Intimate Partner Violence Against Women in the Capital Province of Sri Lanka: Prevalence, Risk Factors, and Help Seeking

Vathsala Jayasuriya¹, Kumudu Wijewardena¹, and Pia Axemo²

Abstract
This article presents findings from a cross-sectional community survey exploring intimate partner violence (IPV) against women in the Western province of Sri Lanka. Findings show that lifetime prevalence of physical violence (34%), controlling behavior (30%), and emotional abuse (19%) was high and the prevalence of sexual violence was low (5%). Young women and those with partners who abused alcohol/drugs and had extra-marital affairs are at increased risk of violence. Although living in a patriarchal society, low prevalence of child marriages and lack of dowry-related violence could be to Sri Lankan women’s advantage relative to their Asian counterparts in preventing IPV.

Keywords
intimate partner violence, Sri Lanka

Introduction
The focus on violence against women in South Asia is a recent phenomenon, and the emerging knowledge base documents the importance of family violence, especially violence directed against the women living in this region. (Naved, Azim, Bhuiya, & Persson, 2006; Schuler, Hashemi, Riley, & Akhter, 1996). Of the many types of family violence, intimate partner violence (IPV), that is, violence instigated by intimate male partners within the

¹University of Sri Jayewardenepura, Nugegoda, Sri Lanka
²International Maternal and Child Health (IMCH), Uppsala, Sweden

Corresponding Author:
Vathsala Jayasuriya, Department of Community Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura, Gangodawila, Nugegoda, Sri Lanka
Email: v.jayasuriya@londonmet.ac.uk
context of marriage or cohabiting relationships, is one of the most prevalent forms (Krantz & Garcia-Moreno, 2005).

Fifty-one percent of the 18.7 million Sri Lankan population are women, and they enjoy a relatively better position compared to other South Asian women, in terms of a higher life expectancy than men (75 years in women compared to 70 years in men), and equal school enrollment and literacy rates (Department of Census and Statistics, 2003). Compared to other regional settings, the Sri Lankan birth rate is low and age at marriage is high (e.g., mean age at marriage 25 years vs. 14 years in Bangladesh; De Silva, 2004; Wijayatilake, 1995).

Although these national statistics seem favorable to women, they do not reflect the existence of patriarchal gender roles as in other regional settings. Even though a few Sri Lankan women have managed to obtain posts in the upper echelons of government, with Sri Lanka being the first country to boast of a female prime minister, at present only 5% of parliamentarians are women (Department of Census and Statistics, 2007). Unequal access to money, resources, and power have forced large numbers of women to migrate to the Middle East for domestic work (70% of all international migrant workers are women) and young unmarried women seek work in garment factories in the export promotion zones under difficult conditions (Women in Development [WID] IQC, 2004). Economic reforms and welfare programs, too, favor men in resource allocation and prioritization. During the rehabilitation process following the Indian Ocean tsunami in 2004, 85% of the reallocated land was given in the name of male household members, even where the original land owners were women (Gomez, 2008). Although this may be partly embedded in the head of the household concept, which is considered an exclusively male role, it also indicates the subordinate status and lack of decision-making power of Sri Lankan women.

The civil armed conflict of more than two decades, due to a separatist organization’s demands for an independent state, affected women not only in the Northern and Eastern parts of the country, but all over Sri Lanka in different ways. Women have been compelled to become heads of households following the death or disappearance of partners, sons, brothers, and fathers. Women must also care for male relatives who have become physically incapacitated as a result of violence. Recent surveys have shown that 29% of households in the North and East and 19% of the households in the rest of the country are headed by women, the majority of whom are widows with low educational levels (Department of Census and Statistics, 2008). This conflict also increased women’s direct exposure to violence as well as their vulnerability through displacement, poverty, and unemployment.

Examination of police statistics and media reports only give an indication of a fraction of crimes committed against women in the country. Analysis of press reports in 1998 (Centre for Women’s Research, 2001) revealed 129 incidents of murder committed within the home and the main perpetrator of these acts (65%) was the husband. Empirical studies on the subject only emerged in the past two decades, and these estimate the prevalence of IPV in the range of 18% to 72% in different populations and age groups (Deraniyagala, 1992; Moonesinghe, 2002; Samarasinghe, 1991; Subramaniam & Sivayogan, 2001). Only two of these studies (Deraniyagala, 1992; Samarasinghe, 1991) pertain to the current study.
area, the Western province, and these are diverse in choice of study population, definition of violence, and methods of assessment of violence, thus limiting their comparability with regional and international data.

