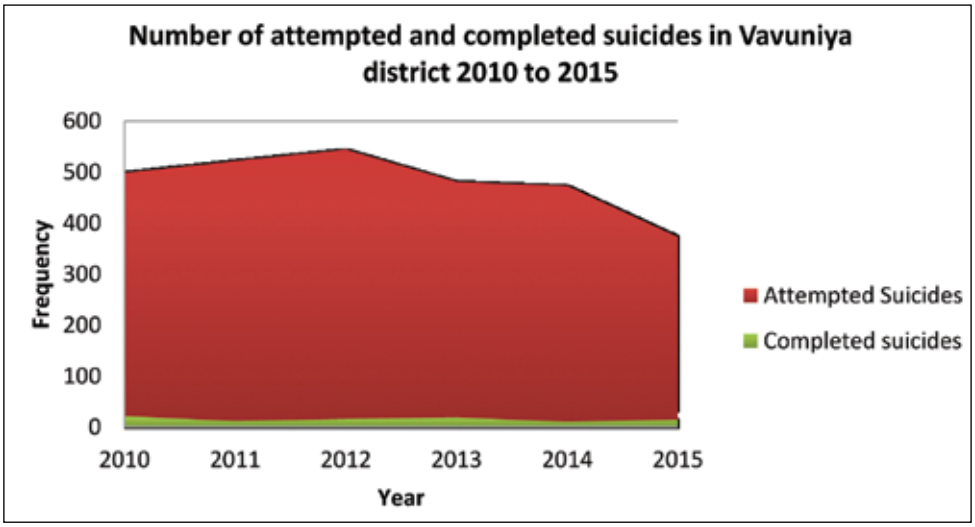
In 2011, the national suicide rate for Sri Lanka was 18.3 per 100000, suggesting that at least in the districts of Mullaitivu, Killinochchi, Jaffna and Batticaloa, the rate was significantly higher (see Table 4). Additionally, several medical mental health professionals who were interviewed have also substantiated these claims. Psychiatric clinics of the Mannar District Hospital report that the total numbers of suicides spiked around 2014, coinciding with the resettlement of communities (see Figure 2). Officials at the clinic suggested that this was linked to individuals' inability to cope with the stressors placed on them during the resettlement process. These stressors were often related to deficiencies in the provision of basic facilities such as livelihoods support, educational support, and others.

Figure 2: No. of Attempted Suicides and Deaths Resulting from Suicide in Mannar



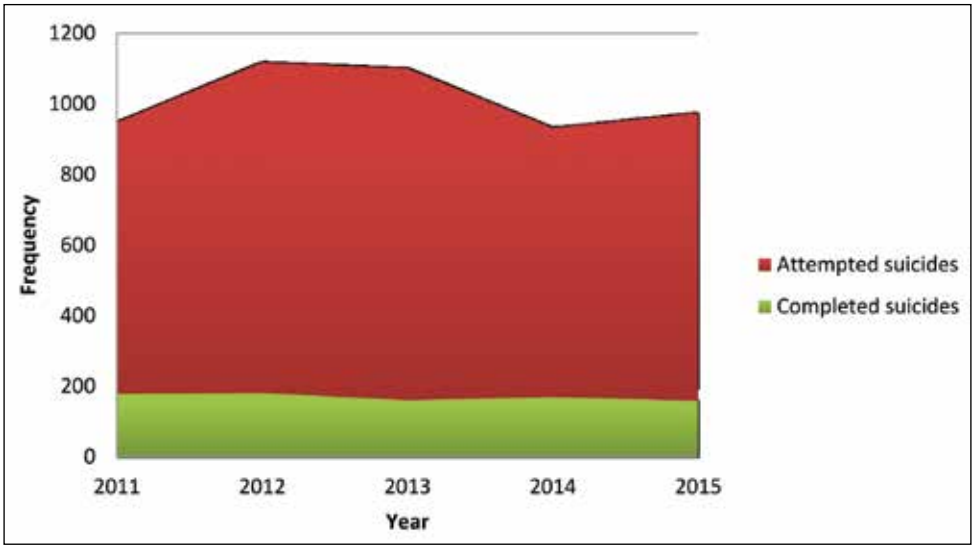
Source: Data provided by the Psychiatric Unit, Mannar Hospital

Figure 3: Number of Completed and Attempted Suicides in the Vavuniya District



Source: Data provided by General Hospital, Vavuniya

Figure 4: Number of Attempted and Completed Suicides in Jaffna District



Source: Data provided by the Jaffna Teaching Hospital

Many key informants who were involved in social welfare and mental health service provision identified depression—related to economic factors—as being instrumental in attempted suicides and deaths resulting from suicide (see Table 1 for the prevalence of mood disorders and other psychological disorders). The inability to engage in meaningful livelihoods and economic activity, as well as the repressive elements of the social environment (including constant fear and anxiety, harassment and hopelessness), were identified by key informants as risk factors for attempted suicides and completed suicides. The literature identifies three main factors that lead to suicide, namely burdensomeness—a feeling that one is a burden to those around them, as exemplified by their inability to fulfil their social roles; thwarted belongingness—an inability to form and maintain intimate relationships, and the acquired capability for suicide—a desensitization to fear and pain inducing stimuli, such as violent and aggressive stimuli (Bryan, Cukrowicz, West, & Marrow, 2010). One experience that was identified by FGD participants and key informants as a direct precedent for attempted suicide and suicides was being entrapped by debt. Numerous financial institutions, as well as some non-governmental institutions, operate microfinance schemes that specifically target women in these areas. Key informants as well as FGD participants said that these loans are given at extremely high interest rates, but with little paper work and no collateral. This is followed by aggressive collection strategies when women are not able to pay. Both key informants and FGD participants identified particular cases where women had committed suicide in the wake of the psychological distress that they experienced in relation to the inability to pay back microfinance loans. The burdensomeness that is experienced by these women for having entrapped their families and loved ones in such a situation cannot be underestimated. A key informant explained the situation in the following manner:

