THE PREVALENCE AND PATTERN OF WIFE BEATING IN THE TRINCOMALEE DISTRICT IN EASTERN SRI LANKA

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Abstract. A descriptive cross-sectional study was carried out to determine the prevalence and to identify some socio-demographic factors associated with wife beating in the Medical Officer of Health (MOH) area of Kantale in the Trincomalee district of eastern Sri Lanka. A random sample of 417 women in the age category 18-49 years constituted the sample population. Data were obtained by focus group discussions followed by the administration of a structured questionnaire by trained interviewers. The prevalence of reported wife beating among ever-married women was 30% and the prevalence of wife beating in the year preceding the study was 22%. There was no significant association between wife beating and ethnicity of the study population or a particular age group of either the batterer or the victim. Moreover, wife beating was associated with an early age at marriage for women, low-income, a low standard of living index, large families and alcohol consumption by the batterer. A significant inverse relationship between domestic violence and the level of education of both the batterer and the victim was also identified. Contusions, typically distributed in the region of the head, face and neck were found to be the commonest type of injury suffered by battered women. A majority of women, irrespective of their level of education and employment status placed the welfare of their children as the prime reason for continuing to stay in an abusive relationship. The study concludes that wife beating is a serious health and social problem for the women population of Kantale. Intervention is recommended in relation to key issues identified by the study, including alcohol abuse by men, relative lack of education among the population, lack of family planning, societal influences promoting teenage marriages of the girl-child and absence of programs aimed at creating awareness on wife beating.

INTRODUCTION

There is convincing evidence that violence against women is a significant health and social problem affecting virtually all societies (Heise *et al*, 1994). In every country where reliable, large-scale studies have been done, it has been reported that 20% to 67% of females have been assaulted by the men they live with (WHO, 1997). Furthermore, Goodstein and Page (1981) ominously predict that the actual occurrence rate of wife beating probably far exceeds the reported cases. The spectra of abuse related injuries suffered by battered women range from simple contusions to fatal burns (Saravana-pavananthan, 1982). Moreover, even a single episode of violence may carry profound psychological consequences such as sleeping and eating disorders, anxiety and panic attacks (Heise *et al*, 1994). One study in rural India reports that deaths due to wife beating were the second-largest cause of deaths in pregnancy (Ganatra *et al*, 1998) clearly indicating that the impact of wife beating can extend beyond the woman victim.

In South Asia, where wife beating is said to be common as well as particularly severe, as much as 47% of women in rural Bangladesh (Schuler *et al*, 1996) and 45% in rural India (Rao, 1997) have admitted being beaten by their husbands. Although national data samples

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are scarce, community based and small-scale studies done in Sri Lanka indicate that violence against women is widespread and an important cause of morbidity among women. Surveys place the prevalence of wife beating as varying from about 30% on the conservative side; to as high as 60% (Samarasinghe, 1991; Deraniyagala, 1992). Taking into account the sensitive nature of the problem and the societal and cultural norms which shroud it, it can be expected that these statistics may under estimate levels of violence as a result of gross under-reporting. Indeed, researchers agree that the tendency among women is to minimise, rather than inflate the incidence of beating (Mullen *et al*, 1988). We can therefore conclude that wife beating prevalent in our society is likely to be higher and hence a much larger social problem than we now know it to be.

This study attempts to assess the extent of domestic violence in the medical officer of health (MOH) area of Kantale, in the Trincomalee district of eastern Sri Lanka. Sri Lanka is home to a multi-racial, religious and cultural population with different races predominant in different parts of the country. In this respect, Kantale, which has a multi-racial community, was expected to portray a near equal representation from all racial, social and religious backgrounds of Sri Lanka, which is a considerable advantage when analysing the socio-demographic variables associated with wife beating. This study also explores the association between wife beating and the woman's social and economic dependence on her husband, a trait common to South Asian cultures. In addition, other possible contributory factors for the violence, which bear particular relevance to the subcontinent, such as extended family situations and alcohol addiction, have been examined.

MATERIALS AND METHODS

Kantale is an agricultural, rural town in the Trincomalee district in the eastern province of Sri Lanka. Although Sri Lanka has a population consisting of a majority Sinhalese (74%) and minority Tamil (18%) and Muslim (7%) races, uniquely, the three major ethnicities are almost equally represented in the Trincomalee district, the breakdown being Tamils 34.3%, Sinhalese 33.3% and the Muslims 29.3% (Ministry of Helath, Sri Lanka, 1997). The religious composition of the population closely follows the ethnic ratio, with most Tamils, Sinhalese and Muslims being of Hindu, Buddhist and Islamic faiths respectively. Other minorities constitute 3% of the total population.

