Review of Research Evidence on Gender Based Violence (GBV) in Sri Lanka

Second Edition

SRI LANKA MEDICAL ASSOCIATION
COLOMBO

2011

SLMA Women's Health Committee

Editors

Professor Jennifer Perera
Chairperson Women's Health Committee

Dr Nalika Gunawardane
Convenor, Women's Health Committee

Dr Vathsala Jayasuriya
Member, Women's Health Committee

ISBN 978-955-9386-23-0

Message from the Chairperson of the Women's Health Committee

It gives me great pleasure to send this message on the launching of the updated second edition of this book on gender based violence. This book includes summaries of research work on gender based violence (GBV) with the objective of informing, both the personnel in the health sector and other stakeholder organisations who are interested in addressing the health issues of (GBV) in Sri Lanka. The first edition of this book was published in 2007 under the leadership of Prof. Chandrika Wijeratne in collaboration with the UNFPA, and I congratulate her for initiating the project and completing it successfully. It is the plan of the Women's Health Committee (WHC) to update the document every four years as, numerous studies are being conducted to determine the incidence of GBV and, to understand the factors that may reduce the occurrence and negative outcomes of GBV. Our main objective is to stimulate doctors, health care personnel and others who come into contact with victims and survivors of GBV to join hands with us, to deal with health and related issues of GBV.

Since 2007, the WHC, with other partners, has been addressing the issue of GBV in Sri Lanka. Numerous symposia and training programmes were conducted to increase awareness among health care personnel and other stakeholder sectors. It was unanimously agreed that the need of the hour was dialogue with key planners and policy makers to encourage the development of a sustained multisectoral approach to address GBV. Such a response is critical for combating the hidden, but pervasive problem of GBV and protecting women's health and rights. The entire health system need to respond, along with legal and social services, to support survivors of violence. It is heartening to note that the Gender Focal Point, led by the Family Health Bureau under the flag of the Ministry of Health, has taken significant steps to educate and train grass root level health care personnel through well structured training programmes. Additionally, several hospitals have been provided with crisis centres dedicated to providing appropriate care, shelter and referral services to affected individuals. Hospitals have linked up with other social support services to provide better services to GBV survivors.

Much of the information provided in this comprehensive document is a result of long hours of hard work and dedication of many members of the Women's Health committee (WHC) and my sincere gratitude is extended to all of them for their dedicated work and team effort. I gratefully acknowledge the contribution of Dr Ishani Wickramage who tirelessly worked towards preparing a comprehensive document within the short period allocated for completing the task. Financial support from WHO is sincerely acknowledged. The WHC looks forward to many more happy years of partnership to achieve its goals.

I invite all health care personnel and others interested in addressing GBV in Sri Lanka to read this book and join with us by taking extra measures in your day to day work to identify GBV and implement appropriate measures to address the health and psychosocial effects on affected individuals.

Prof. Jennifer Perera
Chairperson, Women's Health Committee
Sri Lanka Medical Association

PREFACE

This compilation of research published between 1982 and 2011 on Gender Based Violence (GBV) in Sri Lanka will be a valuable source of information to all stakeholders engaged in dealing with this subject.

This publication clearly highlights many facets of the problem and the need for a collaborative effort by many stakeholders. It will serve as an eye opener to all stakeholders regarding the magnitude of the problem in the country and will provide a stepping stone to convince them of the need for a multisectoral approach in dealing with violence and the importance of joining hands with each other to address the issue in a fruitful manner.

As the head of the nodal agency for Maternal and Child Health including Gender and Women's Health in the Ministry of Health which has initiated many steps to address the issue of GBV in the country, I congratulate the Women's Health Committee of the Sri Lanka Medical Association lead by Prof Jennifer Perera on their success in the compilation of summaries of research work on Gender Based Violence.

I hope that this publication will be updated regularly, thus making it a useful resource for all interested in issues related to GBV.

Dr Deepthi Perera
Director, Maternal and Child Health
Family Health Bureau
Ministry of Health

CONTENTS

Executive Summary

This document summarises the literature published between 1982 and 2011 on gender based violence (GBV) in Sri Lanka. In our attempt to collate the scientific information on GBV in Sri Lanka, the selection of research was based on pre-determined criteria, viz. to include research and exclude case studies that describe individual experiences. A great majority of the research was on GBV on women. The evidence were classified based on its focus and was included under different themes i.e., Research on GBV at different stages of life of a woman, GBV in different environment settings, clinical manifestation of affected groups and response of organizations towards GBV.

The literature review showed that there was a paucity of research evidence on locally relevant interventions to minimize GBV. The impact of domestic violence on members of the household, morbidity and mortality patterns of affected families, long term psychological and physical development of affected children and the long term effects on the victims were other notable areas where no evidence was found.

Despite certain limitations the committee was able to collate a considerable amount of data that will convince any reader that GBV is indeed a significant social and public health problem of considerable magnitude in Sri Lanka. While GBV includes violence against men and women, in the majority of cases the victims are women. The pattern of GBV in Sri Lanka encompasses physical, sexual, psychological and emotional violence and parallels current worldwide trends. The cumulative impact of violence experienced by girls and women is immense, especially in terms of its impact on their physical and mental health and its consequences, both immediate and long term. It is evident that GBV is currently not addressed adequately by the health care and other relevant sectors in Sri Lanka.

Introduction

Gender-based violence (GBV) includes all forms of violence involving women and men based on their gender. GBV may be experienced throughout the lifecycle of an individual, starting from intrauterine life.

This report presents a summary of the literature published between 1982 and 2011 on GBV in Sri Lanka. Both the health and the non-health related aspects of GBV have been researched by many professionals including medical officers, lawyers, sociologists, psychologists and by many organizations dealing with gender issues. Many study populations at risk of GBV have been studied in different settings.

To ensure the quality of the data, evidence was collated only from research, and case studies which described individual experiences were not included. A collection of published and unpublished research highlighting violence towards women in the form of domestic violence, intimate partner violence, violence at the workplace and violence in public transport is included in this review. GBV involves violence against both men and women on gender based issues. However, there appears to be a significant dearth of published scientific data on GBV against men in Sri Lanka.

The main sources of research in this document include the Center for Women's Research (CENWOR), The Marga Institute, The International Center for Ethnic Studies (ICES), The Post Graduate Institute of Medicine (PGIM), Women In Need (WIN), World Health Organization (WHO), International Labour Office (ILO), Sri Lanka Medial Association (SLMA), Fredrich Ebert Stiftung Foundation, American Solidarity Center, Women and Media Collective, University of Colombo, University of Sri Jayawardenepura and e-journals.

The evidence presented in this document is categorized according to the various groups of individuals sampled in the different studies. Where relevant, under each category, we have tried to focus on several areas; the magnitude of the problem, the health effects of GBV and the factors associated with GBV. Recommendations and strategies to address GBV and the training needs identified by different researchers are presented in a separate section. The methodology of each study is presented in summary including its validity and this will facilitate comparison between studies.

The literature survey is limited by GBV being a controversial and more 'recent' area of research interest, with only a few organizations and individuals addressing its many aspects. The few available publications were all funded by international organizations. Unpublished data was difficult to access. In some studies, since the original publication was unavailable and authors not accessible, we had to depend on published conference abstracts alone. Furthermore, logistical problems limited the studies to resource centers in and around Colombo. Despite these limitations we were able to collate a considerable amount of evidence that will convince any reader that GBV is a significant problem in Sri Lanka, and needs to be addressed as an important issue by the healthcare sector.

What is Gender Based Violence?

In 1993, the UN Declaration on the Elimination of Violence against Women offered the first official definition of gender-based violence:

Article 1: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life.

Article 2 : Article 2 of the Declaration states that the definition should encompass, but not be limited to, acts of physical, sexual, and psychological violence in the family, community, or perpetrated or condoned by the State, wherever it occurs. These acts include: spousal battering; sexual abuse, including of female children; dowry-related violence; rape, including marital rape; female genital mutilation/cutting and other traditional practices harmful to women; non-spousal violence; sexual violence related to exploitation; sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; forced prostitution and arbitrary deprivation of liberty whether occurring in public or private life.

The 1995 Beijing Platform for Action expanded on this definition, specifying that it includes: violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery and forced pregnancy; forced sterilization, forced abortion, coerced or forced use of contraceptives; prenatal sex selection and female infanticide. It further recognized the particular vulnerabilities of women belonging to minorities: the elderly and the displaced; indigenous, refugee and migrant communities; women living in impoverished rural or remote areas, or in detention.

Ratification of Conventions relevant to violence by Sri Lanka

Sri Lanka has ratified a number of international conventions relevant to violence and is committed to ensure both the promotion and the protection of these international standards. Sri Lanka ratified the International Covenant on Economic, Social and Cultural rights (ICSEC of UN General Assembly resolution 2200A (XXI) of 16th December 1966, New York) on 11th June 1980, the International Covenant on Civil and Political Rights (ICCPR of 16th December 1966, New York) on 11th June 1980, the Universal Declaration of Human Rights (UDHR of 10th December 1948, Paris), the UN Convention on the Elimination of all forms of Discrimination Against Women (CEDAW of 1979) in 1981 and the UN Declaration on the Elimination of Violence Against Women (DEVAW of UN General Assembly resolution 48/104 of 20th December 1993, Vienna) in 1993.

Initiatives on GBV in Sri Lanka

In March 1993, the Women's Charter was formulated in Sri Lanka. The Ministry of Women's Affairs has initiated an action plan to address the issue of violence through the establishment of the National Committee on Women. The Sri Lanka Medical Association established the Women's Health Committee during the Presidency of Professor Anoja Fernando in 2001. The Gender Focal point in the Ministry of Health was established in the Family Health Bureau more recently.

GBV through the life cycle

2.1. GBV during childhood and adolescence

Several studies focusing on child abuse highlight GBV in childhood especially sexual abuse (incest, rape).

Magnitude of the problem

A study conducted in the early 1990s among 899 pre-university and undergraduate students in Sri Lanka revealed that 18% of the boys and 4.5% of girls had been sexually abused in childhood. Most of the perpetrators were known parties such as relatives, neighbours, teachers and priests. The same questionnaire was administered to girls after a lecture on child abuse, and the numbers increased from 4.5% to 12.3%, divulging the abuser as a brother, uncle or father (De Silva, 1998).

Among both younger and older children in Sri Lanka, more girls than boys, are exploited for child labour as domestics. Boys are exploited more for child prostitution, theft and the sale of drugs (Department of Probation and Childcare services, Ministry of Social Services, 1998).

In 2002, a study was conducted on 21 cases of incest, through institutions dealing with the victims of incest in the Central Province of Sri Lanka. The study revealed that the typical incest victim is a girl child below 12 years of age, who is unable to resist incestuous advances by an older family member. The commonest abuser had been the girl's own father, followed by the stepfather, uncle or older brother (Silva, 2002).

According to 2003 police records, the majority of victims of grave sexual abuse (seduction, rape, incest and procreation) were girls (78%), especially younger girls under 16 years of age (Ministry of Health, 2008).

Reports of GBV, although anecdotal, are commonly encountered in the local newspapers and an analysis of newspaper articles was carried out to assert the nature and magnitude of the variety of harassments that women and children undergo in Sri Lankan society. One hundred and ten published articles in Sinhalese and English daily news papers between May 2007 and August 2007 were reviewed (Weerakkody & Kumara, 2007). Among the 76 victims whose age was reported, 68.4% were underage (≤ 17 years). Teenagers between the ages of 13 and 17 years were the most vulnerable to harassment. Among the underage, sexual harassment was the most prominent (88%). Rape was the most prevalent type of harassment reported, numbering 57 victims, out of which 48 were children. Out of the 20 cases of killing reported, 2 victims were children. 60% (66) of the offenders were known to the victims, of which the majority (40.9%) were close family members. The other categories of offenders were boyfriends (who were either having a relationship with the victim, trying to build a relationship or had failed to do so) (19.7%), close family friends and relations (16.7%), a variety of service providers such as school van drivers, Samurdhi officers, policemen, teachers, principals and caregivers at children's homes (16.7%) and domestic house masters or mistresses (6%) (Weerakkody & Kumara, 2007).

A cross-sectional survey was conducted among late adolescents through schools in the Southern Province, to estimate the prevalence of physical and emotional abuse and to identify demographic and behavioural correlates of such abuse. A regional sample of 2,389 students, 1099 male and 1290 female, (98% 18 years of age) was surveyed using a self-report anonymous questionnaire. Of the participants, 54% were female. There was a higher prevalence of physical abuse and emotional abuse among boys than girls. Of the total, 22.4% (n = 246) of males and 15.7% (n = 202) of females reported having been subjected to physical abuse at least a few times in the 3 months preceding the survey ($p<0.05$). 31.3% (n = 324) of males and 25.4% (n = 328) of females reported having been subjected to emotional abuse at least a few times in the 3 months preceding the survey ($p<0.05$) About 14% of male and female students reported having been subjected to some form of sexual abuse (Perera & Ostybe 2009).

A study was conducted among 1322 Sri Lankan undergraduates (mean age 21.8 years, 59% females) on juvenile victimisation via a questionnaire consisting of different modules such as child maltreatment, conventional crime, peer-sibling victimisation, indirect victimisation, introduction to substances and parental deprivation. 44% and 36% had experienced sexual and physical maltreatment respectively. In both categories males were affected more than females ($p < 0.001$). Physical abuse had commonly taken place at school (51%) and home (40%). Witnessing violence at home was the highest form of indirect victimisation (66%). 10% were introduced to substances in childhood (Fernando & Karunasekera, 2009).

In an analysis of GBV rates among clients visiting 'Mithru Piyasa' at Matara General Hospital, child abuse accounted for 8.43% (Samarakoon 2011).

Health and psychosocial effects of GBV

Incest and rape of children have been found to result in unwanted pregnancies and illegal abortions (CENWOR, 2001).

A study was conducted on a cohort of girls subjected to sexual abuse, who were resident in an approved school run by the Department of Probation and Child Care, to assess how sexual abuse impacts on personality adjustment and integration into society. A sample of 23 abused girls (of a total of 84 resident girls), 3 house mothers, 4 teachers, the school principal and 2 women from the village was assessed using standardized instruments including questionnaires, interviews, discussions, case records and a standard personality test. It was shown that being subjected to sexual abuse negatively affected the girls' personality adjustment in physical, mental, social and emotional capacities (Ramakrishnan, 2002).

In a study on victims of incest in the Central Province, the author attempted to elucidate the reasons for under-reporting of incidents of incest. It was found out that there was a tendency among older females in the family to ignore or cover up incest cases even when the girl child has reported it to them. These cases are reported to relevant institutions by anonymous letters or by the victim herself only when a pregnancy results or when healthcare is needed. The tragic consequences of this experience included trauma, disruption of schooling, separation from the family, moving to crisis centers, stigma, further victimization by others, unwanted pregnancy, sexually transmitted infections and inability to return to a normal life (Silva, 2002).