The Literature on IPV Against Women

The Magnitude of the Problem

For centuries, South Asian women have been governed by sanctions of caste, religion, family values, and culture (Ghosh, 2004). International recognition of IPV as a serious crime against women has now made it possible to openly discuss gender-based discrimination, violence against women, and gender-based violence in these settings. This is evident by the large number of studies on IPV reported from the region since the 1990s (Bates, Schluler, Islam, & Islam, 2004; Fikree, Jafarey, Korejo, Afshan, & Durocher, 2006; International Centre for Research on Women, 1997; Jejeebhoy & Cook, 1997; Kyu & Kanai, 2005; Naved & Persson, 2005; Peedicayil et al., 2004; Schuler et al., 1996).

Studies of IPV from Bangladesh and India are important in providing context for the present study. A number of recent papers from Bangladesh (Garcia-Moreno, 2006; Naved & Persson, 2005; Schuler et al., 1996) indicate that the prevalence of physical violence (PV) in marital relationships is high, ranging from 32% to 72%. The lifetime prevalence of PV in Bangladesh from the WHO multicountry study (2005) on domestic violence ranged from 40% in urban areas to 42% in rural sectors. The rates for lifetime sexual violence (SV) in these two sites were 34% and 40%, respectively (Garcia-Moreno, 2006). Peedicayil and colleagues (2004), who conducted a large community survey in India, estimated the lifetime prevalence of PV as 41%.

Of the limited literature from Sri Lanka, one of the earliest studies (Deraniyagala, 1992) within the current study setting reports the prevalence of “wife abuse” as 54% based on a sample of currently married women. Another survey in an urban slum area in the western province (Samarasinghe, 1991) found a 60% prevalence of PV among currently married women. However, both these studies were affected by overrepresentation of lower social classes in the sampling. According to studies from North Central and Central provinces (Moonesinghe, 2002; Subramaniam & Sivayogan, 2001), prevalence of “wife battering” was 30%, current PV was 11%, and current SV was 3%. All these studies were limited to currently married and cohabiting females, thus excluding a vital group of victims who may have separated from their husbands due to the violence itself. With the exception of the study by Moonesinghe, other major limiting factors in terms of comparability in these early studies is the lack of uniform definitions of violence and abuse and use of non-standard measures of violence.

Measuring Intimate Partner Violence

Early studies of IPV from numerous settings lack uniform definitions of violence, use non-standard assessments of violence, and are based on non-comparable study populations.
The World Health Organization’s (WHO) multicountry study of domestic violence (2005; Garcia-Moreno, 2006) addressed these data comparability issues by developing standard methodologies and instruments that could be used to measure violence in different settings, including Bangladesh and Thailand. The WHO study instrument incorporated the Conflict Tactics Scale (CTS) to develop a questionnaire to assess IPV. The CTS approach is particularly useful for international comparisons, as it asks women about specific acts of violence, rather than allowing the woman to interpret the violent acts as abuse. The CTS approach, though, has been criticized for lack of cultural adaptability (Naved et al., 2006); for example, when respondents are asked about degrading or humiliating sexual situations (see Box 1), what they consider as such varies from setting to setting. This limitation can be somewhat overcome by providing suitable, culturally acceptable examples of situations considered degrading or humiliating in the local setting. Despite criticisms, the CTS has been widely accepted and also endorsed by the WHO as an instrument suitable to measure prevalence of IPV and its characteristics in community settings.

**Factors Associated With Intimate Partner Violence**

Evidence from other settings has demonstrated personal, situational, and sociocultural factors that can predict risk of IPV (Ellsberg, Heise, Pena, Agurto, & Winkvist, 2001). Even though regional data are limited, it has been shown that factors ranging from young age of the women to low educational attainment, low socioeconomic status, substance abuse, family history of violence, and community violence can increase risk of IPV (Schuler et al., 1996).

However, risk predictors such as personal, family, and community characteristics could vary in different settings; for example, employment may be important in a developed country as a means of economic independence, whereas in an Asian setting receiving “dowry” (bride money) may be more important in family conflict and violence (Ghosh, 2004).