> *"Even today, there was a case of a woman who had committed suicide because she was indebted to a microfinance company. This is a scourge. She had written a letter and said that a land she owned could be sold and her debts can be settled. The companies also pursue extremely aggressive ways of collecting the debt. The debt collectors will come and stay at your doorstep. Often the husband doesn't know that the wife has got a loan. They will only find out when it becomes a problem. This causes many problems in the family, too."*

Though more women attempt suicide, there is a greater number of men who complete suicide relative to women, seeming to indicate that the burden in terms of fatality, was felt significantly more by men.

In youth group FGDs, men were more likely to express frustration around being unable to play the role of the provider for their families. For many, the frustration they felt at the inability to find suitable work, even if they had overcome difficult circumstances to complete their higher education, was significant. The associated burdensomeness could, given the right conditions, lead to suicidal thoughts. An FGD participant said:

> *"We had to go through much hardship to complete our education. We spent time and money and finished our degrees. We don't have any jobs. We are no different to someone who has no education. When parents want to discourage children they point to us. They say look at him, he studied and what good has it done him. People laugh at us. This will affect our prospects for marriage. Parents don't like to give their daughters to someone who doesn't have a job. They will say how can he look after a family. Parents think of their child's wellbeing."*

The emotional numbing that prevents individuals from forming intimate relationships and the existing disintegrated nature of relationships puts many in the community in danger of having feelings of thwarted belongingness. While as human beings, belongingness is a primary need that is experienced, the inability to form or to maintain intimate relationships, as in the case of a spouse leaving or the break-up of an intimate relationship, can result in suicidal thoughts and actions. As aforementioned, emotional numbing and the inability to express emotion has already created difficulties among communities in terms of forming intimate relationships. The collective trauma further exacerbates the disintegration of family and community ties leading to greater susceptibility of feelings of thwarted belongingness.

Thirdly, some key informants described the desensitization to violence and aggression that was experienced by many in their communities (Somasundaram & Sivayokan, 2013). Tarabah, Badr and Usta (2015) found that prolonged exposure

to violence led to greater levels of desensitization to violence. This desensitization to violence impacts the manner in which a person responds to such events (Bryan, Cukrowicz, West, & Marrow, 2010). The general response to witnessing violence is fear and dread. However, long-term exposure to such events creates a situation whereby these responses are diminished.

> *"The younger generation, today was born during the war. They heard the sounds of the shells when they were in their mother's wombs. When there is the smallest conflict they will first react in violent and aggressive ways. This is not a normal way of reacting."*

Therefore, with repeated exposure, situations that should generate responses of fear and dread fail to do so. Even under conditions of thwarted belongingness and feelings of burdensomeness, individuals may be deterred by the fear and the dread that they would feel when engaging in a painful act of self-harm. However, an individual desensitized to such fear and dread may have the ability to proceed with such behaviour. Given this understanding of suicide, clearly the war exposure that the communities suffered has the propensity to make them more susceptible to self-harm and suicide.

Impacts on Cognitive and Intellectual Development of Youth and Children

Thirty years of conflict created disruptions in the educational sector in the North and East. A vast majority of those who are served by these educational facilities are a generation that has already been traumatised by the experience of conflict. As one key informant explained, they belong to a 'lost generation' (see Table 1 for data on psychological distress among children). He believed that the continuous exposure to violence negatively impacted the cognitive, emotional, and intellectual development of this generation. There were no schools or other educational facilities to act as a buffer against this. This generation comprises today's youth in the Northern and Eastern provinces. Thus, while they battle with the psychological distress that results from exposure to war, many of them also have to contend with the inadequacy of their educational credentials and training, which make them unemployable in the formal sector. Similar findings have been seen elsewhere. For example, Leon (2012)

found that the development stage at which a child is exposed to war has specific outcomes for them. He also found that in his Peruvian sample, children exposed to war had 0.31 fewer years of education than others in their cohort. Given the value placed on formal sector employment with special emphasis on public sector jobs, the frustration of being unable to secure a 'good job' or any job at all can potentially make these youth more vulnerable to anti-social activities and other negative behaviours.

Almost a decade after the war ended, perceptions of the paucity of educational infrastructure still remain amongst the community. A lack of educational infrastructure and support services that facilitate a sound education are key deficiencies identified in a majority of the FGDs and KIIs that were conducted. The impacts of poor educational opportunities are felt very early on in children's lives. This is substantiated by data that show that a large proportion of schools in the Northern and Eastern Provinces score very low on congeniality (the congeniality score looks at infrastructure and facilities available in a school that make the school atmosphere suitable for learning). The Ministry of Education in 2007 found that 47.8% of schools in the Northern Province and 36.9% of schools in the Eastern Province were very uncongenial (MOE, 2015). In addition to the lack of infrastructure, the lack of oversight is also seen as a problem. As one Early Childhood Development Officer pointed out, the Montessori and Preschools that are operated in her area are not regulated in any discernible manner, and therefore there is no quality assurance of the services provided. In her view, since some early skills that need to be developed are not facilitated in these settings, students are unprepared and have no basis to learn the skills that are imparted in the primary school setting. She was especially critical of private institutions, which did not come under any form of supervision.