In the study by Perera & Ostbye (2009) on childhood sexual abuse among late adolescents in Southern Sri Lanka, the odds of having undergone childhood sexual abuse among males were significantly higher among those who had low self-esteem, those

who reported any use of alcohol and those who reported family conflict. The odds of childhood sexual abuse among females were significantly higher among those who had suicidal ideation, those who reported any use of alcohol and those who reported family conflict.

In the survey by Perera and his team (2009) on physical and emotional abuse among late adolescent school children, logistic regression analysis revealed that school absenteeism, deliberate self-harm, substance use and family conflict were associated with physical and emotional abuse.

Factors associated with GBV

Information collected through law enforcement authorities and community workers indicate that an increasing number of girl-children of migrant women remain unprotected and become victims of abuse sometimes ending in incest, unwanted pregnancies and illegal abortions (CENWOR, 2001).

In the study on sexually abused resident girls in a school run by the Department of Probation and Child Care, it was discovered that there was a correlation between being subjected to sexual abuse and the following factors: low socioeconomic status, higher number of members in the family (65% of the abused had 3 or more children in the family) and the birth order (eldest or youngest in the family had a prevalence of 30.5% each of being subjected to sexual abuse). Having both parents alive was not a protective factor, as the majority (52%) of the abused girls had both parents alive. 53% had mothers employed abroad as domestic aides. The majority of the victims (35%) were living with relatives during the time of abuse. (17% - living with both parents, 13.5% - living with mother and step father and abused by the step father). In 89% of the cases, the abuser was known to the victim (32.5% - boyfriend, 14% - father, 14% - uncle). Most of the abuse (30%) has taken place in the victim's own home (26% - at a hotel, 17.5% - at the house of a friend of the abuser). 65% of the assaults had occurred during the afternoon (Ramakrishnan, 2002).

Moonasinghe (2002) in a study on a cohort of pregnant women in the Badulla district found that physical and sexual abuse of children often occurs in successive generations of families, with a link between having a history of child abuse and becoming a victimizer later in life.

In the study on victims of incest in the Central Province of Sri Lanka, most of the reported cases were from impoverished rural or semi-urban families that were disrupted by domestic violence, alcoholism of the father, marital instability and long term absenteeism of the mother (Silva, 2002).

In the study conducted among late adolescent school children in Southern Sri Lanka on child sexual abuse, students with middle or upper socioeconomic status, not living with parents and studying science and mathematics were more likely than others to report having been sexually abused during childhood. Socio-economic status and BMI (body mass index) were not found to be associated with physical and emotional abuse (Perera & Ostbye, 2009).

The effects of witnessing violence, on children

The effects of witnessing GBV on the development of children and the effect of continuance of GBV on children have been study components in a few studies conducted in Sri Lanka.

In the study on the victims of domestic violence conducted by WIN, the author has

emphasized that 82% of the children of victims were also affected by witnessing the battering. Emotional symptoms such as intense crying, fear, restlessness and anxiety, anger towards the father, deterioration of school work, sadness, depression, aloofness, disobedience, insecurity and leaving home were identified among these children, based on the mothers' responses (De Silva, 1994).

Jayatunge (1998) conducted a study on women and violence at the Wendesiwatta settlement with a sample of 212 individuals including 63 women. The data was gathered using interviews and questionnaires. The author found out that 42% of the children of battered mothers were under stress. This was found to be further aggravated by the economic instability caused by violence at home.

A link between having a history of physical and sexual abuse during childhood and becoming a victimizer later in life was discovered in a study done in the low income urban families of the Colombo district (Moonasinghe, 2002).

Analysis of a series of cases of wife battering showed that, in 8% (5) of the families, the children were not attending school. In one family children turned violent (Vidanapathirana, 2007).

In the study conducted among Sri Lankan medical students on exposure to family violence, the results of correlation analysis show that the more frequently the participants witnessed inter parental violence, the more they revealed high levels of dissociation (r=0.184, p<0.01), anxiety (r=0.146, p<0.05), depression (r=0.278, p<0.001), and sleep disturbances (r=0.152, p<0.05). Also, the more frequently the participants experienced violence by their parents towards themselves, the more they revealed high levels of dissociation (r=0.197, p<0.01), anxiety (r=0.173, p<0.01), depression (r =0.286, p<0.001), and sleep disturbances (r=0.143, p<0.05) (Haj-Yahia & De Soyza, 2009).

A study on the consequences of hitting children / corporal punishment was done among 12 year old school children in the Colombo district (n=1226). The authors found out that the experience of corporal punishment was moderately, but directly and significantly, associated with psychological maladjustment in children. This association was found to be mediated by non-parent-to-child violence: the child's knowledge on the violence between parents, experience of peer and teacher violence and violence in the child's community (De Soysa *et al*, 2010).

2.2. GBV among ever married women and intimate partner violence

Magnitude of the problem

Studies done in populations of various ethnic, socio-economic and educational backgrounds in Sri Lanka show a prevalence of GBV between 20% and 60% (Deraniyagala, 1992, Nirthanan, 1999, Samarasinghe, 1991, Jayasuriya et al 2011, Kuruppuarachchi, 2010, Jayatilleke *et al*, 2010, Jayaweera *et al*, 2010, Jayatilleke *et al*, 2011). These studies vary in their choice of study designs, settings and populations as well as in the definitions and terms used to describe gender based violence; ranging from domestic violence, wife beating, wife battering to intimate partner violence.

Community based studies of gender based violence with the ability to determine the magnitude of the problem in local settings have been conducted from as early as 1991. One of the earliest of these studies, carried out as a cross sectional descriptive study with the objectives of determining the incidence and causes of domestic violence, was among 200 women living in urban low-income community in the Colombo district

drawn from all ethnic groups (Deraniyagala, 1992). Sixty percent of the women surveyed reported that they were subjected to domestic violence during the period of their marriage or cohabitation. Almost all of them (98%) had been beaten more than once.

Another study, conducted during the same period, sampled urban and rural communities in four locations in Sri Lanka (Colombo, Halmillawa in Anuradhapura, Nochchiya in Kurunegala and Pitakanda in Matale) (Samarasinghe, 1991). The majority of the households were from the lower middle class. This cross sectional study using an interviewer administered questionnaire was similar to that done by Deraniyagala (1992) among the urban low income community in Colombo. The definition used for this study was domestic violence; 'any assertive behaviour, verbal as well as physical, although innate, when provoked by words / actions of others or by conditions existing in the environment surrounding the potential aggressor'. This definition was similar to that used in the previous study. The results showed a similar prevalence of domestic violence in the urban and rural communities (Colombo – 21.7%; Halmillawa – 23.3%, Pitakanda – 23.3%), except in Nochchiya (31.7%) which is a rural area in Kurunegala. Of the total study population (n=515), 32.4% reported domestic violence during their marriage. Verbal abuse was reported more frequently than physical abuse. The majority of the women had been abused in adulthood (86.7%) in comparison to childhood (13.3%)

A similar cross sectional study was conducted in 1999, in the Medical Officer of Health area (MOH area) of Kantale in the Trincomalee district, among a sample of 417 women aged 18-49 years (Nirthanan, 1999). The reported prevalence of 'wife beating' among ever married women was 30% in that year and 22% for the year preceding the study.

Interviews with health care providers and the judiciary have also added valuable insights into the magnitude of GBV. A study done in 2000 focused on 52 victims of domestic violence in the Nuwara Eliya, Anuradhapura and Matara districts, using information gathered through interviews with criminal justice agencies (courts, police), other state agencies including medical services, Grama Sevaka, non governmental organizations and the victims of domestic violence (Hussein, 2000). The 52 victims had experienced multiple types of violence: domestic violence (48%), marital rape (23%), and family violence (3.8%), rape by a boyfriend (3.8%), economic violence (36.5%), social abuse (19.2%) and verbal/emotional abuse (51.9%). In the majority of relationships, violence had started 2-5 years after the marriage, while in some it had started even before or immediately after marriage. Most women reported occasional abuse (40.3%) of a moderate degree (44.2%).

Another record-based study to determine the prevalence of violence against women in Sri Lanka was carried out on police records (Mowlana *et al*, 2002) in the Nugegoda and Hatton areas. Based on these records, women aged 26 to 40 years were found to be most vulnerable to violence and, in contrast to other studies, neighbours (56%) were the most likely perpetrators of violence against these women with 12% incriminating husbands as perpetrators.

In the study where 110 articles published in Sinhalese and English daily newspapers between May 2007 to August 2007 were reviewed, the majority (94.6%) of the offenders were men, with 3.6% being women. Rape was the most prevalent type of harassment reported, amounting to 57 victims. Out of the 20 cases of killing reported, 18 were adults, of whom seven died following severe physical injury inflicted by husbands (Weerakkody & Kumara, 2007).

Healthcare settings have been commonly used, to study GBV and, according to the results of a survey among married females attending the out-patient department of the North Colombo Teaching Hospital, out of 242 participants 98 (40.5%) reported some form of abuse by their male partner. The prevalence of abuse reported was physical abuse 19%, verbal abuse 23%, emotional abuse 23% and sexual abuse 7% (Kuruppuarachchi, 2010).

Another community-based survey of domestic violence was carried out in six districts; Colombo, Kurunegala, Nuwara Eliya, Ampara, Batticaloa and Vavuniya (Jayaweera *et al*, 2010). In a sample of 697 households, selected via random sampling, 44.9% (313) women admitted that they were victims of spousal violence.

Violence in dating relationships, among unmarried partners has not been commonly studied in Sri Lanka. One such study was conducted among unmarried female undergraduates of the Arts, Science and Law faculties of the University of Colombo on issues related to love relationships among undergraduates (Gunawardena *et al*, 2010). Among a sample of 283 students, 52.3% of the students were currently engaged in love relationships. More than one third of the respondents (36%) reported that they were aware of instances where the relationships were initiated against the will of the female being coerced into such situations due to fear of being harassed (59%). Another 55.5% of respondents were aware of instances where female students were forced to continue love relationships against their will, for fear of being physically harassed by the male partner (63.3%). Thirty six percent of the respondents knew of instances of physical violence against the female partners within a love relationship and 57.2% knew instances of verbal abuse. Another 21% reported they knew of instances where violence was used by male partners to force sexual activities. Among them, 57.3% knew of verbal abuse and 23.7% of physical abuse used to forcibly initiate sexual activities. More than 60% reported knowing females who agreed to sexual relationships unwillingly due to fear of breaking up of the relationship.

A community based survey to determine the prevalence of intimate partner violence against women was conducted in the Western province in 2006-2007 using a WHO questionnaire previously used in a multi-country study on domestic violence (Jayasuriya et al , 2011).This study was conducted among ever married women of 18-49 years, selected by cluster sampling. The reported lifetime prevalence of physical violence was 34% and sexual violence 5%. Thirty percent of the women reported controlling behavior by their intimate partners and 19% reported they were subjected to emotional abuse. In terms of severity, most (57%) of the physical abuse was severe acts of violence. Also, most were multiple (62%) and repeated acts (77%) of aggression over time. Although the prevalence of sexual violence was only 5%, in the majority of cases (68%) these were repeated acts. Of the different types of sexual violence, the most common form reported was being physically forced into submission (76%).

A similar study was conducted in the Central Province to describe the prevalence of intimate partner violence by husbands and the association between wives' attitudes towards gender roles and their experience of intimate partner violence (Jayatilleke *et al*, 2011). Among a representative sample of 624 wives between 15 and 49 years of age, 36% had experienced at least one episode of physical, psychological or sexual abuse by their husbands during their life time (ever abused) and 19% had experienced such abuse during the past 12 months (current abuse).

Among the clients who attended Mithuru Piyasa, Matara (a special unit established in

2007 to provide care for survivors of GBV at the District General Hospital, Matara) from January to June 2011, emotional violence (42.7%) was the most prevalent type of violence followed by sexual violence (39.81%). In the majority of cases the perpetrators were husbands (>55%). In 38% of the cases, the abuser was a known person. 1.8% had received death threats by the perpetrators. 76% of the victim had told somebody about the incident (Samarakoon, 2011).

Health effects of GBV

There is evidence that GBV negatively impacts physical, psychological and social health. The following section summarizes the physical, psychological and social effects from different studies. The research evidence on the psychological impact of witnessing GBV on children and the association between suicide and violence are dealt in separate sections.

Physical health effects

Physical health effects are reported by the type of physical violence used, type of injuries, distributions and severity.

Manual assault was more common among the rural communities in Trincomalee (Nirthanan, 1999); whereas 51% of victims among the low income urban community in the Colombo District reported the use of weapons (Deraniyagala, 1992). In the study on intimate partner violence in the Western province, most (57%) of the physical abuse consisted of severe acts such as being hit with fist or an object; being kicked; dragged; beaten up; choked; burnt; threatened with a weapon or used a weapon. (Jayasuriya *et al*, 2011).

In the analysis of newspaper articles on violence against women, physical harassment constituted beating and other physical injuries, murder and suicide. Seven adult women had been killed by their husbands as a result of severe physical harassment (Weerakkody & Kumara, 2007).

When considering the type of injuries encountered in the rural areas of the Trincomalee district contusions were commonly reported. These were typically distributed in the region of the head, face and neck (Nirthanan, 1999).

Psychological health effects

In the study conducted in urban and rural communities in four locations in Sri Lanka, the consequences of trauma following violence were found to lower the self esteem of the victims, which further convinced the victim of her inferiority (Samarasinghe, 1991).

Suicides as a result of GBV

This entity has not been studied as a separate issue; but indirect evidence indicates that GBV may be associated with suicide. These studies have not specifically identified the health effects of GBV related attempted suicides.

A study conducted in 2006 attempted to explore the complexities behind self-inflicted pesticide poisonings among 166 Sri Lankans. The study was conducted in the Uda Walawe area of the Ratnapura district and involved two neighbouring government hospitals. Data was obtained through in-depth interviews. Issues related to "love affairs", arranged marriages and physical, sexual or psychological abuse in the domestic environment were referred to by many self-harmers or their relatives as provoking ingestion of poison. Domestic violence and abuse were seen as major causes of self-harm among 12% of the

affected. While alcohol misuse was often associated with occurrence of domestic violence among the cases interviewed in this study, women respondents also reported being abused without reference to alcohol abuse (Konradsen *et al*, 2006).

In a study of 52 victims of domestic violence in the Nuwara Eliya, Anuradhapura and Matara districts, 15 of the victims reported having attempted suicide and 9 had experienced thoughts of suicide (Hussein, 2000).