Moonesinghe (2002), examining the correlates of abuse among a cohort of pregnant women in the North central province in Sri Lanka, demonstrated that certain female characteristics (i.e., low social class, low educational attainment, history of family violence) and male characteristics (i.e., alcohol abuse, extra-marital affairs, and family history of violence) were associated with an increased risk of IPV.

**Help-Seeking Behavior**

Women in Bangladesh are more likely to seek help from close family networks than from formal support agencies, though this may be a reflection of the scarcity of such services in the region. However, even in countries such as the United Kingdom where such services are freely available, women are more likely to reach out to family members (Regan, Kelly, Morris, & Dibb, 2007). The nature and severity of abuse were determinants of help-seeking behavior among Bangladeshi women and those with higher education levels were more likely to seek help than others (Naved et al., 2006). One of the recent studies of IPV among the Sri Lankan Tamil diaspora in Canada examined women’s accounts of violence and
care seeking (Mason et al., 2008), and it was shown that access was dependent on the cultural acceptability of the services offered. Even though this study relates to a specific group of women living in a community socioculturally diverse from their homeland, it highlights the importance of understanding their behaviors within the correct personal, societal, and cultural context to provide acceptable services.

**Method**

This is the first large-scale study in Sri Lanka focusing on the whole range of IPV, including PV, SV, controlling behavior, and emotional abuse. The aims of this cross-sectional survey covering the capital province of Sri Lanka were to obtain reliable prevalence estimates for IPV, identify possible risk/protective factors, and describe the care-seeking behavior of abused women. The data were collected during January to November 2005. All methods, instruments, and procedures were guided by the WHO protocol and were reviewed by the Ethical Review Committee of the Faculty of Medical Sciences, University of Sri Jayewardenepura, Sri Lanka.

**Setting, Population, and Sample**

The study area is the densely populated Western province (1840 km²), the administrative and commercial capital of the country. The population is mostly Sinhalese and Buddhist (the majority ethnic and religious group in Sri Lanka), but adequately represents the other ethnic and religious groups (Department of Census and Statistics, 2003). Being the capital province, it attracts a large migrant population for education and employment as well as those seeking to leave the areas affected by the civil war in the Northern and Eastern parts of the country (University of Colombo, 2000). This geographic locality consists of highly developed business and residential areas, over crowded urban slums, under-developed rural areas, fishing villages, and agricultural estates such as tea and coconut plantations (Department of Census and Statistics, 2003). Utilizing the capital province ensured that adequate support services were available for the abused women identified during the survey.

The study population included ever-married women in the 18 to 49 years age group. Ever married was defined as having been currently or previously in a legal marriage or in a cohabiting relationship. The sample was limited to the age group of 18 years and above, as it is the legally accepted age limit for marriage in Sri Lanka (Government of Ceylon, 1995). Although customary laws allow Muslim women under 18 years to marry, they were not included due to ethical reasons, as it would necessitate obtaining permission from the legal guardian for the interview and this, in turn, might compromise her safety if she was subjected to violence within the family.

**Survey Method: Recruitment, Measurement, and Procedure**

A total of 750 eligible women were selected by multi-stage cluster sampling. The primary sampling units were the smallest administrative areas; Grama Niladhari divisions
Box 1. Acts of Abuse Measured by the Study Instrument

<table>
<thead>
<tr>
<th>Acts of physical aggression</th>
<th>Acts of sexual aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your partner ever slapped you or threw something at you that could hurt; pushed/shoved or pulled your hair; hit with fist or with something that could hurt; kicked, dragged, or beaten you up; choked or burnt you on purpose; and threatened to use or used a gun, knife, or other weapon against you?</td>
<td>Have you ever been physically forced to have sexual intercourse, when you did not want to; had sexual intercourse when you did not want to, because you were afraid of what your partner might do?</td>
</tr>
<tr>
<td></td>
<td>Have you ever been forced to do something sexual that you found degrading or humiliating?</td>
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</table>