While quality assurance appears to be the main concern with regard to pre-school education, many focus group participants voiced concerns about primary and secondary school education. Key among these concerns is the inability to retain teachers in both primary and secondary educational settings, and the lack of resources to maintain instruction for older students. An FGD participant explained the situation in the following way:

> *"The village school does not have A/L (final standardized examination in the Sri Lankan public school system that serves as the basis for university selections) classes. So if you want to do your A/Ls, you have to go to town. Those who can afford it go to the city and get boarded or rent a house and send their children to school. The roads are not good here and the buses don't run frequently. The children can't depend on this transport to get to school in the town everyday. We can't even send them for tuition in the town. If they go, it gets very late for the children to come home. We have to go and get them. Otherwise it wouldn't be safe."*

Another FGD participant lamented:

> *"The teachers who come to these schools don't want to stay. They want to leave as soon as possible. When we were young we couldn't study because we didn't have money. Now our children are also in the same situation."*

Certainly, the data shows that the provinces under consideration are at a disadvantage in terms of graduate teachers. The graduate teacher to student ratio is much higher in these areas than in other comparable provinces (except in Jaffna), and these ratios are also higher than the national average (see Table 4 for the availability of teachers). The shortfall in graduate teachers is satisfied using higher numbers of trained and volunteer teachers. Many focus group participants lamented that in a number of cases, the local schools do not offer a complete secondary education. They say that many schools only run classes up to the sixth grade, eighth or a maximum of the ordinary level. Once students reach this stage, they are required to attend schools in the main cities. However, with poor infrastructure, including roads and bus services, it becomes impossible for students to travel from home. While a few who can afford to move to the cities do so, others are left with no option other than to end their education. Statistics from the Ministry of Education, however, paint a different picture. The districts under consideration appear to have a comparable number of 1AB schools,[4] which run from year 1 to A/Ls in the science stream. While the student to school ratio is fairly high in the Eastern province, the situation in the Northern

[4] Schools in Sri Lanka are categorized as 1AB, 1C, Type 2 and Type 3, national schools. In terms of facilities and opportunities, national schools and 1AB category schools are considered the best. These are generally concentrated in urban areas.

province remains more equitable. When considering figures at the national level, the Northern and Eastern provinces fare better than the national average (see Table 5). Perhaps the perceptions of the lack of educational facilities and good schools come from the fact that there is a spatial disparity in the manner in which these schools are distributed within the districts, with the 1AB, 1C and national schools being located around urban centers. It may also be the case that while these schools are listed as 1AB, 1C and national schools, the facilities they provide may not be comparable to schools in other districts.

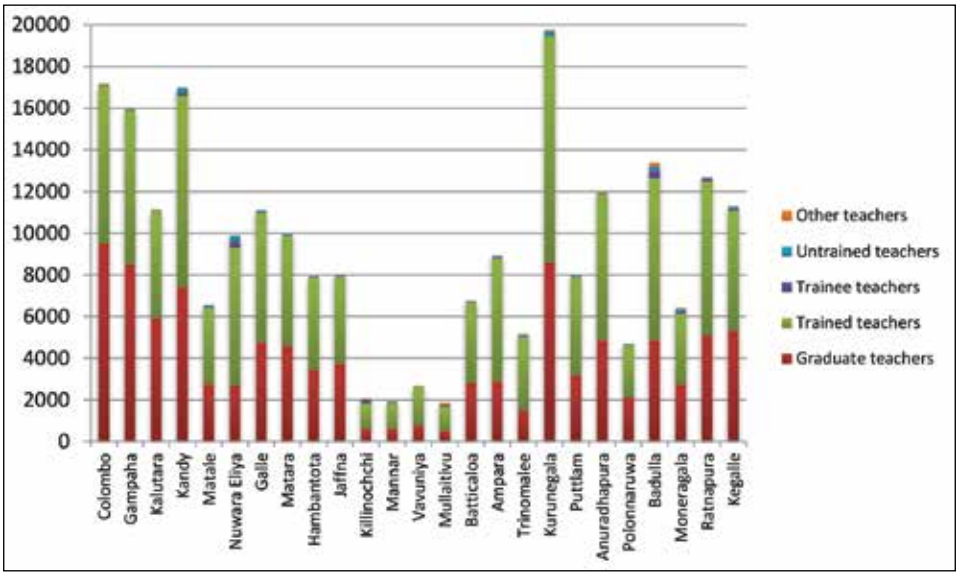
Given the discouraging educational settings, many also point out that drop out rates—especially among male students—are high. The Child Activity Survey 2016 found that the Eastern Province had the highest rate of children not attending school, which was 10.9% of children in the province. Additionally, KIs and FGD participants also pointed to the lack of career guidance in schools. Hence, even when they drop out, they are unable to forge a productive career path ahead. Many young men will leave school to work as unskilled labourers in various settings, while female students may either get married at an early age or find employment in the garment factories. In explaining this phenomenon, many key informants described a situation of fatalistic thinking and learned helplessness, whereby years of neglect make young people believe that they are incapable of achieving anything greater, even when they are provided with opportunities to do so. For example, in a KII with the manager of a technical college, he explained how difficult it was to maintain student numbers for courses. He said:

> *"We provide all the courses free of charge. The girls come. The boys don't. They finish their O/Ls and go to work for the Prima factory. They don't even wait for the results. No one in the schools tells them what they can do. They don't want to have a career, to get training. They only want to earn money, no matter how. We have done some programmes in the schools in this area, but still the numbers are low."*

He describes a situation where students drop out early from school once they sit for their ordinary level examinations, and then set very low standards for themselves regarding what they can achieve. Therefore, even when they hear of courses offered by the technical college or other such institutions free of charge they see no use

for them. This is exacerbated by the fact that many come from families where the parents may not have very much education themselves, and are therefore unable to advise their children on how to choose a career path.