Exposure of children to intimate partner violence

In the study on a low income urban community in the Colombo District, the children were not beaten in the majority of cases and violence was very carefully directed towards women. However, it showed that domestic violence, leading to poor parenting, increased the risk of maltreatment of children (Deraniyagala, 1992).

In the study conducted on the rural community of the Trincomalee district, it was evident that the majority of women victims continued to live within the abusive relationship, placing the welfare of the children as their first concern (Nirthanan, 1999). This repeatedly exposed the children to the violent behavior of parents.

Another study done in 2000 on 52 victims of domestic violence in the Nuwara Eliya, Anuradhapura and Matara districts, showed that in 13 cases, violence was directed at children and in 11 cases the children had witnessed violence among their parents (Hussein, 2000).

A study was conducted among 476 medical students in Sri Lanka to examine the rates of exposure to family violence and to examine the psychological effects of exposure. A self-administered questionnaire containing standard scales was utilized to obtain data. Between 11% and 84% of the participants had experienced at least one act of parental psychological aggression and between 2% and 22% had experienced at least one act of parental physical violence during childhood (Haj-Yahia & De Soyza, 2009).

Factors associated with GBV among intimate partners

Research into GBV has attempted to identify and assess many of the personal, family and community factors associated with GBV in Sri Lankan settings. These factors range from the age of the partners, theireducational and socio-economic status, ethnicity, family size level of violence in the community and behaviours such as alcohol and drug abuse, marital dysfunction and perceptions of gender roles. The following factors have been described as associated with GBV by researchers in the different sectors.

In the study conducted on urban and rural communities in four locations in Sri Lanka, the author concluded that certain fears created by the aggressor and pressure from the aggressors and their families influenced women's attitudes towards domestic violence (Samarasinghe, 1991).

It has been shown that among the low-income urban communities in the Colombo District, economic dependence of the wives on their husbands was not in itself a significant cause of domestic violence. Most victims (70%) were the main income owners of the household and 33% owned the house they lived in. In this study, 37.5% of battered women reported that their husbands were not violent towards other persons and that most of the violence was directed at them in the privacy of their own homes. Sexual jealousy and reluctance/ refusal of the woman to have sex were among causes

identified as leading to violence. Significantly, the male partners of 95% of women who were battered gave no history of violent behaviour prior to marriage (Deraniyagala, 1992).

In the study conducted among victims admitted to the Provincial Hospital, marital (19%) and family (41.9%) problems were identified as the immediate causes of violence (Dias & Fernando, 1995).

In the study on women and violence of the Wendesiwatta settlement (in Awissawella of the Colombo District) on a sample of 212 individuals which included 63 women field based interviews identified superiority, authority and patriarchal attitudes and the inadequacy of international/ national policy and legal directives related to GBV as causes leading to violence against women and its continuance (Jayatunge, 1998). In addition, matters related to children and suspicions were also identified as causes related to violence against women. The author concluded that alcohol was not a cause, but a favourable condition for wife beating.

Moonasinghe (2002), in his study conducted in the MOH area of Kantale in 1999, did not show any significant association between wife beating and ethnicity or age group of either the batterer or the victim (Nirthanan, 1999).In contrast, a descriptive cross sectional study conducted among 1200 pregnant mothers attending antenatal clinics in the Badulla district, records the highest rate of abuse (32.2%) among the Indian Tamil communities in the estate sector. In this study Public Health Midwives collected data through an interviewer=administered abuse assessment questionnaire.

The study by Hussein (2000) on 52 victims of domestic violence in the Nuwara Eliya, Anuradhapura and Matara districts revealed that domestic violence occurred due to several reasons including dowry, alcohol, financial matters, adultery of both partners and failure in wifely duties. Some incidents had occurred without any significant reason. In the rural communities of Kantale, an early age at marriage for women, low levels of education, low income, low index of living standards, large families and alcohol consumption by the batterer were identified as factors promoting domestic violence (Subramanium & Sivayogan, 2001).

In the study on violence against women based on police records conducted in the Nugegoda and Hatton areas, land related disputes were found to be the commonest cause (Mowlana *et al*, 2002).

In the estate sector, philandering among men, suspicion, alleged misbehaviour of the victim, authority of the abuser, victims' vulnerability, extra-marital relationships and issues related to household income were among factors contributing to violence (Wijayatilake, 2003, Palaniappan, 2003).

A cross sectional study in the MOH area of Chilaw among 882 mothers of school going teenagers (Jayasinghe, Jayawardene & Perera, 2006) determined that a low index of living standards and frequent alcohol consumption by the partner were risk factors for intimate partner violence while the women being unemployed was a protective factor.

In 2003, a study to identify factors associated with intimate partner violence was carried out at two tertiary care hospitals in the Gampaha district. Data was obtained from 120 female assault victims. Factors that showed statistically significant association with intimate partner violence included the younger age of the victim, shorter duration of marriage, having less than three children, educational level below G.C.E. Ordinary Level and the use of either alcohol or drugs by the partner (Subodini *et al*, 2006).

In a study at the JMO's office, Colombo, the

author found that the highest number of victims was in the 24-49 year age group. The education level of the majority was less than G.C.E. Ordinary Level and the majority was economically dependent on their partner. The majority of the injuries had been sustained between 3.00pm and 12.00 midnight (Nanayakkara, 2007).

In a case analysis of 64 victims of wife battering at the Department of Forensic Medicine, Faculty of Medicine, Galle, the characteristics of both perpetrators as well as victims have been described. Out of the battering husbands, the majority (n 33, 51%) belonged to the 30-34 years age group. Most (n=51, 80%) were unemployed or daily paid labourers belonging to lower socio-economic group. 88% (n=56) husbands were violent in character, with 25% (n=16) having had a history of imprisonment and 30% (n=19) being gamblers. Alcohol addiction was found predominantly in the perpetrator group, amounting to 70% (n=45) of the subjects. One was a heroin addict and another one was a cannabis addict. 53% (n=33) of the abusers were reported to be suspicious about their wives while 10% (n=7) of these husbands had extra-marital affairs. Psychiatric or psychological disorders were also reported among these men with 30% (n=19) having personality disorders, 29% (n=18) morbid jealousy and 8% (n=5) seeming to have depression. 8% (n=5) of the men had a history of suicide attempts. Only 6% (n=4) were on daily psychiatric treatment.

Out of the 64 victims, the majority were young wives with 42% belonging to the 20-29 years age group. None of them were unmarried and 25% (n=16) did not have children. A low level of education was found in only 16% (n=10) who had only studied up to grade 5. Only 3% (n=2) reported to having extra-marital affairs. A history of imprisonment was reported in one woman. None were taking alcohol or drugs. Mothers of victims had also been abused by their husbands in 8% (n=5) of the cases. The author concludes that although in some studies the women victims were seen as the instigator of violence to which they were subjected, the low prevalence of possibly causative factors among the victims in this study suggests that the women may not be the instigators of violence. 42% (n=27) of the incidents in this study had taken place in the afternoon between 12 noon and 6 pm. (Vidanapathirana, 2007).

In a study conducted on 476 medical students in 2007, it was found that the older the participants' fathers and mothers, the more frequently the participants witnessed interparental violence. Furthermore, it was revealed that the larger the family size, the more the participants reported high rates of witnessing interparental violence. The findings also revealed that the less supportive the participants' family environment, the more frequently they witnessed interparental violence. However, there were no significant differences between male and female participants in reporting witnessing interparental violence. In addition, neither fathers' nor mothers' levels of education nor the family's socioeconomic status, as estimated by the participants, correlated significantly with witnessing interparental violence.

Jayaweera and others (2010) had conducted a study on domestic violence, in 697 households spread over 6 districts in the country. Two thirds of the women interviewed were from middle and upper middle class families. Half of the women were employed, over one third as professionals, administrators and managers in business enterprises. Although the majority of the households had male heads (73.3%) and the male spouse made the major contribution to household income (57.1%), there was no evidence of male dominance in decision making in the majority of households. However, there was a prevalence of spousal violence of 44.9% (n=313). There was no significant difference

in the incidence of domestic violence in the different income groups and in the three ethnic groups despite some differences in the three communities in the acceptance of restrictive social norms that negate the autonomy of women. Evidence indicated that education and material resources have neither reduced the incidence of domestic violence nor empowered the majority of women to resist violation of their human rights or to seek legal intervention to escape from an abusive environment in their homes. Those who have freely chosen their partner for marriage and those who had arranged marriages were equally vulnerable to abuse and violence. The main causes that precipitated violence, as identified by the respondents, were alcoholism (37.4%), incompatibility (23.6%), extra-marital affairs or suspicion (18.2%), conflict over expenditure, pawning/ stealing jewellery (17.9%), disputes with or interference by in-laws particularly mothers-in-law (17.5%), disputes over dowry (9.3%) accusation of neglect of household duties (6.7%) and sexual relations (2.2%). The authors note that the reasons spelled out are most often immediate causes of conflict while underpinning the violent reactions is the desire to exert power and authority in the marital relationship and to pre-empt any challenge or threats to the power structure based on asymmetrical gender relations (Jayawera *et al*, 2010).

The study on intimate partner violence in the Western Province found that younger women (aged < 25 years) were 3 times more likely to be subjected to severe abuse compared to older women. Having partners who abused alcohol and/or drugs, partner's infidelity and presence of children from other relationships also increased the risk of severe violence. The prevalence of all forms of violence was not significantly different between the ethnic and religious groups in the province (Jayasuriya *et al*, 2011).

In a study exploring the perceptions of factors contributing to intimate partner violence among Sri Lankan Tamil immigrant women in Canada, conducted via 8 focused groups with young, midlife and senior women and women who experienced IPV, the study participants recognized gender inequality and financial dependence as contributing factors (Hyman *et al*, 2011).

Among the 212 victims of GBV who attended the 'Mithuru Piyasa' special unit at District General Hospital, Matara from January to June 2011, the majority (46%) belonged to the age group of 15 – 35 years. Almost all were Sinhalese and Buddhists. 80% of the clients were female and 20% of them were male. Majority (69%) of them were unemployed. In 25% of the cases the perpetrators were under the influence of alcohol (Samarakoon, 2011).

Association of GBV with alcohol

The impact of alcohol on domestic violence was addressed in most of the studies conducted in Sri Lanka. The majority of studies concluded that alcohol is associated with GBV but that it was not the only cause.

In the study conducted in Jaffna on 60 cases of wife beating referred by the police for medico legal examination, it was highlighted that among 80% of the battered wives heavy drinking and drunkenness was a major problem among the husbands. In 70% cases, violence had occurred when the husbands were drunk (Saravanapavanthan, 1982).

In a study conducted in 1991 among 40 families in the Kalutara district, 16 men were reported as having turned violent against women. Children were also harmed in 16 families. Alcohol intoxication was the only reason given by women for violence (Fernando, 1991).

The study among pregnant women in the

Badulla district showed that a husband's alcohol consumption was among the most important correlates of physical abuse (Moonasinghe, 2002).

In the low income urban community of the Colombo district 82% of women experienced physical abuse for reasons other than alcohol consumption (Deraniyagala, 1992).

A community based cross sectional study was done in the MOH area of Thambuththegama on alcohol consumption by the fathers and family well being (Wijeratne, 1994). Data was collected from both partners in 634 families by the Public Health Midwives using an interviewer administered questionnaire. A significant association was demonstrated between the father's alcohol consumption and the occurrence of verbal and physical abuse within families. The level of alcohol consumption was significantly related to the frequency of abuse.

Another study was conducted among 31 women who were admitted to a provincial hospital following incidents of domestic violence and presenting with injuries needing surgical attention. The study found that 67% of the assailants were reported to be under the influence of alcohol. The authors concluded that alcohol does encourage men to engage in aggressive behaviour and to use dangerous weapons to inflict injuries on others (Dias & Fernando, 1995).

In Nirthanan's study (1999) in the Trincomalee district there was a statistically significant ($p<0.05$) association between wife beating and alcohol consumption by the batterer. Alcohol was also identified by most of women the study as the predominant factor instigating and aggravating wife beating. Focused group discussions showed that alcohol was mostly a trigger or excuse for domestic violence and the root causes were other issues, among internally displaced persons (IDPs) and the local community (Olupeliyawa & Ziard, 2004).

In the case analysis of 64 victims of wife battering at the Department of Forensic Medicine, Faculty of Medicine, Galle, 45 (70%) husbands were alcoholics (Vidanapathirana, 2007).

In the study on domestic violence conducted in six districts, alcoholism was identified by the respondents as the main cause that precipitated violence (37.4%) (Jayawera *et al*, 2010).

Of the clients who attended Mithuru Piyasa, Matara, from January to June 2011, 25% of the perpetrators were under influence of alcohol (Samarakoon, 2011).

In the study on intimate partner violence in the Western Province, it was found that having partners who abused alcohol and/or drugs increased the risk of severe forms of violence (Jayasuriya *et al*, 2011).

According to a discussion with Women In Need, Colombo, in 2008, information recorded by service providers does not identify alcoholism as a primary cause of domestic violence in particular and GBV in general. Alcoholism is recorded as shown by many studies (Baklien & Samarasinghe, 2004), as an excuse to perpetuate acts of violence against women. It is argued that the indemnity offered by the law where intoxication brings in mitigatory sentences for grave offences promotes this practice.

The effect of patriarchal values and attitudes on GBV

The male dominant values and attitudes prevalent in patriarchal societies that help to perpetuate violence against women have been documented in many settings. A similar pattern of behavior was observed by many of

the Sri Lankan authors.

A study done on 40 families in the Kalutara district inquired into the values and attitudes of respondents. It was shown that wife beating was considered as an acceptable solution to marital disagreement by both partners. Majority of the women accepted the subordinate status of women and believed that the male is more powerful. None of the women questioned the right of the man to assault her and none of the women wanted the police to intervene. Nevertheless, rape and abduction were perceived differently and they believed that the police should be informed (Fernando, 1991).

The study conducted on women and violence in the Wendesiwatta settlement included diverse ethnic and religious groups from different areas. Among the sample of 212 individuals studied there were 63 women who were interviewed. The reports of different types of abuse and their frequency were similar to those of other studies. The author identified some beliefs, attitudes and values related to violence against women. Belittling the women was found to be a common factor which affects the sustenance of a healthy relationship in the family, resulting in sexual frustration and separation even if they continue to live under the same roof (Jayatunge, 1998).

Men were found to believe that women were passive, passionate objects to be used for quenching their aggressive sexual desires. Men stated that the inadequacy of opportunity to satisfy their sexual desires was a reason for wife beating. They believed that men harass and beat their wives for pleasure and leisure and held that it was the sole responsibility of the women to keep the marriage intact. Women were found to be ignorant of their rights, believe that the men have the right to beat them and place a greater value on privacy. The fear of reprisal made women tolerant to assault; most were dependent on men and there was an inadequacy of support networks (Jayatunge, 1998).