<table>
<thead>
<tr>
<th>Emotional stresses</th>
<th>Controlling behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your partner ever, insulted you or made you feel bad about yourself belittled or humiliated you in front of others; done things to scare or intimidate you on purpose (by the way he looked at you, by yelling and smashing things); or threatened to harm you or someone you care about (children)?</td>
<td>Tries to keep you from seeing your friends</td>
</tr>
<tr>
<td></td>
<td>Tries to restrict contact with your family of birth</td>
</tr>
<tr>
<td></td>
<td>Insists on knowing where you are at all times; ignores you and treats you indifferently</td>
</tr>
<tr>
<td></td>
<td>Gets angry if you speak with another man;</td>
</tr>
<tr>
<td></td>
<td>Is often suspicious that you are unfaithful</td>
</tr>
<tr>
<td></td>
<td>Expects you to ask permission before seeking health care for yourself</td>
</tr>
</tbody>
</table>

and a number of these were picked proportionate to the population size. A cluster consisted of 30 households, and the primary location of the cluster was randomly picked from a regularly updated list of households from the local administrative office. The data collector visited the chosen household and recorded the age and marital status of all eligible women living there (ever-married women in the age group of 18 to 49 years). From this list, only one eligible woman was picked by lottery for the interview. In order to protect the respondents, the study was introduced as a reproductive health survey to the community and the family, with only the respondent being told the true nature of the questions.

The women’s health and life events questionnaire developed by the WHO (Garcia-Moreno, Heise, & Ellsberg, 2001) was translated to Sinhalese, the local language spoken by the majority of the population, and adapted to suit the local dialect. The original structure and content were retained. Female data collectors with training in social work, counseling, and prior experience of working with abused women were recruited and trained. Data collection was conducted in the respondent’s home at a convenient time, where it was possible to ensure complete privacy. The local primary health clinic was used as an alternative venue for the interview when necessary. The respondents were offered contact and referral information for centers providing services for abused women in instances where it was safe to receive and keep such information.

The survey instrument consisted of specific questions on violence perpetrated by intimate partners within their lifetime, and specifically within the past 12 months. Prevalence of physical violence, sexual violence, controlling behavior, and emotionally abusive acts were measured using the responses to the questions shown in Box 1.
The respondent also answered questions regarding sociodemographic characteristics (age, religion, and ethnicity; education level; employment), nature of the marital relationship, duration of the relationship, dowry agreement and ability to meet this agreement, perceived family support in crises, level of violence in the community, her responses to violence, and the reasons for these actions. The socioeconomic status of the household was determined using the Standard of Living Index (SLI), which is derived using a number of indicators such as source of drinking water, type of latrine, availability of electricity, equipment, and ownership of vehicles.

Ten in-depth interviews were conducted by the principle investigator to describe the violence and care-seeking behavior according to the women’s own perceptions, and anonymous quotes from these interviews are included in the discussion of the results.

**Statistical Analysis**

The analyses consist of descriptive summaries, prevalence estimates, and logistic regression analysis of factors associated with IPV. A woman was categorized as abused if she answered “yes” to any of the relevant questions under each type of abuse, that is, physical, sexual, emotional violence, and controlling behaviors (see Box 1). The baseline population for prevalence estimates was adjusted according to the age-sex distribution of the Western province population (Department of Census and Statistics, 2003). Data analysis was performed with statistical software SPSS version 13.

**Results**

Out of 750 eligible women contacted for the survey, 97% consented to the interview, and these women were not in any way different from the non-respondents or the population of women in the western province. The majority of the sample was Sinhalese (92%) and Buddhists (83%), with educational and literacy levels (83% completed secondary-level education, 93% literacy) compatible with western province rates (79% and 93%, respectively; Department of Census and Statistics, 2003).

Previous studies of IPV were biased due to oversampling of lower social classes; therefore, it was necessary to establish that the sample was not over-representing members of lower social classes in relation to the study population. According to the SLI classification, the majority (52%) of the sample had a medium standard of living, whereas 31% had a low standard of living; these proportions were compatible with western province data (Central Bank of Sri Lanka, 2004).

**The Magnitude and Spectrum of Abuse**

The results affirm the presence of the whole spectrum of abusive behaviors, ranging from extreme control, to emotional abuse, physical violence, and sexual violence (see Table 1).