Figure 5: Numbers of teachers as derived from the Preliminary Report of the School Census 2016.



Source: Data from the School Census Preliminary Findings Report, 2016

Table 5: Number of Teachers in Sri Lanka in 2016 by District (Teacher to Student Ratio within Brackets)

District	Students	Graduate Teachers	Trained Teachers	Trainee Teachers	Untrained Teachers	Other Teachers	Total
Colombo	379840	9517 (39.9)	7550 (50)	23	72	28	17190 (22.1)
Gampaha	361008	8491 (42.5)	7410 (48.7)	6	95	25	16027 (22.5)
Kalutara	227984	5923 (38.5)	5136 (44.4)	21	31	33	11144 (20.4)
Kandy	279180	7392 (37.8)	9216 (30.3)	125	258	9	17000 (16.4)
Matale	101367	2727 (37.1)	3686 (27.5)	48	96	8	6565 (15.4)
Nuwara Eliya	163661	2722 (60.1)	6587 (24.8)	323	261	11	9904 (16.5)

Galle	223303	4743 (47.1)	6236 (35.9)	33	96	1	11109 (20.1)
Matara	166941	4588 (36.4)	5281 (31.6)	48	46	12	9975 (16.7)
Hambantota	136026	3460 (39.3)	4405 (30.9)	28	43	7	7943 (17.1)
Jaffna	**118139**	**3749 (31.5)**	**4187 (28.2)**	**32**	**53**	**16**	**8037 (14.7)**
Killinochchi	**32741**	**607 (53.9)**	**1207 (27.1)**	**221**	**5**	**4**	**2044 (16.0)**
Mannar	**26890**	**569 (47.2)**	**1279 (21.0)**	**35**	**50**	**9**	**1942 (13.8)**
Vavuniya	**37081**	**755 (49.1)**	**1826 (20.3)**	**4**	**34**	**62**	**2681 (13.8)**
Mullaitivu	**28463**	**503 (57.2)**	**1162 (24.5)**	**92**	**17**	**81**	**1855 (15.3)**
Batticaloa	**131887**	**2817 (46.8)**	**3835 (34.4)**	**15**	**79**	**4**	**6750 (19.5)**
Ampara	**162381**	**2883 (56.3)**	**5913 (27.7)**	**32**	**92**	**22**	**8942 (18.2)**
Trinomalee	**99812**	**1492 (66.9)**	**3523 (28.3)**	**24**	**96**	**27**	**5162 (19.3)**
Kurunegala	336609	8614 (39.0)	10846 (31.0)	35	253	16	19764 (17.0)
Puttlam	168011	3184 (34.7)	4718 (35.6)	22	101	16	8041 (20.9)
Anuradhapura	198961	4841 (41.1)	7021 (28.3)	29	61	52	12004 (16.6)
Polonnaruwa	87963	2130 (41.3)	2487 (35.3)	27	47	4	4695 (18.7)
Badulla	185901	4832 (38.4)	7820 (23.8)	343	229	168	13392 (13.9)
Moneragala	102522	2730 (37.5)	3399 (30.2)	100	141	39	6409 ((15.9)
Ratnapura	218613	5113 (42.8)	7383 (29.6)	121	65	3	12685 (17.2)
Kegalle	168046	5342 (31.4)	5744 (29.2)	100	105	4	11295 (14.9)
Sri Lanka	4143330	99724 (42)	127857 (32)	1887	2426	661	232555 (18)

Source: Data from the School Census Preliminary Findings Report, 2016

Table 6: Number of Schools in Sri Lanka by District (School to Student Ratio Within Brackets) from the School Census, 2016

District	Students	1AB	1C	Type 2	Type 3	National Schools
Colombo	379840	80 (4748)	77 (4933)	140 (2713)	108 (3517)	37 (10266)
Gampaha	361008	69 (5232)	103 (3505)	184 (1962)	180 (2006)	17 (21236)
Kalutara	227984	50 (4560)	66 (3454)	162 (1407)	141 (1616)	18 (12665)
Kandy	279180	60 (4653)	161 (1734)	216 (1292)	213 (1310)	35 (7977)
Matale	101367	20 (5068)	66 (1536)	101 (1003)	136 (745)	12 (8447)
Nuwara Eliya	163661	35 (4676)	89 (1838)	150 (1091)	274 (597)	7 (23380)
Galle	223303	67 (3333)	70 (3190)	111 (2011)	183 (1220)	28 (7975)
Matara	166941	45 (3709)	72 (2319)	127 (1314)	119 (1402)	22 (7588)
Hambantota	136026	38 (3579)	66 (2061)	127 (1071)	89 (1528)	16 (8502)
Jaffna	**118139**	**50 (2362)**	**42 (2813)**	**149 (793)**	**198 (597)**	**7 (16877)**
Killinochchi	**32741**	**12 (2728)**	**14 (2339)**	**37 (885)**	**41 (799)**	**2 (16370)**
Mannar	**26890**	**16 (1680)**	**21 (1280)**	**31 (867)**	**65 (414)**	**5 (5378)**
Vavuniya	**37081**	**12 (3090)**	**22 (1686)**	**45 (824)**	**93 (398)**	**5 (7416)**
Mullaitivu	**28463**	**14 (2033)**	**10 (2846)**	**40 (712)**	**59 (482)**	**3 (9488)**
Batticaloa	**131887**	**34 (3879)**	**54 (2442)**	**105 (1256)**	**164 (804)**	**10 (13188)**
Ampara	**162381**	**35 (4639)**	**68 (2387)**	**148 (1097)**	**186 (873)**	**11 (14762)**
Trinomalee	**99812**	**25 (3992)**	**59 (1691)**	**98 (1018)**	**130 (768)**	**9 (11090)**
Kurunegala	336609	72 (4675)	186 (1809)	302 (1114)	330 (1020)	28 (12021)
Puttlam	168011	35 (4800)	69 (2435)	158 (1063)	107 (1570)	7 (24002)
Anuradhapura	198961	37 (5377)	97 (2051)	173 (1150)	250 (795)	6 (33160)
Polonnaruwa	87963	24 (3665)	33 (2665)	58 (1517)	133 (661)	4 (21991)
Badulla	185901	48 (3872)	131 (1420)	192 (968)	230 (808)	27 (6885)
Moneragala	102522	35 (2929)	46 (2229)	119 (862)	94 (1091)	9 (11391)
Ratnapura	218613	55 (3974)	90 (2429)	250 (874)	206 (1061)	14 (15615)
Kegalle	168046	48 (3500)	93 (1806)	185 (908)	204 (824)	14 (12003)
	4143330	1016 (4078)	1805 (2295)	3408 (1216)	3933 (1053)	353 (11737)