An attitudinal survey was carried out among all the categories of health care workers to assess their awareness on violence against women and the actions taken by them when faced with victims. The results showed that the majority were of the view that most of the offences against women may be sexually motivated. The vast majority of the healthcare workers interviewed (96%) were willing to undergo training on this subject (Mowlana *et al*, 2002).

Traditional belief about sex and sexuality that subordinates women in relation to men also places women at increased risk of GBV. Studies related to male and female sexual habits and beliefs are limited. However, a study done in Colombo and its suburbs and in tourist destinations such as Hikkaduwa, Negombo, Galle and Tangalle among 105 female and 31 male commercial sex workers highlighted the cultural beliefs about gender and sexuality. It was revealed that while female sexual purity is expected by society, engaging in sexual activities was recognized as a fundamental necessity for men (Miller, 2002).

In 2006 a study carried out in Kandy examined the role of patriarchal values among the victims of wife abuse. The objective of this research was to analyze how concepts of patriarchal values are operational and how they manifest in domestic situations. The researcher established that the subordinate status of wives is often emphasized and reinforced through patriarchal values, based on practices such as dowry, extended or patrilocality based residence types, patrilineal descent based property ownership, the gender based household division of labour and norms related to the control of female mobility within traditional Sri Lankan families (Bulumulle, 2006).

Cultural and societal norms that accept violence

In many societies where GBV is prevalent, society itself enforces cultural norms that condone and accept violence. Women in such societies, who are victims of GBV, are seen to then normalize and accept violence in their lives without seeking interventions. Similar phenomena have been demonstrated by Sri Lankan researchers.

A study using structured interviews of men and women in the estate sector found that 74% of the women were of the opinion that husbands have the right to beat their wives. However 95% of the men were of the opinion that husbands should not beat their wives (Palaniappan, 2003).

A study on beliefs about wife beating among medical students was conducted on a sample of 476 Sri Lankan medical students, of which 50.6% were women and 49.4% were men. The participants' ages ranged from 19 to 34 years. Participants completed a self-administered questionnaire that explored six beliefs about wife beating, attitudes towards women, marital role expectations and exposure to family violence. Beliefs about wife beating were determined using a revised version of the Inventory of Beliefs about Wife Beating, developed by Saunders, Lynch, Grayson and Linz (1987). The following beliefs were addressed: justifying wife beating, battered wives benefit from beating, helping battered wives, husbands are responsible for their violent behaviour and punishing violent husbands. Attitudes towards women were assessed using the short version of the Spence and Helmreich (1978) Attitudes Towards Women Scale (ATWS).

The results showed that most of the students justified wife beating, believed that women benefit from wife beating and held that the wife bears more responsibility than the husband for violence against her. At the same time, most participants had expressed their willingness to help battered women. The authors also found that the vast majority of students opposed divorce as a solution to wife beating and were against punishing violent husbands. Although 71.3% of the participants had expressed some level of agreement with the statement that "even when a wife's behaviour challenges her husband's manhood, he is not justified in beating her", 23.2% of the participants had still expressed some level of agreement with the statements "it would do some wives good to be beaten by their husbands" and "occasional violence by a husband towards his wife can help maintain the marriage". Between 14% and 24% of the Sri Lankan medical students had expressed some level of agreement that women benefit from beating (Haj-Yahia & De Soyza, 2007).

In the same study on the beliefs of the medical students, 75.5% of the participants showed that a significant variance existed regarding each of the beliefs inquired into by the questionnaire. This is explained by the authors as being related to the students' patriarchal approach toward women and marriage and by their exposure to violence in their families of origin. Male participants were significantly more likely than their female counterparts to justify wife beating. In addition, the authors identified that lower parental levels of education and lower socio economic status of their families, led to a the greater tendency to justify wife beating. The results of this study also showed that the stronger the Sri Lankan medical students held traditional attitudes toward women and the more patriarchal and non egalitarian their expectations of marriage, the greater their tendency to justify wife beating. The results did not demonstrate any significant correlation between the participants' trauma symptoms and the functioning of their families on one hand and their tendency to justify wife beating on the other. However, the authors concluded that the more the students witnessed and experienced family

violence during childhood and adolescence, the greater their tendency to justify wife beating (Haj-Yahia & De Soyza, 2007).

Kuruppuarachchi (2010) conducted a study on intimate partner violence (IPV) among married females attending the out-patient department of the North Colombo Teaching Hospital. The majority of the females surveyed believed that violence by the male partner should be tolerated. In the study on intimate partner violence in the Western Province, more than 50% of the women interviewed 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 demonstrating the underlying societal values that make violence acceptable (Jayasuriya *et al*, 2011).

A study conducted in the Central Province on the association between intimate partner violence (IPV) and wives' attitudes toward gender roles found that they were more likely to experience psychological abuse by husbands if they did not believe that "a good wife always obeys her husband". Although several published studies on intimate partner violence suggest that traditional gender role attitudes tend to increase women's vulnerability to IPV, this study demonstrates how women in Sri Lanka accept these cultural norms in order to reduce the IPV (Jayatilleke *et al*, 2011).

2.3. GBV during pregnancy

GBV during pregnancy has been highlighted as a significant problem that needs to be addressed by health care professionals. Different aspects of abuse during pregnancy have been investigated in both urban and rural communities. Some studies have specifically focused on pregnant women, whereas others have considered the phase of pregnancy as a part of their study.

Magnitude of the problem

The reported prevalence of violence during pregnancy ranged between 5% - 53% in different settings and populations in Sri Lanka.

Among 200 women in a low income urban community in the Colombo district (1992), 42% were found to have experienced domestic violence during pregnancy (Deraniyagala, 1992). It is important to highlight the tenfold difference in the prevalence rates between the low income urban community and pregnant mothers of the Badulla district. However, underreporting may be a cause of this difference as the study in Badulla was carried out among mothers who attended the antenatal clinics.

A study was done in 1994 among 45 women victims of domestic violence, with the aim of highlighting the medical perspectives of wife assault. In this study a structured questionnaire was used to obtain case profiles and views on wife assault. Of this sample, 53.3% were identified as assaulted during pregnancy and 4 stated that they received blows to their abdomen (De Silva, 1994).

A study carried out in 2002 among pregnant women attending antenatal clinics in the Badulla district was mainly directed at developing an abuse assessment questionnaire that could be used by Public Health Midwives (PMH) to identify pregnant women who are victims or at risk of abuse (Moonasinghe, 2002). A sample of 1200 pregnant women identified through cluster sampling was interviewed by the PHMs using an interviewer administered questionnaire. The prevalence of physical abuse were 'ever-abused' 18.3%, 'current abuse' 10.6% and 'in current pregnancy' 4.7%. In addition 2.7% of women reported sexual abuse during pregnancy. The prevalence of abuse was reported to be

highest when the women's age at marriage was 19 years or less. The husband was found to be the main perpetrator of violence, followed by the mother-in-law. Among the 20% of women who were abused when pregnant, the frequency of abuse was at least once a week.

A cross-sectional descriptive study was carried out on a random sample of 110 in-ward post-natal mothers at the De Soysa Hospital for Women in 2005 (Dinusha *et al*, 2006). The objectives were to identify types of abuse, vulnerable groups and the effect of abuse on pregnancy outcomes. The results showed that 30% of women had experienced some sort of abuse during pregnancy. Of those abused, 76% of them had experienced physical abuse, 76% had experienced emotional abuse and 51.5% had experienced both. It was also found that 18% had experienced sexual abuse during pregnancy. Abuse was reportedly higher among unmarried mothers (66%) and in the 40-50 year age group.

In an interview based study of 52 victims of domestic violence in the Nuwara Eliya, Anuradhapura and Matara districts, 40.4% reported experiencing violence by their partner during their pregnancy (Hussein, 2000). The results of the study on women's health and domestic violence against women in the Western Province of Sri Lanka however reports the prevalence of violence to be less during pregnancy than when not pregnant (Jayasuriya et al, 2011).

Health effects of GBV

Health effects of violence during pregnancy can be grave not only for the woman but also the foetus. Although studies on pregnancy related complications of GBV are limited in Sri Lanka, some studies have examined this issue in detail.

In the study done at the De Soysa Hospital for Women in Colombo, adverse foetal outcomes were seen in 52% of the abused mothers as compared to 24% in the non-abused group. The odds of an abused mother having an adverse pregnancy outcome were 3.25 times higher than that of a mother who had not been abused during pregnancy (Dinusha *et al*, 2006).

The prospective cohort study on 820 pregnant mothers in the Gampaha district showed that the pregnancy outcome worsened with the psychosocial stress associated with physical and verbal abuse (Abeysena, 2002).

Contusions and lacerations appeared to be the commonest outcomes of physical abuse during pregnancy. The study in the Badulla district reported that 37% of the physically abused women were severely abused and about 20% needed hospitalization following the assault (Moonasinghe, 2002).

Factors associated with GBV

In the Badulla District the prevalence of GBV during pregnancy was found to be higher within the nuclear families (59.3%) compared to extended families and where the practical support to women is low (62.5%). A history of previous marriage of the husband and a history of wife abuse were also significantly associated with higher incidence of physical abuse. There is evidence to support the fact that physical abuse is more common among women who are not married but living together with their male partner (consensual relationships) than among married women. Prevalence was seen to be lowest among who grew up within their own families but there was no association with the number of siblings or the birth order (Moonasinghe, 2002).

In the study done at the De Soysa Hospital for Women in Colombo, it was found that abuse during pregnancy occurred

independent of the socioeconomic status, employment status or the planning of the pregnancy. Abuse rates were found to be higher in mothers with alcoholic male partners (Dinusha *et al*, 2006).

2.4. GBV in the elderly

Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person (Action on Elder Abuse Bulletin, 1995). In the fast increasing elderly population of Sri Lanka, GBV among the elderly is a minimally researched area of study.

Magnitude of the problem

Studies show that elder women are more likely than men to be abused. The most common forms of abuse are assault and neglect in providing medical care (National Report on Violence and Health: Sri Lanka 2008).

A study was conducted on the prevalence of elder abuse among elderly residents in the Galle MOH area. A cross-sectional household survey was conducted on 268 women and 97 men selected from 15 PHM areas in the Galle MOH area using an interviewer-administered questionnaire. Validated instruments were used to identify existing abuse and potential for abuse. More females than males reported to have undergone three types of abuse: physical abuse (females 9.8%, males 4.1%, p=0.21), emotional abuse (females 28.3%, males 20.6%, p=0.28) and neglect (females 85%, males 75.3%, p=0.01). However, more males suffered financial abuse than females (females 18.5%, males 33.5%, p=0.01). A significantly lower proportion of females than males had daily opportunities for social interaction (females 50.2%, males 66.7%). In screening for potential for being abused, 81.5% females and 88.7% males reported positively, for at least one item in the tool (p=0.22) (Perera, *et al*, 2010)

Health effects of GBV

Suicides among the elderly are on the increase. The underlying cause of some of the suicides has been the result of abuse at the household level. More elderly males than females were found to have committed suicide. The mortality rate of men aged 65 years and over in Sri Lanka due to intentional self-harm was 92.6 per 100 000 population in 1997, the highest rate for all age groups. The corresponding rate of 20.0 for females was also relatively high compared to other age groups (Ministry of Health, 2002).

Factors associated with GBV

Elderly people who were older were more likely to undergo GBV than their younger-elderly counterparts. The elderly who were disabled, those who did not have any financial assets and were entirely dependent on their children, those who lived in the urban setting where all other household members went out for work and elders who lived in an institution were found to be more likely to be abused (Center for Health Development, World Health Organization 2008).

Chapter 3

GBV in different environmental settings

GBV in different employment/ work settings

Working women in different sectors, irrespective of their socio-economic status are subject to different forms of violence. Some studies have focused on the working women in general, whereas some studies have been confined to specific sectors considered to be at high risk for GBV and these are discussed in the following section.

3.1. GBV in the industrial sector

GBV in the workplace, ranging from sexual harassment to rape has been reported in many settings. Although such studies are limited, they provide some important evidence of the problem in the public and private sector.

A study was done to find out whether sexual harassment is a problem in Sri Lankan workplaces. A sample of 321 respondents was chosen from among a cross section of three industries; wholesale and retail industry, educational sector and financial intermediary sector using the snowball sampling technique (Adikaram, 2005). It was found that 62.3% of respondents had experienced unwanted and unwelcome sexual behaviours at the workplace at some point in their lives. Further, 37.4% of respondents had experienced this more than once. Physical harassment was the commonest type and peer harassment the commonest form. Victims identified unwelcome touching, unwelcome patting, persistent invitation for sex as constituting sexual harassment.

More importantly, 50% of respondents were not aware of legislations dealing with sexual harassment in Sri Lanka and most of the workplaces did not have policies to deal with the problem. Most of the victims had resorted to non-assertive methods of handling unwanted behaviour and only 8% of the victims had formally lodged complaints with the relevant authorities. The author also concludes that the respondents rejected the idea that they use their sexuality as a way of gaining employment benefits (Adikaram, 2005).

A sample survey was conducted by on 1200 women workers in 9 government departments during a period of three months. Contrary to the findings of the earlier study, only 0.9% of respondents reported being sexually harassed in the office (Beddewela, 1996).

Management level personnel of 29 different organizations situated within Colombo were interviewed about sexual harassment at the workplace using a standard questionnaire. The results showed that 69% of managers were aware of the concept of sexual harassment at the workplace. The author found that only 17% of these organizations had sexual harassment policies in place (Gamage, 1999).

3.2. GBV in the plantation sector

A significant amount of research has been done on GBV in the plantation sector in Sri Lanka. Plantation workers face GBV not only in their own homes but also during their work in the estate field. Reports of harassment, rape and abuse of estate workers by male supervisors are frequent.

Magnitude of the problem

A UNFPA funded descriptive cross sectional study (2003) on GBV among 350 randomly selected women workers in estates in Hatton used an interviewer administered questionnaire to collect data. The study showed that 83% of women were victims of GBV, irrespective of their civil status. The violence was not limited to the home but occurred in the workplace, school, kovil and bus. The abuse at workplace was contributory to reducing productivity in the estates. Within the plantations sector, the prevalence of GBV was higher in the rural (86%) than urban (54%) areas. This contrasts with findings from non estate communities. The abuser at home was a close family member and at the workplace it was the supervisor or the Kangani (Wijayathlake, 2003).

A majority of the victims in the plantations sector were found to have suffered non-sexual physical abuse (43.3%), which compares similarly with other communities. In 37% of the cases the perpetrators had used various types of weapons for attacking. In the rural communities cooking utensils, pestles and mammoty were more frequently used when compared to instruments used in the urban settings (sticks, knives and fire brands). A significant proportion had also undergone verbal (35.8%) and sexual (19.5%) abuse (Wijayathilake, 2003).