Thirty-four percent of the women interviewed suffered PV by intimate partners during their lifetime, and 30% were subjected to controlling behaviors.
In terms of severity, most (57%) abuse consisted of severe acts (hit with fist or something else; kicked, dragged, or beat up; choked; burnt; threatened to use or used a weapon). Also, most were multiple (62%), repeated acts (77%) of aggression over time. Although the prevalence of SV was only 5%, in the majority of cases (68%) these were repeated acts. The prevalence of SV in the study setting seems low (5%) compared to other forms of abuse reported here and also compared to the 37% reported in Bangladesh from the WHO survey (Garcia-Moreno, 2006). Although lack of cultural sensitivity in the questions on SV could lead to under-estimation, this was minimized by using appropriate examples and terms relevant in the local context. It is also possible that the actual prevalence of SV in this setting is low as a previous estimate of SV was only 3% (Moonesinghe, 2002).

Even though questions on different types of violence were presented separately, it is possible and likely that the same women are subject to many types of violence. The level of overlap between PV and SV is apparent in Figure 1, as almost all cases of SV (except 3) occurred with PV and the majority of these were associated with severe PV (29 out of 37). Of the different types of SV, the most common form reported was being physically forced into submission (76%). This distinction between PV and SV should be observed with caution as the range of acts considered SV can vary from direct SV such as rape to the use of physical force to produce submission, to the mere non-resistance to sexual acts following physical violence (Sleutel, 1998). The point at which it becomes SV rather than PV or vice versa can be obscure and variable based on the abused women’s own interpretations, and this can affect prevalence estimates of both PV and SV.

### Risk Factors for IPV

The degree of overlap between different forms of violence was examined, and two categories of IPV, severe \( (n = 144) \) and moderate \( (n = 107) \), were defined for the regression analysis. The distinction between moderate and severe violence was based on the likelihood of an act causing physical injury, a convention that has been used in other international studies (Garcia-Moreno et al., 2001; McCauley, Kern, Kolodner, Derogadis, & Bass, 1998). First, the characteristics were compared at the univariate level and factors that were statistically significant \( (p < .05) \) were then included in the logistic regression model. As only two of the characteristics were significant for moderate abuse (living with relations,
partner’s daily/regular consumption of alcohol and/or drugs) the factors associated with severe abuse are discussed here (see Table 2).

Young women (aged < 25 years) were 3 times more likely to be subjected to severe abuse compared to older women. Similar findings were seen in Bangladesh (Naved & Persson, 2005), Nicaragua (Valladares, Pena, Persson, & Hogberg, 2005), and Albania (Burazeri et al., 2005). The ages at risk were different in these countries: 15 to 19 years in Bangladesh, <20 years in Nicaragua, and 25 to 34 years in Albania. This is likely a reflection of the ages at marriage in each setting; for example, the median age at marriage in Bangladesh is 14 years (Bates et al., 2004) compared to 25.5 years in Sri Lanka (Abeykoon, 2000).

Women with partners who abused alcohol and/or drugs were at increased risk of severe violence. As almost all the men who abused drugs were also abusers of alcohol, these two factors were considered together for this analysis. Partner’s infidelity and presence of children from other relationships also increased the risk of severe abuse.