State of the Mental Health Sector

While the health sector in general seems to have improved, the provision of mental health services still seems to lag behind (Sritharan and Sritharan, 2014). As one key informant explained, the system is plagued by shortages of staff, with hospitals in the North and East being unable to retain doctors—especially those from the South (see Table 1 for the availability of psychiatrists). Further, there is reportedly a lack

of coordination between the different service providers and a general deficiency in resources allocated to mental health within the health sector. According to the Sri Lanka National Health Accounts Report 2013, 3.2% of the Current Health Expenditure (CHE) is spent on mental health. This is in comparison to 35.2 % of the CHE which is spent on non-communicable diseases, 9.8% on reproductive health and 4.8% on cardiovascular diseases. A medical professional explained this situation:

> *"Southern doctors don't come here. If they come it is only for a 2-year training period. Once it is over they leave. They are not committed to the work that they do… People get burnt out, people leave the first chance they get."*

Other consultant psychiatrists who were interviewed as part of this assessment, reiterated this description. In addition to what is provided in the hospitals, the Sri Lankan government has ensured that mental health services are provided through counsellors affiliated with the Ministry of Women and Child Affairs and the Ministry of Social Empowerment, Welfare and Kandyan Heritage, who are stationed at each Divisional Secretariat Office. These ministries also have other officers, such as the Women's Development Officers, Child Protection Officers, Early Childhood Development Officers, Social Services Officers, and others. While this format is followed to a great degree in most parts of Southern Sri Lanka, during visits to Divisional and District Secretariats, it was found that many of these positions were vacant in numerous DS divisions in the Northern and Eastern provinces. This was especially true of the counsellor position. Key informants in these offices said that in places where a counsellor was not available, one of the other officers would often step in to fill the void.

Additionally, informants indicated that policies regarding services offered by these officers are formulated in the ministries and then communicated to them. These programs are formulated for the country as a whole, and therefore the special circumstances of the North and East are not taken into account. Thus, while programs are regularly conducted, informants believed that they have limited effectiveness. Furthermore, officers lament that despite the formulation of programs, they have limited funds to conduct them. They also noted that while they attempt

to make community visits, the remoteness of certain areas and the unavailability of community members during office hours pose significant problems. In areas that are multilingual, language also serves as a barrier to successful service provision. These concerns were expressed by all social welfare service providers interviewed in the District and the Divisional Secretariats. An Early Childhood Development Officer noted:

> *"We get our programs and funds from the ministry. I haven't done any programs yet this year, because I haven't got any funds. I have heard that the funds will be given soon. But I don't know. We really don't get any funds from the District Secretariat, though we are in this office. We only give our progress to them once a month."*

Another Women's Development Officer explained difficulties with language:

> *"There is only one counsellor in this district. There is no one in this office. So I have to play the role of counsellor as well. I can mange with Tamil but I can't really provide counselling in Tamil. I try to manage with the other officers here who speak Tamil but the clients don't really get a good service."*

Similarly, a medical professional also alluded to the language barrier in service provision:

> *"Finally, we have a Tamil speaking consultant psychiatrist. He only comes two days a week, but at least he is Tamil speaking. Psychiatry is about talking to people. Before, we would have to have a medical officer translate what the patients were saying and then translate to the patient what the psychiatrist was saying. There was no feeling in that exchange. Now patients can talk directly to the doctor. That is better for the patient."*

Additionally, those who were attached to the DS offices also spoke about the deficiencies in resources that prevented them from providing satisfactory services to their clients. One of them summarised the situation in the following manner:

> *"We have no dedicated space to speak to the people who come to see us. People come to talk about very private things. We cannot provide the*

privacy they require. They have to sit at our table and talk. There are other people all around them."

The lack of coordination among these different entities was also expressed as a significant concern. These concerns were expressed by almost all of the social welfare service providers at Divisional Secretariats and were also echoed by health professional who were interviewed. For example, despite the officers being located in the District Secretariats and Divisional Secretariats, their programs run independent of these entities. This was also said to sometimes lead to the replication of activities. Additionally, while case conferences are held in many of the districts in the North and East, it was noted that little coordination takes place outside of these meetings. Some KIs advocate for a format that creates mental health teams in the hospitals, which can provide comprehensive mental health services to the community. As one Women's Development Officer pointed out:

"Though we are in the same office, our programs come from the ministry. Sometimes the district secretariat staff do programs with women and I don't know. I am going to the same communities and doing the same programs. This is not really useful. We could get better results by coordinating."