A study was conducted on the status of the human rights of women in the plantation sector in four districts in Sri Lanka – Nuwara Eliya, Kandy, Kegalle and Galle. Data was collected from a sample of 649 women working in the estates via focused group discussions.

Of the victims of GBV among the women working in the estates, in 66% of the cases the perpetrator was a male such as the husband, father, brother or estate authorities (Kanganies i.e. male supervisors). 21% of the perpetrators were women, and 13% identified the community as the perpetrator. Women who have been subjected to violence from Kandy and Nuwara Eliya districts stated that they fully depended on their trade union leader and the estate leaders to either take legal action or go to the police, as they were of the belief that all their actions had to be guided by these authorities and felt helpless bypassing them. Estate leaders, 100% of them being male, acted to stop the women from taking action against offenders and were supportive of the aggressors in most cases. 52% of the women said they were afraid to go to the police station to complain as they did not know how to speak the Sinhalese language, how to read or write in Tamil language and due to previous immense difficulties they have undergone due to lack of the national identity card. Police stations were also found to be lacking women police officers (Chandrabose, 2007).

A study was commissioned by the International Labour Office (ILO) on sexual harassment at work in the plantations sector. Data was collected through a literature review and an in-depth analysis of specific action against sexual harassment at the enterprise level, using focused group discussions, interviews with individual women workers, employers, managers, ILO representatives, other key informants and review of case reports. The author concluded that all forms of sexual harassment were prevalent varying in frequency and a wide spectrum of interpretations exists within the range of manifestations. The management and other officials appeared to be unaware of the daily occurrence of harassment in their workplaces. Women continued to work as they feared loss of employment if they resisted sexual harassment. The victimized women had felt further harassed when the news spread and they were blamed. Only very few had made protests (Wijayathilake & Zackariya, 2001).

Health effects of GBV

In the study commissioned by the ILO, the victimized women were found to continuously suffer varying degrees of emotional stress that affected their work. Women expressed negative feelings such as anger, shame, humiliation, helplessness, guilt and confusion (Wijayathilake & Zackariya, 2001).

Another form of abuse faced by estate workers, especially females, is the compulsion to undergo permanent family planning methods. It was found that 52% of the women had been forced to undergo compulsory family planning by the estate medical authorities. They had undergone ligation & resection of tubes (LRT) procedure usually done in unhygienic estate dispensaries and 32% of the women had no clear idea about the method of family planning that they had undergone (Chandrabose, 2007).

Reproductive coercion was also identified as a form of GBV in the plantations sector. Males tried to convince their wives on female sterilization as most of them were reluctant to undergo vasectomy owing to different socio cultural beliefs (Palaniappan, 2003).

Factors associated with GBV

In the estate sector the organization of the work hierarchy, male supervision of female workers and the working environment in the fields contributes to women workers' vulnerability. In the study commissioned by ILO, sexual harassment was found to be more pervasive at lower levels of the workers' hierarchy. The younger women who lived alone were more vulnerable. At times the perpetrators were co-workers, or even subordinates and not necessarily those in authority. Family members were also found to be guilty (Wijayathilake & Zackariya, 2001).

3.3. GBV among women migrant workers

Magnitude of the problem

A study of the health problems and abuses experienced by women returning after being employed in the Middle East was conducted in all 11 MOH areas in the Colombo DPDHS division and the Colombo Municipal Council area. Three groups of returning migrant workers in the age group of 20- 49 yrs were enrolled in the study. The three groups were, those who returned within the previous two weeks and locally employed and unemployed women who had returned within the past 5 yrs. Trained Public Health Nursing Sisters (PHNS) used an interviewer-administered questionnaire to determine the status of abuse among women. The results showed that 10.8% of recently arrived migrant women, 13.2% of women locally employed and 6% of unemployed migrant women had been sexually abused. In comparison to unemployed women (16.4%), physical abuse was 1.7 times greater among migrant women (25.2%). Psychological abuse was assessed using seven questions and analyzed separately. A high proportion of migrant women (86%) reported being psychologically abused and this was 12 times greater than that reported by locally unemployed females. (Munasinghe *et al*, 2004).

Health effects of GBV

The study in the MOH areas of the Colombo district showed that women with a history of physical and sexual abuse had a poorer mental status. Among the 25% of returnee women who were physically abused, the type of abuse ranged from physical assault to burn injuries. Physical assault in the country

of destination was reported to result in early return, return without wages, problems at home on return and even permanent physical disability. It is also emphasized that the sexual exploitation of migrant women can result in unwanted pregnancies, induced abortions, severe psychological trauma and even death (Munasinghe *et al*, 2004).

Factors associated with GBV

The authors of the study conducted on migrant workers in the Colombo district identified the main reason for physical abuse of women being their inability to cope with the workload (Munasinghe *et al*, 2004). Other studies have not inquired into the possible contributory factors in detail.

3.4. GBV in the Free Trade Zones and in garment factory workers

Magnitude of the problem

A study on the safety of women Free Trade Zone workers was conducted among 1344 workers in Biyagama, Katunayake and Koggala Free Trade Zones. An interviewer-administered questionnaire was used for data collection. According to the results, traveling appears to present the greatest risk of sexual harassment and was the setting of GBV 83% of the victims. Sexual harassment at the workplace was experienced by 57% and at the place of residence by 36%. Koggala had the highest proportion of harassment in all three settings. It was further shown, in all three zones, that non-physical harassment in the workplace is the most frequent type of abuse, occurring up to more than 30 times per month. The author also stressed that some female managers and supervisors who are expected to provide protection were identified as being among the perpetrators of harassment (Perera, 1997).

A household survey was conducted among women in the garment and textile industries to study gender roles and relationships. As a part of this study 52 households of female Free Trade Zone workers were visited and interviewed. The results showed that 10.5% of women garment workers had experienced violence outside the domestic sphere. Four of them had confronted rape. Only 2 of them reported sexual harassment at the workplace. Similar proportions of violence were reported among other sectors of the textile industry; rural garment factories, home based garment industries and women handloom workers. Within the domestic sphere, the response to abuse had been mostly passive. Three of the victims had attempted suicide. Some women had returned to the parental home while others had decided to seek the assistance of the police. (Jayaweera & Sanmugam, 2001).

Factors associated with GBV

Night travel did not appear to be associated with a greater risk than travel by day. Two of the commonest factors leading to harassment were found to be travel on lonely or unprotected roads and travel by bus (Perera, 1997).

Violation of patriarchal norms as shown by disobedience to the husband, retorting back and neglect of household duties were related to violence at home. Economic constraints, suspicion, infidelity and extra marital issues were other causes (Jayaweera & Sanmugam, 2001).

3.5. GBV among medical students

Several studies have been done in Sri Lanka which focused on different aspects of GBV among the medical students.

The prevalence of gender related harassment among medical students, the nature of harassment and the availability of counseling and support in the Faculty of Medicine were studied among 250 medical students who had spent three or more years in the University of Colombo. This cross sectional study was carried out using a pre-tested self-administered questionnaire and

inquired about all three forms of abuse, viz. verbal, physical and sexual. Among the 163 female students sampled, 71.8% had experienced gender related violence at least once during their course of study in the university. The prevalence among the 87 male students was 25.3%. The commonest type of abuse was verbal. Physical and sexual harassment were among the other types of violence experienced. Most of these incidents had occurred during the clinical appointments. The authors found that in all types of activities within the university, females encountered gender related violence more frequently than males. Further, the wide range of perpetrators did not significantly differ among males and females. One exception was female students, who were abused by their current male partners. Teachers were implicated as the commonest perpetrators, among the non-peer categories (Perera *et al*, 2006).

This study also focused on the reactions of the medical students following gender related violence. Only 43.4% of the students (males 18.2%; females 48.7%) who were subjected to some form of gender related violence had reported the occurrence. The majority of the victims had informed their friends or family members but almost none had informed a person in authority. The many reasons identified for failure to inform did not significantly differ between males and females. 53 stated that they knew of another student who had undergone gender related violence within the university premises. A significant finding was that 9.2% of women and 4.6% of men thought that the violence inflicted was culturally acceptable in the society (Perera *et al*, 2006).

3.6. GBV in public transport

The few studies about GBV in the public transport system have focused on sexual harassment.

Magnitude of the problem

A study was done in 2004 with the objective of assessing the prevalence, knowledge and some associated factors of sexual harassment among women using public transport. Sexual harassment was defined in this study as 'any unwelcome sexual comments, advances or requests for sexual favours that humiliate, threaten or embarrass the victim'. The forms of harassment ranged from uninvited touching, sexist remarks and/ or jokes and verbal, to visual or physical conduct of a sexual nature. This descriptive cross sectional study was conducted in the Maradana railway station on a sample of 200 women. The study population included various categories of females who were schooling, involved in higher education and working. Respondents were interviewed by female medical students. In addition to these interviews, focused group discussions were carried out among the first year undergraduates of the Faculty of Medicine, University of Colombo. The study showed that the prevalence of ever being harassed when using public transport was 94%. No statistically significant difference in the frequency of harassment between the youngest and the oldest age groups was evident. The most common form of sexual harassment was unwanted physical contact and this was experienced by 90% of the females. An obscene gesture by males was the next most common problem (70%). Less than 10% of females had experienced the display of sexually explicit objects and photographs while traveling in public transport. The exposure of genitals by males while traveling was experienced by 30% of the females. The authors also found out that 75% of affected women had been subject to such harassment up to five times during the two weeks prior to the study (Amarasinghe *et al*, 2004).

The authors also inquired about perceptions of sexual harassment among women using public transport. Fifty percent of the study population had known that unwanted physical contact is a common form of sexual harassment during public transport and 45% knew that deliberate touching of the body was a form of sexual harassment. Sexual jokes and comments were also considered as

forms of sexual harassment. Sixty percent of the study population knew that there was a law against sexual harassment. However most of them did not know what the law was. The impression among the majority was that offenders escaped punishment as the law was not properly implemented. Knowledge of the law was related to the level of education of the respondents.

The authors found, that only 2.1% of the women respondents had reported to the police following the worst incident. Various reasons such as fear, embarrassment and unawareness of the law were given for not reporting. Some women have taken various other forms of reactions such as moving away, scolding or attempting to assault the offender. The women who reported were found to be aware of the law against the offenders. Seventy percent of the victims have said that the others in the vehicle had not made any response after witnessing the sexual harassment (Amarasinghe *et al*, 2004).

Another study focusing on sexual harassment at the workplace and on the way to work was conducted on 1200 women working in nine government departments. The author found that 81.3% of the women interviewed had complained of sexual harassment while traveling to work by public transport. The main types of harassment were reported as unwanted touching and patting, usually by the bus conductors and male commuters (Beddewela, 1996).

Health and psychosocial effects of GBV

Among victims of sexual harassment in the public transport system, 7% had sustained minor physical injuries such as abrasions, contusions and small cuts on their body, especially while trying to move away from the offender. The authors have also identified some psychological effects on the victims such as fear of traveling in public transport, anger, mental instability etc. (Amarasinghe *et al*, 2004).

Factors associated with GBV in public transport

The authors of the study at the Maradana railway station had inquired about the factors associated with sexual harassment during the public transport. Sixty seven percent of the victims were found to be traveling alone when they were harassed. The focused group discussion was able to identify some factors that may have been contributory. The factors relating to the victims were: wearing 'unsuitable' clothes, traveling alone, falling asleep, crowding, not being watchful about certain males and not protesting against sexual advances. The factors related to the offenders were: consumption of alcohol, mental distress, age group (middle aged and elderly) and low socio economic background (Amarasinghe *et al*, 2004).

3.7. GBV among internally displaced persons (IDP) affected by the war and / or tsunami

Several investigators have conducted their studies on internally displaced persons in the North-East conflicted areas and the tsunami affected areas. They have tried to highlight the GBV issues in these sectors both during and after the disaster/ conflict.

Magnitude of the problem

A study was conducted on sexual and gender based violence in the areas affected by the war in the Northern and Eastern regions of Sri Lanka. It focused on twelve locations grouped into three categories: conflict affected areas predominated by the LTTE (Batticaloa. Vavuniya, Mullativu and Killinochchi); areas directly affected by the war and having both government and LTTE presence (Trincomalee, Jaffna, Ampara and Mannar) and areas immediately surrounding the conflict areas (Anuradhapura, Polonnaruwa, Moneragala and Puttalam). The study was done through an analysis of hospital records, police stations and welfare centers. According to the results, the

majority of the victims were in the age group of 20-44 years. The perpetrators were mostly men, who were often related to the victims. The occurrence of sexual and GBV was primarily in the domestic environment. The author concluded that the authorities concerned either do not have the capacity/ awareness or expertise and resources to collect and maintain GBV/ sexual harassment data in a systematic manner. She further stated that all institutions investigated, both government and non governmental, are seriously lacking in both awareness of and the capacity to recognize sexual and gender based violence as a specific type of offence which requires to be dealt in a specific manner (Wijayathilake, 2004).

Olupeliyawa and Ziard (2004) conducted a study on domestic violence among internally displaced persons (IDP) in the Puttalam District. The study was based on the definition that domestic violence may include but is not limited to physical and sexual abuse, denial of financial support and emotional deprivation, the use or threat of using legal sanctions against a partner, denial of rights and physical and emotional abuse of children. The main objectives of this study were to describe the contributory factors of domestic violence, to compare the incidence among the IDP and local communities and to describe the reasons for underreporting of domestic violence. Data was collected by reviewing secondary data (police records, medico legal records), focused group discussions and completion of self-administered questionnaires. The results have shown that the incidence of reported domestic violence was lower in the IDP community when compared with the local community. The authors attribute this difference to underreporting in the IDP community.

A study was done in 2006 on the role of international organizations and international NGOs in the prevention and response to GBV in Sri Lanka among organizations having specific in-situ GBV programmes in tsunami-affected areas. The study determined whether GBV was an issue of concern for tsunami-affected women and whether the incidence of GBV had increased sine the tsunami. Fieldwork was carried out in the Jaffna, Batticaloa, Ampara, Matara and Galle districts over a period of eleven weeks. The research was qualitative and used semi-structured interviews with key staff of these organizations to obtain information. The author concluded that whether or not an organization sought or had the capacity to address GBV in a particular location was dependent on previous GBV work such as whether prevention and response mechanisms, services and sectors were available prior to the tsunami. Other influences included how well established an organization was in the area, the existence of capable local partners, the presence of staff with knowledge or interest in GBV work and the role of local activism in drawing attention to women's needs. GBV activities in the first few months of the disaster were relatively few and related to pre-tsunami GBV initiatives (Fisher, 2006).