**Violence Cuts Across All Ethnic, Religious, and Social Classes**

The prevalence of all forms of violence was not significantly different between the ethnic and religious groups in the province, even though it is commonly believed that levels of control and coercion are greater among some ethnicities. This was not reflected in the results, possibly due to the equal levels of education and social status enjoyed by all communities in this part of the country (De Silva, 2004).
<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Unadjusted odds ratio (95% confidence interval)</th>
<th>Adjusted odds ratio (95% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt; 25 years (25+, reference category)</td>
<td>2.4 (1.4-3.9)</td>
<td>3.0 (1.5-13.9)</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No schooling /primary Level</td>
<td>1.9 (0.9-3.9)</td>
<td>1.2 (0.4-4.4)</td>
</tr>
<tr>
<td>Secondary level</td>
<td>1.5 (0.7-2.9)</td>
<td>1.3 (0.2-3.7)</td>
</tr>
<tr>
<td>Illiterate (literate, reference category)</td>
<td>4.3 (2.3-7.8)</td>
<td>4.1 (0.5-11.2)</td>
</tr>
<tr>
<td>Lack of family support (family support, reference category)</td>
<td>1.8 (1.1-2.8)</td>
<td>1.1 (0.2-4.5)</td>
</tr>
<tr>
<td>Standard of living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>3.7 (1.6-8.9)</td>
<td>0.4 (0.1-1.3)</td>
</tr>
<tr>
<td>Low</td>
<td>8.9 (3.7-21.6)</td>
<td>1.3 (0.4-4.5)</td>
</tr>
<tr>
<td>Lack of own income (with own income - reference category)</td>
<td>1.5 (0.9-2.2)</td>
<td>1.2 (0.3-4.3)</td>
</tr>
<tr>
<td><strong>Partner characteristics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled laborer</td>
<td>3.2 (1.4-8.8)</td>
<td>2.5 (0.3-8.6)</td>
</tr>
<tr>
<td>Laborer</td>
<td>2.2 (0.8-6.0)</td>
<td>1.9 (0.4-9.8)</td>
</tr>
<tr>
<td>Police/armed forces</td>
<td>3.2 (1.1-9.7)</td>
<td>2.7 (0.9-8.4)</td>
</tr>
<tr>
<td>Alcohol/ drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily/regularly</td>
<td>2.8 (1.6-4.8)</td>
<td>4.4 (2.0-10.6)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>0.9 (0.5-1.5)</td>
<td>0.5 (0.3-2.9)</td>
</tr>
<tr>
<td><strong>Marriage duration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>0.6 (0.3-1.0)</td>
<td>0.3 (0.2-2.8)</td>
</tr>
<tr>
<td>5-9 years</td>
<td>0.6 (0.3-0.9)</td>
<td>0.4 (0.1-1.4)</td>
</tr>
<tr>
<td>Lack of dowry (dowry given, reference category)</td>
<td>3.8 (2.2-6.8)</td>
<td>3.1 (0.8-7.6)</td>
</tr>
<tr>
<td>Fights with other men (No, reference category)</td>
<td>4.5 (2.7-7.3)</td>
<td>3.2 (0.9-7.8)</td>
</tr>
<tr>
<td>Affairs with other women (No, reference category)</td>
<td>3.8 (2.1-6.9)</td>
<td>4.0 (1.5-11.0)</td>
</tr>
<tr>
<td>Children with other women (No, reference category)</td>
<td>6.6 (3.1-13.8)</td>
<td>4.8 (2.3-14.3)</td>
</tr>
<tr>
<td>Living with partner’s relatives (No, reference category)</td>
<td>0.5 (0.3-0.7)</td>
<td>0.4 (0.2-1.8)</td>
</tr>
</tbody>
</table>
Prevalence of violence was highest in those with a low standard of living (49% compared to 29% in the high standard of living group). However, this relationship was not confirmed by the logistic regression analysis when other variables such as age, education level, and partner characteristics (i.e., substance abuse) were included. Much of the increase in prevalence among those with a low standard of living is explained by women entering into marriage at younger ages, low educational attainment, and their partner’s being more likely to be substance abusers.

**Help-Seeking Behavior**

*If she can stay, why can’t you?* Disclosure and recourse were not options considered by the majority of abused women. More than half of the abused women (58%) had not revealed the violence to anyone, this interview being the first time they ever talked about the violence in their lives. Reasons for not disclosing the abuse included embarrassment (43%), concern for family reputation (24%), and fear of more violence (12%). Some women (8%) accepted violence as normative behavior, and this was reinforced by family and friends; for example,

> “Everybody has problems, you must save your marriage . . . you must not leave the house, you will lose it [the marriage] if you leave . . . everyone here [in this community] is beaten, even his mistress; if she can stay, why can’t you?” (Respondent 2)

*Things will get better.* Those who do seek help were likely to do so when they could no longer endure the abuse (45%), when he abused or threatened to abuse her children (20%), and when she sustained severe injuries (10.5%). Extended family and neighbors were the most common source of help (55%), and they sometimes intervened even without the victim directly asking for help. This is mostly the case in urban slums, fishing communities, and among tea estate workers. Among the upper and middle social classes in urban and rural areas, neighbors are reluctant to intervene even when they are directly told about the abuse.