While for several decades, various community-based organizations have also played a significant role in providing mental health services, these have dwindled over the years due to the withdrawal of funding. With many of the NGOs and INGOs withdrawing from the region immediately after the end of war, programs they had funded became unsustainable. Thus, while there is a dire need for mental health services, especially given the experiences of the communities, the weaknesses in mental health service provision likely prevent them from receiving adequate help.

Psychological Resilience and Growth

While the more pervasive story in the Northern and Eastern province is that of psychosocial distress, our interactions with communities also allowed for the identification of resilience and psychological growth in certain individuals. While this was not as common as distress, it is nonetheless important to acknowledge these instances, as they may provide insight into how resilience and psychological

growth can be facilitated in other sections of the communities in the North and East. Therefore, this brief section will focus on summarizing some such cases.

The Emergence of 'Different' Leaders

The correlation between caste and social class with regard to leadership has traditionally been quite stark, especially in the Tamil communities of the North and East (Pfaffenberger, 1990). The social upheaval experienced during the war, as well as the social space provided by the end of the war for more formal leadership roles, have enabled members of groups that were traditionally excluded from such positions to step up to claim these opportunities (Somasundaram, 2003; Somasundaram and Sivayokan, 2013)

Many newly resettled communities have 'leaders' who are not formally appointed by any entity, but work to represent the interests of their communities. In one such community, we met an individual who was willing to take this mandate to the next level. Hailing from the traditionally depressed 'Karaiyar,' or fisher caste, this particular individual had no previous exposure to leadership until he was subject to displacement. Being brought to the fore as the leader of the displacement camp, he sees himself as a force that challenges the perceived political hegemony of the 'higher' castes that are believed to disregard the concerns of the depressed castes. He describes the challenges faced by the depressed castes in the following way:

> *"We are traditionally fisher people. That is what we want to do. When we were provided houses in this location, the military also opened up the fisheries harbour for our use. But the kovil [Hindu temple] prevented us from engaging in our trade, saying that the path to the fisheries harbour falls through the sacred lands. They said because we were of a depressed caste we could not trespass through this land. But this is our right. We are only asking to engage in our livelihoods."*

As described by other key informants, depressed castes are thought to often suffer exclusion in education, in job opportunities, and even in places of worship. Therefore, this type of leadership may prove quite significant. He expressed plans to run for local government elections and is in the process of building alliances, some

of which are quite unorthodox. For example, he spoke positively of the relationship his community has built with the military. He explained this relationship as thus:

> *"They built these houses for us. These are really well planned houses. They even did an attached bathroom for us. They told us, we destroyed your houses and we are building them back for you. We have to appreciate this. We have a really good relationship with the military."*

He also explained that rather than contesting through a traditional Northern Tamil political party, his affiliation was with a Southern Sinhala dominated political party. While this type of leadership is causing some tensions, such leaders are opening up opportunities for underrepresented and less powerful groups to have their voices heard. The fact that this individual has emerged as a leader, in spite of the difficult circumstances associated with displacement and caste discrimination, suggests resilience and psychological growth on his part.

While this resilience and growth results from different factors, one key informant identified religiosity and spirituality as being key. Physically disabled, due to being hit by a shell, he describes how he became suicidal:

> *"I had returned from abroad and the war was going on here. A shell hit me. No one knew whether I was going to survive. I couldn't work, which meant that I couldn't support my family. My children were small. My wife became the head of our household. I tried to commit suicide. My wife saved me. She convinced me that we would get through this difficult time. That I was not a burden. I feel God saved me because I have to give more to my community. Now I help my wife in any way I can. I can talk in English, so I can take our story to society."*

His faith is clearly visible in this statement. Additionally, his wife's ability to connect with him during a very low point, and the role it played in his survival, also needs to be acknowledged. It again underscores the importance of strengthening families and social interactions in these communities. It also shows the importance of providing space for religious and spiritual practices, and of increasing inclusivity for all sections of communities in religious organizations. This individual serves as

a liaison between his community and the outside world. He serves as a translator to the many visitors to his community, while advocating for improved living standards and opportunities for his community.

Propensities for Empathy

There is little doubt that ethnic tensions exist in many places in the North and East. However, in many communities that were visited, it was found that people had a more nuanced understanding of the conflict than is generally portrayed by the media and other groups. They showed a significant capability to empathize with members of other ethnic groups. In an FGD conducted in a Sinhala community, respondents spoke of the dangers posed by elephants and the need to build an electric fence:

> *"We said build an elephant fence that went around both our village and the Muslim village. Elephants don't differentiate between Muslims and Sinhalese when they attack. Recently two Muslim men were attacked. They didn't listen."*

Similarly, in a village that was protesting the perceived unequal distribution of water, they explained:

> *"We don't want to keep the water all to ourselves. We know there are poor communities down stream who suffer just like us. We are saying, don't favour one group. Distribute the water between all communities equally."*

This was despite the fact that they had drinking water that would last only for a few days. What is clearly visible is that despite tensions, these communities, perhaps because of the shared experiences of hardship, are able to empathize with others and speak of the need for social justice in how the 'other' is treated. Given the necessity for reconciliation, this empathy can be galvanized to encourage conflict transformation and a just peace.