Health and psychosocial effects of GBV

According to the study done in the Puttalam District, there were 30 admissions due to domestic violence at the Puttalam Base Hospital over a period of six months. This was less than 10% of the total number of cases reported to the police and most of the injuries were grievous in nature. The authors stated that most of the victims get admitted only if medical attention is essential (Olupeliyawa & Ziard, 2004).

A study was carried out on females affected by the violence of war among a sample of Tamil women under the age of 40 years. 30 women from Reclamation West area of Jaffna district and from the Colombo District who has been widowed or had their husbands disappear due to the civil war were enrolled in the study. Primary data was collected though questionnaires, case studies and interviews and secondary data via resource profiles of the Jaffna District Secretariat and Divisional Secretariat. A high prevalence of different types of issues were faced by these women: psychological problems; Jaffna 60%, Colombo 60%, economic problems; Jaffna 80%, Colombo 20%, socio cultural problems; 6% each in Jaffna & Colombo, legal issues; Jaffna 6%,

Colombo 13%. The types of psychological problems seen were depression (79.5%), stress (76.6%), post traumatic stress disorder (29.5%), suicidal tendency (33%), somatization (36%) and anxiety (33%). The issues faced due to the violence due to war were further multiplied by the traditional cultural practices prevalent in the society such as widows being considered 'inauspicious' and not being allowed to play an important role in family events, not being allowed to wear flowers, 'pottu', 'mehendi' or wedding necklace and the attitudes against remarriage (20% in Jaffna, 0% in Colombo). Women widowed by war were further found to face cursing due to their widowhood (39.5%), lack of protection and being an easy target for sexual abuse (23%), and isolation (29.5%) (Navaratnam, 2010).

Factors associated with GBV among displaced persons

In the study done in the Puttalam District the authors have also focused on the contributory factors of instances of domestic violence reported to the police stations and attempted to compare these factors between the two groups; IDPs and the local community. The use of alcohol and extra marital relationships were found to be the main contributory factors in both communities. Demands for dowry, gambling and presence of extended family in the same household were more prominent in the local community than among the IDPs. Unemployment among men, custody of children, childlessness and the men's suspicion of the actions of women were more prevalent among the IDPs when compared to the local community. Focused group discussions showed that alcohol was mostly a trigger or excuse for violence where other root causes were present (Olupeliyawa & Ziard, 2004).

The authors have tried to identify the reasons for underreporting of domestic violence. Fear of social stigma, influence of the mosque committee, lack of other means of support, perception of the incident as the fault of the victim, unacceptability of being single, concern for children and the hope of change in the partner were some of the reasons identified (Olupeliyawa & Ziard, 2004).

Jayasena and Nastasin (2008) conducted a study on 45 women from two locations affected by the tsunami, Weligama and Hambantota. Data was collected via focused group discussions and in depth interviews. 45% of the women lived in temporary shelters or other people's houses. The women claimed verbal abuse by their spouses has increased since the tsunami due to the many hardships faced. They identified increase in alcohol consumption by their partners as a cause for this as there were more opportunities for alcohol use as many illegal liquor joints had sprung all over the tsunami affected coastal areas and as the men had lost their livelihood and spent more time on drinking. Also, living in temporary shelters provided easy access to women and even girls, which often led to family quarrels which resulted in domestic violence. One woman reported her child being raped. Lack of proper employment, loss of livelihood in agricultural occupations and economic hardships led to marital problems and domestic violence. Women were subject to physical violence, but they claimed its frequency and severity were the same as prior to the tsunami.

Chapter 4

Clinical manifestations and care seeking behaviour of GBV survivors

Several investigators have focused on the victims of GBV referred to health care services such as hospital admissions and medico legal referrals.

4.1. Data from medico-legal settings

A study was conducted in Jaffna on sixty cases of wife beating which were referred by the police for medico-legal examination. Interestingly, the author found that in 60% of the cases, the complaints were made to the police officer after 10 years of marriage. He attributed this to the fact that the majority of women were illiterate and most of them were economically dependent on their husbands. As only 7% of the injuries were grievous the author concluded that assault was not usually premeditated and there had been no intention on the part of the husband to cause severe bodily harm. No specific inquiry had been made about the perpetrators in this study (Saravanapavanthan, 1982).

An analysis of some selected aspects of female survivors of intimate partner violence was done at the Judicial Medical Office, Colombo. This descriptive cross-sectional study carried out over a period of one year enrolled 300 victims of intimate partner violence. Out of these 300 survivors, 258 were found to have been beaten with hands and feet by their partner. Weapons were used on a majority of the victims and 43 had been attacked with sharp weapons (Nanayakkara, 2007).

Sixty four female victims of wife battering who were referred to the Department of Forensic Medicine, Faculty of Medicine, Galle from May-2004 to May-2006 were interviewed to describe and interpret the injuries and to describe medical, social and legal aspects of wife battering. 36 victims were reviewed 6 months after the police complaint. Data were analysed to find descriptive statistics. Majority (n 35, 55%) of the victims had faced more than 10 occasions of assault. All 64 victims (100%) had been punched, 41 (64%) had been kicked and 44 (69%) had been assaulted with some kind of weapon. In 88% (56) of the cases, assaults had begun with initial threatening, while in 54% (34) no prior warning had been evident. Some kind of psychological abuse was prevalent in 100% (64) of the victims. All had been verbally abused with 80% (51) having been threatened. 28% (18) of the victims had been prevented to access for food, TV, medicine, friends or relatives (Vidanapathirana, 2007).

In the study at the JMO's office, Colombo, the commonest site of injury was identified to be the head and face, followed by the upper limbs. The commonest type of injury was contusions (98.3%), followed by abrasions (44.3%), lacerations (31.3%) and burns (9.6%). Some of the victims had suffered several types of injures (Nanayakkara, 2007).

In the study on 64 victims of wife battering at Department of Forensic Medicine, Faculty of Medicine, Galle, 58 (91%) of the women had injuries such as black eyes, tram line contusions and slap marks. Out of the 58 injuries, 95% were non grievous in nature. Head injuries amounted to 33 (51%) of the injuries and black eyes to 13 (21%) (Vidanapathirana, 2007).

4.2. Data from hospital admissions

A study was conducted among 31 women who were admitted to a provincial hospital following incidents of domestic violence and presenting with injuries needing surgical attention. Rape and abortions were excluded from this study. The victims were

from the agricultural sector and of lower socioeconomic status. A structured questionnaire was used to collect information. In this study none of the respondents have denied that the injuries were due to domestic violence and 35% of the victims had disclosed that the husband was the perpetrator. Another 25% had identified an immediate family member as the perpetrator. The frequency of abuse was related to the nature of the relationship between the perpetrator and victim – the more intimate the relationship, the more passive the response of the victim. In some instances, more than one perpetrator was involved and there was a tendency for non intimate females to be abusive towards the victim with the support of their male kinsmen. The victim had been admitted to hospital by a close family member in 58% of the instances, the husbands usually having disappeared from the scene. The study also showed that weapons had been used on 83% of the victims. In the majority of cases the injuries had been too severe to use public transport (Dias & Fernando, 1995).

A record-based study was undertaken on behalf of the International Women's Rights Action Watch - Asia Pacific in 1999. Data was obtained from hospitals, police stations, courts and crisis centers maintained by non-governmental organizations. The study analyzed 187 injuries presenting to 45 different hospitals and the types of injuries identified were seen to be similar to those reported in other studies. The study showed that staff in the smaller hospitals were reluctant and unwilling to handle cases of domestic violence because of the related legal implications. Among victims who attended the larger general hospitals 62.2% failed to identify the perpetrators, whereas the proportion that identified their perpetrators increased as the hierarchical status of the hospital became less (Wijayathilake & Gunaratne, 1999).

In the study on 52 victims of domestic violence in Nuwara Eliya, Anuradhapura and Matara districts, 25 were found to have sought medical assistance following the incident. Most of the victims had lied to the doctor regarding the cause of injury. Some women had been reluctant to seek medial treatment for fear of their husbands being remanded. In some instances, the women had been advised against going to the hospital by the family. The author noted that counseling services at hospitals for the victims of domestic violence were inadequate. The author had also inquired about the other types of support received by the victims following violence. The women victims had received support from his family (17.3%), community leaders (19.2%), her family (67.3%), neighbours (36.5%) and women's organizations (19.2%). When inquired about the women's response to violence, it was revealed that 17 (32.6%) and 6 (11.5%) had left the house temporarily and permanently respectively. Regarding the current status of the marriage, 17 (32.6%) were living with their abusive partner while the others had been either abandoned by the husband (23%), separated (25%) or divorced (7.6%) (Hussein, 2000).

Kuruppuarachchi (2010) conducted a study on 242 cases of intimate partner violence (IPV) at the North Colombo Teaching Hospital. The findings revealed that a quarter (26.9%) of those who suffered physical violence sought medical treatment for their injuries, but only two of them (0.8%) divulged the reason for the injury to medical staff. More than three quarters (79%) of those abused were in the relationship for more than ten years.

In the study at 'Mithuru Piyasa', District General Hospital, Matara, the commonest injury which occurred due to violence was a blackout. Minority (0.45%) had suicidal thoughts and suicidal attempts were 0.9%. 11.7% needed to be referred to the psychiatric clinic and 100% received counseling at the centres (Samarakoon, 2011).

The complaints that GBV victims sought hospital care for mostly, were unrelated symptoms such as sleep disturbance, loss of appetite, and headaches, rather than the violence itself (Jayasuriya *et al*, 2011).

4.3. Care seeking behavior of GBV survivors

In the Western Province study using the WHO methodology, 11% had sought health care but only 5% had revealed the true nature of their injuries. Own parents and family was the most common (52%) source of help. The commonest reason for not reporting was found to be stigmatization by society. Importantly, 92% of the respondents welcomed the opportunity to talk about their experiences during the survey (Jayasuriya, 2011).

In the study on intimate partner violence conducted in the Western Province in 2011, 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. Those who did seek help were likely to do so when they could no longer endure the abuse (45%), when the perpetrator abused or threatened to abuse victims children (20%), or when the victim 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. Although it is recognized that service access for abused is low, abused women were more likely than non-abused women (64% vs. 29%, respectively, $p < 0.05$) to visit hospitals for other ailments The minority who sought help from formal support services, including health care providers at the hospital and the police, were stigmatized and judged (Jayasuriya *et al*, 2011).

Experiences of non-governmental organizations dealing with GBV

Studies done on victims at Women In Need (WIN), a voluntary non-profit organization, have focused on different aspects of the victims such as seeking the assistance of the police, courts and NGOs.

A study done in 1994 among 45 women victims at WIN explored the medical perspectives of wife assault. The objectives of this study were to improve the case recognition, identify the psychological effects on the family and dispel myths and establish the realities about wife assault. For the purpose of this study, wife assault was defined as any physical violence inflicted by the man on his wife, using weapons or physical force. A structured questionnaire in all three languages was used to obtain a case profile and to explore different views on wife assault. The study showed that more than half the victims (53.3%) were aged 35-44 years. Separated women continued to be at risk of assault from their former partner (24%). 53.3% of the women had been assaulted during pregnancy out of which four women stated that they had received blows to the abdomen (De Silva, 1994).

The author was able to identify that 68.8% of the victims had consulted a doctor, but 26.6% of them had not divulged the cause to the doctor. The majority (80.6%) of those who had sought medical care had consulted a primary care physician. Most women had consulted doctors for emotional, physical and psychosomatic symptoms. The author emphasized that 82% of the victims had reported that witnessing the battering had affected their children (De Silva, 1994).

In the study done in Jaffna, the injuries sustained in most beatings were non-grievous and were seen mostly to be contusions in the region of the head, neck and upper limbs. Periorbital contusions were the most frequent (60%). Lacerations (22%), incised wounds (8%), injuries to the musculoskeletal system (7%) and scratches on the necks with sub-conjunctival haemorrhages due to strangling (5%) were among other injuries identified. The majority (62%) had been assaulted with weapons, while others had been punched (18%); kicked (5%) and 15% had been subjected to various other forms of violence (Saravanapavanthan, 1982).

In the study done on victims at WIN, the offenders were from all social classes and different occupations. This study showed that alcohol was responsible for battering only in 18% of the cases, while in 69% battering had occurred whether or not alcohol was consumed (De Silva, 1994).

An investigation was done to assess whether women are at risk for learned helplessness response due to uncontrollable events in the childhood/ adulthood. It also studied the gender role orientation among women subject to domestic violence who are unwilling to leave the abusive relationship. The study was based on 30 consenting victims of domestic violence who visited WIN during November 1996 to April 1997. According to the results of this study the author concluded that many women were not at risk for learned helplessness response due to uncontrollable events in the childhood (30% at risk and 70% at low risk, correlation coefficient = 0.228). However, 80% of the victims were at high risk for a learned helplessness response due to many uncontrollable events experienced in their adult relationship (correlation coefficient = 0.688). The research also found a positive correlation of 0.663 between the variables of gender role orientation and fear of divorce. Thus as the score on the gender role orientation scale increased, the fear of divorce also increased (Matthew, 1997)

Chapter 6

Response of the police, judiciary and availability of legal support for victims

In the study conducted among 31 women victims of domestic violence admitted to a provincial hospital, the authors concluded that the police bear a negative attitude to domestic violence and that police officers were reluctant to follow up cases and arrest the men who had beaten their wives. The majority (83%) of the victims in this study had made a police entry with the aim of future protection rather than with the intention of prosecuting the assailant (Dias & Fernando, 1995).

A study on domestic violence using primary data collected from reports from hospitals, police and the courts over a period of one month in November 1998 revealed a negative picture on how the authorities handled cases of domestic violence. Out of the cases reported to the police, 38.8% was reported as 'gave evidence' and 38.6% as 'came to a settlement'. It reflects the approach of the police that in matters of domestic violence, they act as mediators rather than as law enforcers (Wijayatilake & Guneratne, 2000).

The literature survey for articles and reports on intimate partner violence in Sri Lanka reveals that a common belief in Sri Lanka, even among medical students and police officers, is that intimate partner violence is a personal matter and that outsiders should not intervene. (Jayatilleke *et al*, 2010).