Only 23% of the abused women accessed any of the institutions providing services, including the police, hospitals, courts, social services, legal aid, women’s organizations, and religious institutions. Less than 2% of the abused had accessed health care services, social services, and women’s organizations providing services for abused women in relation to their problem. The few who sought help from formal support services, including health care providers at the hospital and the police, were stigmatized and judged. For instance, a woman seeking shelter at the local police station at 2.00 am because of the severe beatings by the husband was given the impression that it was wrong for a woman to be traveling alone at night, as it is only commercial sex workers who do so: “When I went to the police station they looked at me in a strange way (implying that I was a women of loose morals), asked me why I came at this time. . . .” (Respondent 6). Another woman reported that a caregiver at a hospital-based center for abused women had implied that it was her fault for getting beaten: “The nurse told me that I would have said something wrong for him to beat me up . . . or approached him at the wrong time . . .” (Respondent 3).
Although service access for abuse is low, abused women were more likely than non-abused women (64% vs. 29%, respectively, $p < .05$) to visit hospitals for other ailments, such as sleep disturbance, loss of appetite, and headaches, rather than the violence itself. They also visited religious places, soothsayers, and native healers, seeking solace from problems that they perceive to have led to the abuse, such as extra-marital affairs, the husband’s substance abuse, and his lack of employment. One abused woman advised by a local soothsayer sought divine intervention at the Hindu temple (kovil) to “save” her estranged spouse from the “other” woman (his mistress):

I went to this place where they do Anjanum eli [a soothsayer who uses the reflection of a lighted lamp to look into the future]. He said this is a bad period for me . . . she [the mistress] has done something [voodoo] to him for him to forget us. He will help me to get my man back. I have to do pooja [offerings] at the kovil for seven days. I can only pray . . . things will get better . . . when this bad period is over. (Respondent 2)

Discussion

This study presents evidence of the magnitude of IPV in the capital province of Sri Lanka, ranging from controlling behavior to emotional abuse, physical violence, and sexual violence. Even though the comparability of these rates with previously reported local rates are restricted due to methodological differences, rates obtained from the WHO study should be less affected by this owing to standard instruments and definitions. According to the WHO study, the prevalence of PV in Bangladesh was 39.7% in urban areas and 41.7% in rural areas. The rates of SV in these two areas were 37.4% and 49.7%, respectively (Garcia-Moreno, 2006; Naved et al., 2006). These rates are much higher than Sri Lankan rates, and the discrepancy is greater for SV. In cross-country comparisons as such, differences in age structure and socioeconomic status of the samples are possible confounders; however, this effect did not significantly alter the results when it was explored by the WHO study team (Garcia-Moreno, 2006), and it could be presumed to be the same in this comparison. Indigenous practices, such as giving bride money (dowry) at marriage, could contribute to the inter-country variations within the region. In Bangladesh and India (Bates et al., 2004; Ghosh, 2004), having a dowry agreement and being in debt in terms of this agreement posed a significant risk of abuse. This practice, though still prevalent in the study setting in Sri Lanka, did not pose a significant risk of IPV.

Prevalence estimates of IPV should also be viewed in context with emerging evidence of disclosure patterns and care-seeking behaviors of abused women. Under-reporting due to stigma and fear is a well-known issue addressed in quantitative estimates of IPV; however, other culturally defined characteristics may be more important in different settings. For example, a young woman abused by her partner was reluctant to discuss the matter for religious reasons as it is considered unholy to do so: “We don’t like to talk about these things . . . you know is against our religion . . . we are not supposed to talk bad about the man . . . it is a sin if we do” (Respondent 3).
The prevalence of SV (5%) and emotional abuse (19%) observed here could be partly explained by limitations of the instrument, which requires the women to define “sexually degrading acts” and “insults.” Although sexually degrading acts are somewhat culturally defined, emotionally abusive acts, such as “insults” or “belittling,” are defined by women’s relative position to men in society. In communities where women’s status in relation to men has always been low, they will not be able to interpret these behaviors as insulting or belittling on their own. From abused women’s accounts here, it was evident that they had been “forced” to go to work abroad, “intimidated” into not contacting the police, and admonished for not having food ready, but none of these acts was considered by the women as abusive or violent. This is one of the limitations of using standardized instruments for assessment of IPV. It is necessary for future adaptations of the CTS/WHO instrument to incorporate better descriptors of what constitutes such acts, and the instrument must be adaptable to the study setting.

Perceptions of being a “good” wife and that the man should be the “boss” are gendered norms seen in patriarchal societies that promote women’s subordinate status. The majority of the women surveyed, both in the abused and non-abused groups, believed that a “good” wife obeys her husband even if she disagrees with his view, that it is important for the man to show he is the “boss,” and that a wife is obliged to have sex with the husband even if she doesn’t want to. More than 50% of the women in this study also believed that disobedience, refusal of sex, asking him about affairs with other women, and his “suspicions” of her infidelity are “good” reasons for a man to abuse his partner. Although this was a community-based survey limited to the western province, it represents the gender norms and perceptions instilled in our society, which perpetrates not only overt violence but also norms that promote men’s extreme control over many aspects of women’s lives.