Conclusion

This assessment found that there are significant numbers of individuals still suffering with psychological distress and disorders, but the environment has not adjusted to provide them with successful treatment that would enable them to be fully reintegrated into society. Significant among these forms of psychological distress and disorders are PTSD, depression, and anxiety. In many communities, emotional disturbances were witnessed which prevent individuals from forming strong attachments. This has immediate repercussions for present day social interactions that can then manifest into behavioral problems and difficulties with interpersonal relationships further down the line. . Early research by Bowlby (1982), and the more recent works of Pesonen, Raikkonen, Heinonen, Kajantie, Forsen and Eriksson (2007) show that disruptions in childhood attachment often impact adult interpersonal relationships. Therefore, if not remedied, the consequences will be witnessed with the next generation. Furthermore, suicide, alcohol abuse, and addiction also emerged as significant concerns, and many pointed to the new threat of substance abuse that is particularly affecting the youth. These issues can often times be traced to the dysfunction that is often witnessed in communities in the North and East. Additionally, inadequate facilities for education and training also hinder the normal cognitive, intellectual and emotional development of children. The assessment also found that despite a dire need, the provision of mental health services is inadequate. While there is widespread psychosocial distress, there are also cases of resilience and psychological growth that have emerged.

Recommendations

Given the findings of this assessment of the Northern and Eastern provinces, we have attempted to formulate recommendations for how the situation can be improved.

We recommend that the discourse about the use of alcohol be removed from the moral realm, and that the stigma around drinking is diminished among those working to remedy the situation. In this way, individuals who are addicted will be more willing to seek help.

Also, rather than advocating for a zero tolerance approach to alcohol, it maybe more beneficial to advocate for a harm reduction approach. Unlike an abstinence perspective, which focuses on the complete avoidance of alcohol, the harm reduction model teaches users how to use alcohol in a manner which does not negatively impact them or those around them.

While prevention and awareness programs are important, they need to be supported by pharmacological and medical interventions where necessary. Therefore, it is important to support the establishment of residential care services for addicts; these services should be available through existing public health services, as well as through entities that are more community based. In both cases, it is imperative that the long term sustainability of these facilities are seriously considered during their development.

It is also recommended that authorities take steps to reduce the availability of alcohol, namely by prosecuting those who engage in the trade of illicit liquor. During our interviews and focus groups, it was clear that many communities question the role played by the police in prosecuting those involved in the trade of illicit liquor. They believe that this trade has thrived either due to the patronage of authorities or because the authorities are inefficient. Thus, steps may need to be taken to ensure that the authorities function within their mandates to prevent or block the trade of illicit liquor, or more simply to highlight their existing efforts.

It is recommended that programs target skills development in areas such as financial management, especially through grassroots organizations (including women's development societies). These can especially help women to avoid conditions such as debt traps, that often lead to stress and depression. Hansen (2015) found that women who were provided with training in managing their finances had better outcomes in terms of empowerment when they received microcredit. Additionally, some form of monitoring for financial institutions is also required to prevent the potentially negative impacts of micro-financing.

Historically, counselling services were introduced as a stop-gap measure, without real consideration for the skills and training that would normally be required by a professional counsellor. At present, recruitment into the rank of counsellor hinges

on a one-year diploma. This is wholly inadequate in terms of preparation for the job that needs to be done. Therefore, it is recommended that the manner in which counselling services are perceived is revisited and revamped. This should be both in the government sector as well as within community based organizations that provide mental health services. One step that can be taken to improve the level of professionalism in this sector is to provide additional higher education opportunities within Sri Lanka or abroad for these officers.

To support these services, various community members could also be trained to provide services like psychological first aid and befriending. While this is not the same as counselling, it has been found that if psychological first aid and befriending are provided in the initial stages of a psychological crisis, individuals exhibit much better outcomes (Uhernik & Husson, 2009).

In addition, it is also important that the National Mental Health Policy takes a disaggregated approach, taking into account the unique circumstances of the Northern and Eastern provinces. Thus, a bottom up approach, which allows feedback and input from the ground level to be taken into account, needs to be adopted by the ministries when formulating policies.

The government can also ensure better service provision by filling existing cadre positions, such as counsellors in the divisional secretariats and consultant psychiatrists in the hospitals etc. with those from this region, especially given the high levels of unemployment among graduates in the area. Incentives can also be offered to ensure that new hires remain in these positions. The Jaffna University, the Eastern University and the South Eastern University should also be encouraged to provide quality training to their graduates in mental health service provision, in collaboration with other Sri Lankan Universities, which may have more expertise.

It is also recommended that mechanisms are put in place whereby mental health teams that include psychiatrists, medical officers of mental health, clinical psychologists, counselors, psychiatric nurses, social workers, and others work together. This would increase the efficiency of mental health service provision by reducing the replication of programmes, promoting the effective use of funds, and by distributing cases more appropriately among the different levels of service provision. A discussion about

the formulation of these teams should be instituted with groups that include all stakeholders, in order to minimize professional conflicts.

Concerns regarding education need to be rectified, as they will have long-term impacts on the coming generations in this region. Part of this effort needs to address career guidance counselling, in order to ensure that guidance is provided to youth with regard to which careers are viable and how one prepares him or herself for these careers.

While counselling has been a more recent development, communities have for centuries practiced rituals—religious or otherwise—that have promoted resilience. For example, 'thukkukkuavadi,' a type of devotional dance, is seen as providing psychologically therapeutic benefits—not only because it fulfils individual needs for belongingness (due to its communal nature)—but also because it is cathartic for reactions to the repression felt by individuals (Derges, 2013). Thus, space needs to be provided for these practices. For example, grieving processes allow communities to express the grief surrounding death and find closure. Therefore, space needs to be open for such practices that will no doubt benefit the psychosocial wellbeing of these communities. Additionally, activities that allow for congregation and assembly with a view to increase building lost social networks should also be encouraged. For many years, assembly in these provinces has been discouraged due to security reasons. However, given that many of these communities are inherently 'accidental' communities (they have come together due to resettlement programmes), mechanisms need to be put into place in order to foster social networks that will serve as protective factors in these communities.