In the study on domestic violence carried out in six districts in Sri Lanka, only 42.5% of the victims had lodged police complaints and only 14.4% had sought legal remedies. 21.1% of the 313 victims had not taken any action and had resigned themselves to their situation. Reasons for inaction were given as avoiding disgrace, maintaining the privacy and prestige of their families, 'for the sake of their children', reluctance to get their married-life affected and being economically dependent on the abuser. The majority (60.4%) had sought mediation, mostly by relatives and friends (54.9%). Most often mediation had not been fruitful. Only 10.9% had obtained counseling, probably due to the lack of its availability. Those who had sought police intervention have had negative experiences. While 30.1% did not report results; 11.3% said that the police were 'useless'; 35.5% had been advised to get back to their homes and live 'peacefully' with their spouses; three women had to cope with sexual advances or sexual abuse by police officers and one woman had to face more violence by the spouse. Only 266 (38.7%) of the women were aware of the existence of the Domestic Violence Act of 2005, of which the majority (73.3%) did not know the provisions of the Act. Focused group discussions conducted among stake holders revealed that some of the chief stakeholders in the community in combating domestic violence were not aware of this Act or its provisions; the least informed being the medical professional and state lawyers (Jayaweera *et al*, 2010).

In the study done on 52 victims of domestic violence in the Nuwara Eliya, Anuradhapura and Matara districts, police assistance was found to be sought in only in 38 (73%) cases (Hussein, 2000).

Samarakoon (2011) reporting from 'Mithuru Piyasa' District General Hospital, Matara, indicated that only 6.7% of the victims were provided legal support.

In the study on 64 victims of wife battering who were referred to the Department of Forensic Medicine, Faculty of Medicine, Galle, 36 of the victims were reviewed after 6 months since lodging a complaint at the police station. All of the reviewed 36 wives were found to be free from being battered following making the police complaint (Vidanapathirana, 2007). Thus lodging a complaint with the police seemed to act as a deterrent.

Research recommendations and strategies to be adopted to address GBV

In this section we highlight the recommendations and strategies to be adoptedbased on the research reviewed throughout the book. Recommendations are categorized into four major groups based on the appropriate implementation strategy.

7.1. Formulate / improve laws and policies

The magnitude of the problem of gender based violence in Sri Lanka, its consequences and the need for a multi-sectoral response is evident from the literature reviewed in this book. Many of the researchers quoted here stress the need for policy makers and planners at the national level to critically examine the policies, programmes and mechanisms in place to protect and uphold the rights of the women and girls in Sri Lanka. The need for a national strategy to eliminate violence against women in the home and the society is imperative. The Ministry of Health is highlighted as an important stake holder in this endeavor. The Ministry of Health should examine its organizational strategies to ensure that vulnerable groups such as young girls, mothers and women in general are given the highest priority.

The role of the heath care sector both curative and preventive, is highlighted and the need to establish a policy in which all service sites and providers implement a violence identification system at entry into maternal and paediatric care is recommended. A line of authority and a care network including healthcare, judiciary, social services, police and NGO's is recommended for survivors of GBV.

The implementation of the Domestic Violence Act, a major milestone in the national campaign against GBV in Sri Lanka, should be strengthened by developing the skills and capabilities of the relevant officials to use the provisions of the Act effectively. Its limitations with regards to sexual violence, elderly abuse and other forms of violence against women should be addressed. Law enforcement officers as well as the health care staff need to be sensitized to the provisions of the Domestic Violence Act and other legal provisions in the Penal Code to protect women from GBV. Continuous training on legal enactments, counseling and gender sensitization is required to bring about a perceptional change among the police and the judiciary so that they treat GBVas a social and legal issue.

Reforming existing laws and value systems that subordinate women in society and at home is a requirement that can be addressed through a concerted effort of policy makers and practitioners at all levels.

The Sri Lankan education system, from pre-schools to the universities, should examine their curricular and extra-curricular activities to ensure that gender stereotyping which places women at risk of GBV is not fostered within these institutions.

7.2. Strengthen the response of healthcare and public health institutions

Identification of victims

It is important for doctors practicing at the level of primary care to be sensitized to GBV/domestic violence among care seekers, especially when there is inconsistency between the injury and the patient's explanation. The primary care setting is recommended as an ideal setting for screening for GBV and is often the critical and initial step necessary to interrupt the 'cycle of violence', as the doctor is often the first to hear about the violence. The

antenatal clinic is also shown as a suitable setting for screening for domestic violence.

Management and support for the victims

The role of the healthcare sector in survival support immediately after violence and in follow up is supported by research in Sri Lankan settings, as in many other countries.

The health sector response can be in the form of screening and routine inquiry, treatment for injuries and complications and offering services such as counseling and psychological support. Some workers recommend special programs for pregnant women, women of child bearing age, working women etc. rather than taking a country wide approach as having the potential of greater efficiency and impact. The report on CEDAW obligations by the Ministry of Women's Affairs recommended that female headed households be considered as a special target group requiring support in post war rehabilitation. Priority needs to be given to them in providing lands and housing. They also need trauma counseling to overcome the shock and suffering undergone with the loss of loved ones and the exposure to sexual violence in the camps

It is recommended that, psychological assistance is provided for both the victim and the aggressor, for the aggressor not to repeat abuse and for the victim to regain self confidence. Guidance and assistance to couples attempting to remain together must also be made available. Authors have emphasized the importance of providing support to families plagued by domestic violence and male alcohol misuse. Measures to improve the quality of life of the most vulnerable groups and to reduce the number of self-harm episodes in the long-term, are essential.

The need to maintain confidential records and documentation not only by the Police but also by the healthcare workers, judicial medial officers, counselors and NGO's providing survivor support is highlighted.

Capacity building among health care providers

It is stressed that health care professionals need to be sensitized on factors related to domestic violence as these factors may be useful in identifying victims when they present to different health care settings. The health care provider who is the first contact person should be sensitized and trained in recognizing, counseling and providing appropriate referral to victims of violence. Fostering an attitudinal change among health care workers on gender based issues is important; in assisting victims to overcome their reluctance to divulge the truth about the violence they have experienced.

Public Health Midwives (PHM) were identified as being competent in interviewing and identifying women in the antenatal clinic, who have been subjected to physical abuse. It is recommended that they be trained for counseling the abuse victims. The public health inspectors are recommended to be trained to talk to male perpetrators.

It is highlighted that more trained social workers, psychologists and psychiatrists would be needed to handle the emotional and psychological problems of both the victims and the aggressors.

The medical curriculum should incorporate topics that emphasize that there is no justification for violence against women, that enhance students' awareness of the suffering and educate students that battered women experience and that battered women are not responsible for violence against them. Medical training programs need to invest in enhancing students' awareness of their own sexist and patriarchal beliefs, in an attempt to counteract their negative perceptions of women and non-egalitarian expectations of marriage. It is also stressed that universities must offer individual and group counseling services to medical students to help them overcome the severe consequences of exposure to violence in their families of origin. The skills required for communicating with abused women and their perpetrator husbands, should be

developed among healthcare workers, including doctors, so that they will be able to provide appropriate assistance to these women to break the cycle of violence.
It is recommended that counseling centers at universities focus on developing better screening to identify and reach students who have witnessed and/or experienced family violence. Practitioners should aim to promote interagency collaboration as well as collaboration within the university for the benefit of the students who are exposed to family violence. Such collaboration would facilitate efforts to identify students who are victims of family violence and provide appropriate interventions.

To combat gender based violence among the elderly, it is recommend to conduct awareness programmes among medical professionals, formulate of locally relevant protocols and risk assessment tools to detect abuse, train medical undergraduates and postgraduates to detect and manage elder abuse and set up committees with professionals from disciplines associated with care of the elderly.

Along with the training and capacity building of healthcare staff, it is also necessary to provide the necessary support infrastructure and systems for referral and care of survivors that are identified. Adequate support services should be offered to those affected such as shelter, medical assistance, counseling and free legal aid. Coordinating with NGOs to increase and improve support services for the victims, improving support services to women such as counseling, legal aid and shelter by Ministry of Women's Affairs and financial support schemes for women are recommended.

Although the role of the healthcare staff is paramount in interventions for GBV, it is also recommended to develop the skills of other stakeholders such as social workers, NGO personnel, religious personnel as they provide a significant contribution in survivor support. Thus it is important to use multiple channels to create awareness and understanding of the problem of GBV, underlying contributory factors and the available services.

7.3. Increase community mobilization

Public awareness and change attitudes

Many researchers have stressed the need to create awareness about the seriousness of domestic violence. Public awareness regarding women being subjected to violence within their homes should be increased. Awareness about GBV should be raised among victims and perpetrators, with the help of healthcare institutions, police and other organizations in the respective areas. The analysis of newspaper articles carried out in 2007 states that newspapers could play a significant role as a voice, which could educate the public and society on the damages and effects of harassment of women. This could be further enhanced through the use of appropriate and attractive language, refocusing the content of the article, and giving priority for the issues included in separate sections of the papers and implementing rewarding systems for different actors on the issue under concern. Electronic media could also be a platform through which social values could be enhanced and where men and women are treated as equal in all spheres of society. It is also suitable as a voice for the voiceless such as victims of harassment.

Especially vulnerable groups such as migrant female workers should be given specific information about abuse and sexual exploitation and of measures to be taken if their safety is compromised abroad. In the estate sector programmes to address social issues such as early marriages, dowry demand, poor family planning, alcohol abuse and gender roles should be addressed. Improving legal literacy among the communities especially women and girls is required so that they can seek protection under the law.

Addressing specific problems such as sexual harassment in public transport requires raising public awareness using both electronic and print media to educate the general public about the sexual harassment of females in public transport. These programs should include information on the

current laws on sexual harassment, methods of sexual harassment and steps to be taken if someone experiences sexual harassment while traveling in public transport. Organizing workshops to increase awareness of sexual harassment in public transport among conductors and drivers and exhibiting posters and stickers against sexual harassment of females in public transport in public places, buses and trains is also suggested. It was also recommended to establish counseling hotlines that support victims of sexual harassment, while ensuring confidentiality.

The role of the school in addressing attitudes and gender stereotyping has been established all over the world. School teachers should be enrolled and trained for this purpose and provided with suitable teaching aids and materials. The university setting provides an opportunity for young females and males to interact and can be used to prevent unfavourable attitudes It also provides an opportunity to give counseling on reproductive health and create awareness of the implications of negative cultural attitudes towards gender and GBV (Weerakkody & Kumara, 2007).

Other community based interventions

Implementing interventions targeting alcohol abuse by men, low educational attainment, low use of contraceptives and teenage marriages of the girl child are essential as these factors directly and indirectly increase women's vulnerability to abuse. The empowerment of women through skills development programs by providing opportunities for employment are also important.

It is essential to enable both men and women to become stakeholders in the process of change and in the interventions. The role of men in interventions to prevent GBV is highlighted by many authors and should be considered in all relevant policies and programmes (Amaraasinghe *et al*, 2004).

7.4. Further research

The emergence of a knowledge base on GBV and its issues in Sri Lanka is encouraging and adds to our understanding of the problem; however, many gaps in knowledge remain. Potential research areas that have been identified by authors of the studies discussed in this document is presented here.

Although we have data on the prevalence and the severity of the GBV in many populations, some marginalized groups such as the elderly, migrants and internally displaced people as well as the socio-economically poor remain understudied. While addressing GBV at the national level, promotion of research on the problem in these vulnerable groups should be a priority.

The need for comparable data by using standardised instruments is recognized as well as the need to incorporate better descriptors of acts of violence, especially of the sexual and emotional types, into existing instruments to increase their cultural and social adaptability to Sri Lanka. Using national surveys such as the Demographic and Health Survey to obtain GBV data as well as other sex-disaggregated data will be useful in further developing the evidence base. Integrating data collection on GBV into the existing monitoring systems of the health and judicial sectors on a continuous basis is also recommended.

There remains the need to research the burden of GBV, quantifying its economic and social cost. The impact of domestic violence on household income, and national income and its health costs need to be assessed. The morbidity and mortality, psychological and physical impact on the families, especially the children, should be examined in detail. The need to develop social and economic indicators to assess the impact of GBV on household status and to incorporate these into existing evaluations is highlighted.

Evidence from other settings has demonstrated personal, situational, and socio-cultural factors that can predict risk of IPV and, although a few authors have

attempted to do so in Sri Lanka there remains a need to examine these factors in detail. The patriarchal structure that perpetuates violence in Sri Lankan societies, and its characteristics that place women at risk of GBV should be researched in different communities. Further, these gender related behaviors and roles of Sri Lankan women are changing in complex ways as women have greater access to employment away from home and freedom to travel within and outside the country. For example single mothers, women moving to work in the free trade zone and urban areas, and those migrating abroad for foreign employment face many challenges that are different from rural women and their risks for GBV are likely to be different. These changes challenge the traditional gender norms and may have implications for the way in which conflicts in intimate relationships are addressed and on the risk of GBV.

The health sector response to GBV is evident from the number of papers reviewed here. However, further research will increase our understanding of the barriers to a coordinated health sector response. It is necessary to examine the underlying reasons for poor care seeking behaviour, lack of follow up and the languid attitude of health care staff in providing care for survivors. 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 and this needs further evaluation to determine ways in which they can be protected.

Research needs to be carried out to determine mechanisms to develop interventional programs to minimize GBV. Although there are many interventions at national, regional and community level these programmes need to be systematically evaluated to assess their impact on reducing GBV. Wherever possible, and whenever resources are available, it is strongly recommended that rigorous practical evaluation studies be conducted in healthcare settings.

The role of other important stake holders that are partners in prevention of GBV including the police, judiciary and the education system should be highlighted through research into current practices and policies so that these can be improved based on evidence.