Young age of the victim was a significant risk factor for IPV, irrespective of educational level, literacy, employment, duration of marriage, or family support. Increasing age at marriage and low rates of child marriage are therefore likely to Sri Lankan girls’ distinct advantage over their Asian counterparts thereby reducing IPV.

Partner’s alcohol/drug abuse and partner’s extra-marital affairs were identified as possible risk factors for severe abuse. Substance abuse, sexual indiscretion, and other risk-taking behaviors are more acceptable for men in South Asian communities. Women, in contrast, are taught that virginity, virtue, and conformity to tradition are essential for women since divorce is stigmatized and chance of remarriage is low (Jayakoddy, 2002). In almost all patriarchal societies, masculine attributes, roles, and behavior are usually given greater status than what is perceived to be feminine. When it is also believed that the man should be the “boss,” this creates a culture in which men are “allowed” to abuse alcohol or drugs and demonstrate their power over women, even in the form of overt violence. A man having a mistress or children from other women creates far greater social complexities for women in a culture that stigmatizes divorce. Even abused women in such relationships will attempt to “save the marriage,” since leaving the relationship is a remote option.

These gendered behaviors and roles, however, are changing for Sri Lankan women in complex ways as they have greater access to employment away from home and freedom to
travel within and outside the country (Hewamanne, 2010). Poverty and lack of economic opportunities (unemployment rates for women are double that of men) have created two trends in employment seeking. Large numbers of women migrate to the Middle East for domestic or garment factory employment; 70% of all international migrant workers are women, and young unmarried women work in factories in the Export Promotion Zones. These changes challenge the traditional gender norms and may have implications for the way in which conflicts and problems are resolved within intimate relationships.

Even though it has been alleged that community violence—living in a violent community—could pose a risk of IPV, this was not seen in the study setting. Although the study setting was geographically distant to the area where the civil war was taking place, it impacts demographically on the population living there due to mass migration and displacement. It is necessary to explore IPV among these displaced communities now living in other parts of the country, dissociated from their traditional systems in the context of changing gender roles, responsibilities, and norms.

This survey gathers, for the first time, community-based data on care seeking and demonstrates the severe inadequacies in formal support services and poor caregiver attitudes. Access to services is low, with less than 2% of abused women seeking help from women’s organizations catering specifically to abused women. The minority of women who reach out to the police, health care, and other services, risk further discrimination by the very systems that purport to support and protect them. The importance and contribution of traditional practitioners such as soothsayers and local healers in providing support for victims also need to be explored.

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References


Bios

Vathsala Jayasuriya, MD (Community Medicine), is a senior lecturer in the Department of Community Medicine, Faculty of Medical Sciences, University of Sir Jayewardenepura; and a former research fellow at the Child and Women Abuse Studies Unit (CWASU) of the London Metropolitan University. Her current research interests include the introduction and integration of gender-based violence into the medical and allied health sciences, gender sensitivity in health care policy and practice, and addressing gender inequity in health care.
Kumudu Wijewardena, MD (Community Medicine), is senior professor of Community Medicine, Faculty of Medical Sciences and former dean of graduate studies at the University of Sri Jayewardenepura. She was awarded an SIDA/SAREC grant in 2004 for the project, “Health and Social Care for Socially Marginalized People.” She is a researcher, lecturer, and an advisor to national and international agencies on reproductive health, migrant workers, maternal and child health, noncommunicable diseases, and gender-based violence.

Pia Axemo, MD, PhD, is a senior lecturer in International Maternal and Child Health, Department of Women’s and Children’s Health, at the University of Uppsala, Sweden. She has worked as clinician, teacher, and researcher in several African countries and held an advisory position on sexual and reproductive health at the World Bank. Her current research activities include social reactions to sexual violence in the society, interventional studies to curb such violence (Tanzania), adolescents’ sexual health and HIV prevention and the role of faith-based organizations (South Africa), and maternal health and life-saving skills at the community level (Tanzania). She is a member of the SIDA-financed International Network on Gender-Based Violence.