However, in order to ensure that some of the most vulnerable groups in these communities receive the services they require, additional research and more specifically needs assessments need to be conducted with each of these groups. For example, the needs of ex-combatants in these communities need to be better understood in order to make sure that they receive tailor made programs and interventions that will enable them to reintegrate in to society.

Bibliography

Bowlby, J. 1982. 'Attachment and Loss: Retrospect and Prospect.' *American journal of Orthopsychiatry*, *52*(4), 664.

Bryan, C. T., Cukrowicz, K. C., West, C. L., and Marrow, C. E. 2010. Emotional responses to trauma. *Journal of Clinical Psychology , 66* (10), 1044-1956.

Derges, J. 2013. *Rituals and Recovery in Post Conflict Sri Lanka*. London: Routledge.

Excise Department. 2015. *Performance Report*. Colombo, Sri Lanka.

Fairbairn, C. E., & Sayette, M. A. 2014. A social-attributional analysis of alcohol response. *Psychological bulletin*, *140*(5), 1361.

Knipe, D. W., Padmanathan, P., Muthuwatta, L., Metcalfe, C., and Gunnell, D. 2017. 'Regional Variations in Suicide Rates in Sri Lanka Between 1955 and 2011: A Spatial and Temporal Analysis.' *BMC Public Health, 17* (193), 1-14.

Lifton, R. J. 1967. *Life in Death: Survivors of Hiroshima*. New York: Random House.

Ministry of Education. 2007. Survival Report 2007. Sri Lanka

Ministry of Education. 2016. Child Activity Survey 2016. Sri Lanka.

Ministry of Education. 2016. *School Census, 2016 - Preliminary Findings*. Sri Lanka.

Ministry of Health and Indigenous Medicine. 2013. Sri Lanka National Health Accounts 2013. Sri Lanka

Ministry of Health and Indigineous Medicine. 2015. *Annual Health Bulletin, 2015*. Sri Lanka.

Hansen, N. 2015. 'The Development of Psychological Capacity for Action: The Empowering Effect of a Microfinance Program on Women in Sri Lanka.' *Journal of Social Issues*, *71*(3), 597-613.

Pesonen, A. K., Räikkönen, K., Heinonen, K., Kajantie, E., Forsén, T., and Eriksson, J. G. 2007. 'Depressive Symptoms in Adults Separated from their Parents as Children: A Natural Experiment During World War II.' *American Journal of Epidemiology*, *166*(10), 1126-1133.

Pfaffenberger, B. (1990). The political construction of defensive nationalism: the 1968 temple-entry crisis in northern Sri Lanka. *The Journal of Asian Studies*, *49*(1), 78-96.

Sheehan, D. V. 1983. *The Anxiety Disease*. New York: Charles Scribner's Sons.

Somasundaram, D. (2003). Collective trauma in Sri Lanka. Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict, 1(1), 1-11.

Somasundaram, D. 2007. Collective trauma in northern Sri Lanka: a qualitative psychosocial-ecological study. *International journal of mental health systems*, *1*(1), 5.

Somasundaram, D. 2013. C. Sivagnanasundaram Oration, delivered September 26, 2013. Jaffna.

Somasundaram, D., and Sivayokan, S. 2013. 'Rebuilding Community Resilience in a Post-war Context: Developing Insight and Recommendations—A Qualitative study in Northern Sri Lanka.' *International Journal of Mental Health Systems*, *7*(1), 3.

Sritharan, J., & Sritharan , A. (2014). Post-conflict Sri Lanka: The lack of mental health research and resources among affected populations. *The International Journal of Humanities and Social Sciences*, 4 (3): 151-156.

Tarabah, A., Badr, L. K., Usta, J., and Doyle, J. 2016. 'Exposure to Violence and Children's Desensitization Attitudes in Lebanon.' *Journal of Interpersonal Violence*, *31*(18), 3017-3038.

Uhernik, J. A., & Husson, M. A. (2009). Psychological first aid: An evidence informed approach for acute disaster behavioral health response. *Compelling counseling interventions: VISTAS*, *200*(9), 271-280.

Volpicelli, J., Balaraman, G., Hahn, J., Wallace, H., and Bux, D. 1999. 'The Role of Uncontrollable Trauma in the Development of PTSD and Alcohol Addiction.' *Alcohol Research and Health, 23* (1).

Wickramasinghe, N. 2009. 'Sri Lanka in 2008: Waging War for Peace.' *Asian Survey*, *49*(1), 59-65.

Wilsnack, R. W., Wilsnack, S. C., Kristjanson, A. F., Vogeltanz-Holm, N. D., & Gmel, G. (2009). Gender and alcohol consumption: patterns from the multinational GENACIS project. *Addiction*, *104*(9), 1487-1500.

Psychosocial Assessment of the War Affected Northern and Eastern Provinces of Sri Lanka: Distress and Growth Post-War

By
Ramila Usoof-Thowfeek

This assessment found that as of 2017 there are significant numbers of individuals still suffering with psychological distress and disorders in Northern and Eastern Provinces, but the health and counselling services were unable to provide them effective interventions for mitigating their ailments. Significant among the forms of psychological distress and disorders are PTSD, depression, and anxiety. In many communities, emotional disturbances were witnessed, which prevent the individuals from forming strong attachments. The developments in post-war period such as the rising debt problem, alcoholism and family breakdown served to further aggravate the psychosocial stress and retard the post-war recovery process.

Dr. Ramila Usoof-Thowfeek is senior lecturer in Psychology at University of Peradeniya.

INTERNATIONAL
CENTRE FOR
ETHNIC STUDIES

ISBN 978-955-580-220-8

Printed by **Horizon Printing (Pvt) Ltd.**