References

1. Abeysena, C 2002, 'The effect of physical activity and physical stress on pregnancy outcome', Dissertation submitted to the PGIM in partial fulfillment of requirements for the degree of MD in Community Medicine.
2. Action on Elder Abuse Bulletin, 1995.
3. Adikaram, AS 2005, "Is sexual harassment a problem in Sri Lankan workplaces?', Sri Lanka Foundation Institute/ Friedrich Ebert Stiftung, Research paper no 3.
4. Amarasinghe, MP, Appuhamy, HDSCP, Arandara, DC, Perera, J 2005, 'A study of sexual harassment of women using public transport', *Gender, society and change*, pp. 88-110, CENWOR, Colombo
5. Abhayanayaka, C, Sumathipala, WLAH, Perera, J 2006, 'Comparative assessment of knowledge and attitudes regarding domestic violence among medical undergraduates', *Tenth National Convention of Women's Studies*, CENWOR, Colombo.
6. Baklien, B, Samarasinghe, D 2004, '*Alcohol and Poverty in Sri Lanka'*, Oslo: Forut.
7. Beddewela, LB 1996, 'Sexual harassment at the workplace and on the way to work', *Sexual Harassment – Sharing of experiences and strategies*, Friedrich Ebert Stiftung, Colombo.
8. Bulumulle, K 2006, 'Role of patriarchal values among victims of wife abuse', *Tenth National Convention of Women's Studies*, CENWOR, Colombo.
9. Center for Health Development, World Health Organization 2008, *National Report on Violence and Health: Sri Lanka*.
10. CENWOR 2001, *Sri Lanka shadow report on the UN Convention on the elimination of all forms of discrimination against women*, Colombo.
11. Chandrabose, AS 2007, 'Human rights of women workers in the plantation sector', Dissertation submitted to the University of Colombo in partial fulfillment of requirements for degree MHR.
12. Department of Probation and Childcare services, Ministry of Social Services 1998, *Second Country Report on the implementation of the Convention on the Rights of the Child*, Colombo.
13. Deraniyagala, S 1992, 'An investigation into the incidence and causes of domestic violence in Colombo, Sri Lanka', Women In Need publication.
14. De Silva, H 1998, *Second country report on the implementation of the convention on the rights of the child*, Department of Probation and Childcare Services, Ministry of Social Services.
15. De Silva, N 1994, 'Wife assault: a medical perspective', *Sri Lankan Family Physician*, vol. 17, pp. 15-20.
16. De Soyza, P, Newcombe, PA, Rajapakse, L 2010, 'Outcomes of parental use of psychological aggression on children: a structural model from Sri Lanka', *Journal of Interpersonal Violence*, vol. 20, no.10, pp. 1-19.
17. Dias, M, Fernando, D 1996, 'Women victims of violence; A study on admissions to a provincial general hospital', *Fifth National Convention of Women's Studies*, CENWOR, Colombo.
18. Dinusha, AK, Dissanayake, SR, Dissanayake, CG, Wickramasinghe, VP 2006, 'Patterns of abuse during pregnancy', *119th Annual Scientific Sessions*, Sri Lanka Medical Association, Ceylon Medical Journal, vol. 51, supplement 1, March 2006.
19. Fernando, V 1991, 'Her Story: Case studies on violence', *Logos*, no.2, June 1991, pp. 87-89.
20. Fernando, AD, Karunasekera, W 2009, 'Juvenile victimization in a group of young Sri Lankan adults', *Ceylon Medical Journal*, vol. 54, no. 3, pp. 80-84.
21. Fisher, S 2004, 'Gender based violence in Sri Lanka in the aftermath of the 2004 Tsunami crisis: the role of international organizations and international NGOs in prevention and response to gender based violence', A dissertation submitted to the University of Leeds Institute of Politics and International Studies, in partial fulfillment of the requirements for the degree of Master of Arts in International Studies.
22. Gamage, PG 1999, 'Sexual harassment at the workplace', Policy Survey Report, American Solidarity Centre.
23. Gunawardena, N, Weerasinghe, MC, Rajapaksa, LC, Wijesekara, P, Chathurangana, PWP 2010, 'Do we know enough about sexuality issues of the youth?', *Twelfth National Convention of Women's Studies*, CENWOR, Colombo.
24. Haj-Yahia, MM, De Soyza, P 2007, 'Beliefs of Sri Lankan medical students about wife beating', *Journal of Interpersonal Violence*, vol. 22, no.1, pp. 26-49.
25. Haj-Yahia, MM, De Soyza, P 2009, 'Posttraumatic Stress Disorder Among Sri Lankan University Students as a Consequence of Their Exposure to Family Violence', *Journal of Interpersonal Violence*, vol. 24, no.12, pp. 2018-2038.
26. Hussein, A 2000, 'Sometimes there is no blood: domestic violence and rape in rural Sri Lanka', International Center for Ethnic Studies.

27. Hyman, I, Mason, R, Guruge, S, Berman, H, Kanagaratnam, P, Manuel, L 2011, 'Perceptions of factors contributing to intimate partner violence among Sri Lankan Tamil immigrant women in Canada', *Health Care Women International*, vol. 32, No. 9, pp. 779-794.
28. Jayasena, A, Nastasin, BK 2008, 'Problems faced by women in rebuilding their lives after the Tsunami', *Eleventh National Convention of Women's Studies*, CENWOR, Colombo.
29. Jayasinghe, D, Jayawardene, P, Perera, H 2006, 'Risk factors for intimate partner violence', *The Eleventh Annual Academic Sessions of the College of Community Physicians of Sri Lanka*, pp. 11.
30. Jayasuriya, V, Wijewardena, K, Axemo, P 2011, 'Intimate Partner Violence of women in the Capital province of Sri Lanka: prevalence, risk factors and help seeking', *Violence Against Women*, vol. 17, no. 8, pp. 1086-1102.
31. Jayatilleke, AC, Poudel, KC, Yasuoka, J, Jayatilleke, AU, Jimba, M 2010, 'Intimate partner violence in Sri Lanka', *Bio Science Trends*, vol. 4, no. 3, pp. 90-95.
32. Jayatilleke, AC, Poudel, KC, Sakisaka, K, Yasuoka, J, Jayatilleke, AU, Jimba, M 2011, 'Wives' attitudes toward gender roles and their experience of intimate partner violence by husbands in Central province, Sri Lanka', *Journal of Interpersonal Violence*, vol. 26, no. 3, pp. 414-432.
33. Jayatunge, AAAVD 1998, 'Women and violence – a case study of Wendesiwatta settlement', Thesis submitted to the faculty of graduate studies, University of Colombo, in partial fulfillment of requirements for the degree of Master of Arts in Women's Studies.
34. Jayaweera, S, Sanmugam, T 2001, 'Women in garment and textile industries in Sri Lanka: gender roles and relations', study series no. 21, CENWOR, Colombo.
35. Jayaweera, S, Sanmuga, T, Dias, M, Nagahawatte, K 2010, 'A Study of Domestic Violence in Selected Locations in Sri Lanka', *Twelfth National Convention of Women's Studies*, CENWOR, Colombo.
36. Konradsen, F, Hoek, W, Peiris, P 2006, 'Reaching for the bottle of pesticide: a cry for help. Self-inflicted poisonings in Sri Lanka'. *Social Science and Medicine*, vol. 62, no. 7, pp. 1710-1719.
37. Kuruppuarachchi, KALA, Wijeratne, LT, Weerasinghe, GDSSK, Peiris, MUPK, Williams, SS 2010, 'A study of intimate partner violence among females attending a teaching hospital out patient department', *Sri Lanka Journal of Psychiatry*, vol. 1, no. 2, pp. 60-63.
38. Matthew, T 1997, 'An investigation into the learned helplessness factors and gender role orientation of the female victims subject to domestic violence, who are unwilling to leave the abusive relationship', Dissertation submitted to the faculty of graduate studies, University of Colombo, in partial fulfillment of requirements for the degree of Master of Science in Applied Psychology.
39. Miller, J 2002, 'Violence against sex workers in Sri Lanka: causes, consequences and remedies', International Center for Ethnic Studies, lecture/ discussion series no. 1.
40. Ministry of Health, Annual Health Bulletin 2002, Colombo, Sri Lanka.
41. Ministry of Healthcare and Nutrition, WHO Country Office for Sri Lanka. National report on violence and Health in Sri Lanka 2008, Colombo.
42. Moonasinghe, LN 2002, 'The prevalence and correlation of physical abuse within marriage in a cohort of pregnant women in the Badulla district', Dissertation submitted to the PGIM in partial fulfillment of requirements for the degree of MD in Community Medicine.
43. Moonasinghe, LN, Rajapakse, LC, Samarasinghe, G 2004, 'Development of a screening instrument to detect physical abuse and its use in a cohort of pregnant women in Sri Lanka', *Asia Pacific Journal of Public Health*, vol. 16, no. 2, pp. 138-44.
44. Mowlana, SOZ, Wijepala, G, Sumanasiri, S 2002, 'Violence against women: A policy planning study for International Development Administration/ World Bank/ Health Services Project, Inter Continental Consortium.
45. Munasinghe, SS, Wickramasinghe, AR, Hettiarachchi, T 2004, 'Health problems and abuses of female returnee migrants', *Ninth National Convention of Women's Studies*, March 2004, CENWOR, Colombo.
46. Nanayakkara, RT 2007, 'Analysis of some selected aspects of female survivors of intimate partner violence reported to the Judicial Medical Office, Colombo', *Fifth Annual Academic Sessions*, Faculty of Medical Sciences, University of Sri Jayawardenepura.
47. Navaratnam, U 2010, 'Issues of Female Headed Households – Jaffna', *Twelfth National Convention of Women's Studies*, CENWOR, Colombo.
48. Nirthanan, P 1999, 'The extent and some factors associated with wife beating in the MOH area Kantale', Dissertation submitted to the PGIM in partial fulfillment of requirements for the degree of MD in Community Medicine.
49. Olupeliyawa, AM, Ziard, MH 2004, 'Reporting of domestic violence among internally displaced persons: a Sri Lankan perspective', *The 40th Conference of Asia-Pacific Academic Consortium for Public Health*, November 2008, Faculty of Medicine, University of Malaya, Malaysia.

50. Palaniappan, G 2003, 'Study on violence against women in the Plantations Communities Project (PCP) estates', CENWOR, Colombo.
51. Paranitharan, P, Edirisinghe, PAS, Williams, S 2009, 'Elder abuse – a wake up call', *Ceylon Medical Journal*, vol. 54, no. 1.
52. Perera, B, Ostbye, T 2009, 'Prevalence and correlates of sexual abuse reported by late adolescent school children in Sri Lanka', *International Journal of Adolescent Medicine and Health*, vol. 21, no. 2, pp. 203-211.
53. Perera, B, Ostbye, T, Ariyananda, PL, Lelwala, E 2009, 'Prevalence and correlates of physical and emotional abuse among late adolescents', *Ceylon Medical Journal,* vol. 54, no. 1, pp. 10-15.
54. Perera, J, Abeynayake, SD, Galaboda, DP 2006, 'Gender related harassment among medical students', *Tenth National Convention of Women's Studies*, CENWOR, Colombo.
55. Perera, J, Abeynayake, SD, Velummayilum, P 2006, 'Gender Distribution in health are occupation in Sri Lanka: situation analysis', *Research Forum: Women's Health Issues*, Women's Health Committee, Sri Lanka Medical Association, 27th May 2006, pp. 14.
56. Perera, J, Ameen, FN, Gamage, HGSS, De Silva, DARD, Harshana, PN, Gunawardane, N 2010,'A study on prevalence of elder abuse among elderly residents in the Galle MOH area', *123rd Annual Scientific Sessions*, Ceylon Medical Journal, vol. 55, no. 1.
57. Perera, M 1997, 'Study on safety of Free Trade Zone workers', Marga institute.
58. Ramakrishnan, PG 2002, 'How sexual abuse impacts on personality adjustment and integration into society of a cohort of girls subjected to sexual abuse (resident in an approved school run by the Department of Probation and Child Care), Dissertation submitted to the University of Colombo in partial fulfillment of requirements for degree MEd.
59. Samarakoon, MASC 2011, 'Experience of Mithuru Piyasa', Mithuru Piyasa, District General Hospital, Matara.
60. Samarasinghe, G 1991, 'Report on some observations on the incidence of domestic violence in four locations in Sri Lanka and the attitudes of women towards violence', Women In Need.
61. Saravanapavanthan, S 1982, 'Wife beating: a study of sixty cases', *Forensic Science International*, vol. 29, pp. 163-166.
62. Silva, KT, Herath, D, Athukorala, V 2002, 'Ravaged Innocence: a study of incest in Central Sri Lanka', study series no. 29, CENWOR, Colombo.
63. Subodini, MA, Seneviratne Babdara, KP, Seneviratne, USC, Siriwardene, SSAAU, Subashini, SDA 2006, 'Factors associated with intimate partner violence: a hospital based study', *Research Forum: Women's Health Issues*, Women's Health Committee, Sri Lanka Medical Association, 27thy May 2006, pp. 20.
64. Subramanium, P, Sivayogan, S 2001, 'The prevalence and pattern of wife beating in the Trincomalee district in Eastern Sri Lanka', *South East Asian Journal of Tropical Medicine and Public Health*, vol. 32, no. 1, pp. 186-95.
65. Sumanasekara, S 2011, 'Report on identifying implementation gaps of obligations under CEDAW', Unpublished data, National Committee on Women, Ministry of Child Development and Women's Affairs.
66. Vidanapathirana, M 2007, 'Does battering of wife occur after police complaint?', *The 9th INPALMS Congress*, Indo-Pacific Association of Law, Medicine and Science, Colombo.
67. Weeerakkody, R, Kumara, SK 2008, 'Threatened Women: Nature and Magnitude', *Eleventh National Convention of Women's Studies*, CENWOR, Colombo.
68. Wijayaratne, PG 1994, 'Father's Alcohol Consumption and Family Well Being', Dissertation submitted to the PGIM in partial fulfillment of requirements for the degree of MSc in Community Medicine.
69. Wijayathilake, K 2003, 'Harsh realities: A pilot study on gender based violence in the plantations sector', Plantation Human Development Trust.
70. Wijayathilake, K 2004, 'Study on sexual and gender based violence in selected locations in Sri Lanka, CENWOR, Colombo.
71. Wijayathilake, K, Gunaratne C 1999, 'Monitoring the progress of discrimination against and the advancement of equality for women', *Sri Lanka Report on Domestic Violence*, CENWOR, Colombo.
72. Wijayathilake, K, Gunaratne C 2000, 'Abuse within the family – a study on domestic violence', *Seventh National Convention of Women's Studies*, CENWOR, Colombo.
73. Wijayathilake, K, Zackariya, F 2001, 'Sexual harassment at work: plantation sector', International Labour Office, Colombo.

Acknowledgements

- Dr Firdosi R Mehta, WHO representative for Sri Lanka for providing funds through the WHO
- Ms Savithri Hirimuthugoda, the librarian of CENWOR (Center for Women's Research)
- The librarian and staff of the Sri Lanka Medical Association
- The librarian and staff of the Post Graduate Institute of Medicine, Colombo
- The director and staff of Women In Need
- Ms Neela Gunasekara and the staff of Ministry of Child Development and Women's Affairs
- Ms Jezima Ismail and the librarian of the Marga Institute
- Ms Thiyagi Piyadasa, the librarian, and the staff of the International Center for Ethnic Studies
- Ms Shyamali Thebuwala of the World Health Organization, Colombo
- The staff of the Women and Media Collective
- The staff of the International Labour Office
- The staff of the Department of Community Medicine, University of Sri Jayawardenepura
- Dr Muditha Vidanapathirana and the staff of the Department of Forensic Medicine, University of Sri Jayawardenepura
- The librarian and staff of the University of Sri Jayawardenepura
- Dr Priyanjalee De Soyza and the staff of Department of Psychology, University of Colombo
- The staff of the Department of Sociology, University of Colombo
- The librarian and staff of the main library, University of Colombo
- The librarian and staff of the library of the Faculty of Medicine, University of Colombo
- Dr Sarojini Manikarajah for coordinating the project on behalf of the World Health Organization
- Dr Enoka Corea for reviewing the language in the final draft