The Ministry of Health in Sri Lanka has designated Medical Officers of Health (MOH) who provide health care at community level within each district of Sri Lanka. These health service areas are termed as "MOH areas". This study was conducted in the Kantale MOH area with an estimated population of approximately 64,800. The Kantale MOH area is further divided into 27 Public Health Midwive (PHM) divisions manned by public health midwives, to facilitate the provision of primary health care at the grass root level.

Study design

A descriptive cross sectional study was conducted during the period of January to December, 1999. The study consisted of preliminary focus group discussions, followed by an interviewer-administered questionnaire for data collection. All married and cohabiting females in the Kantale MOH area, within the age group of 18-49 years constituted the study population. Each PHM maintains an *eligible family register* which contains information of families in the reproductive age group. A random sample of 420 women was selected from the listings in the *eligible family registers*: firstly, the population of each of the 27 PHM divisions in the Kantale MOH area and the number of eligible families it represented were identified; of these, fourteen PHM divisions were randomly selected and thirty families from each selected division were identified from the *eligible family register* by random sampling (using *EPI info* software). The inclusion criteria were : 1) women who were within the age group of 18-49 years ; 2) women who had been married for more than one year (marriage not warranting legal bonding) and 3) women who were

cohabiting with their partners without separation (for a period longer than 30 days) during the past year. During the sampling process, while selecting a sample number, if the woman identified by that number did not meet inclusion criteria for the study, she was dropped and the next number selected, the process being repeated until the required number for the sample was reached. As the *eligible family register* was found to have limitations on information pertaining to the period of cohabitation of couples during the field survey, the women who fell short of inclusion criteria 3, were dropped from the study sample without replacement thus bringing the total sample size down to 417.

Focus group discussions

Focus group discussions were conducted by the principal investigator in three randomly selected locations in the MOH area Kantale with the objective of validating the data to be collected, studying the cultural perceptions of the people and identifying suitable variables for the preparation of study instrument. Participants were selected for focus group discussion from the three major communities in the Kantale locality and constituted married women and mothers with married daughters. The latter category was included in the focus group discussions because they were expected to be aware of marriage and family life among two generations, their own and their daughters'.

Six focus group discussions, each with a participation of 10 women, were conducted with the principal investigator facilitating the discussions with a pre-designed schedule as a guide, while a trained public health midwife served as the recorder and observer. All women took part in the discussion with enthusiasm and discussed the issue of wife abuse at length. Data was recorded and when necessary clarification from the contributing participant(s) was sought on important issues addressed by the focus group discussion. The focus group discussions helped to identify some variables associated with wife beating, the pattern and type of violence and the degree of social acceptance of the issue in the area and this data were used for the designing and preparation of the study instrument.

Interviewer-administered questionnaires

An interviewer-administered questionnaire was used to collect data for the study, as this method is reasonably independent of the respondents' level of education. The instrument was prepared based on the data collected from the focus group discussions. While most of the questions were of closed type and the respondents were asked to choose the answers with which they agreed most, the questionnaire also carried some leading questions, considering the complexity and sensitivity of the subject. Of the two parts, the first carried questions on interviewer identification and socio-demographic variables while the second explored the issue of wife beating. Taking into account the recall bias, only the respondents who had undergone beating during the past 12 months were asked to answer detailed questions pertaining to the frequency and nature of wife beating. The interviews with the women were conducted in the absence of the male partner.

Trained public health midwives from the community, who were well accepted by the local women, were recruited as interviewers for data collection. The interviewers were familiarized with the questionnaire and were trained over a period of four weeks to administer the questionnaire. The training and familiarization process was strengthened by role-plays, which helped to identify and rectify shortcomings on the part of interviewers. Following this exercise, a pilot study was carried out among twenty women, who were not included in the main study sample, prior to the actual study. The final study instrument was perfected after minor modifications.

The data was analysed by SPSS™ software. Chi-square test was used to assess the statistical significance of the association between the respective predictor variables and outcome variables. A $p < 0.05$ (95% confidence interval) was considered as statistically significant.

RESULTS

The mean age of women in the sample population was 30.5 ± 7.2 (mean ± SD) years while the mean age of marriage was 20.1 ± 3.8 years. About 95% of the women had attended school with the majority (64.7%) having completed secondary school education (grades 6 to 10). Most (81.3%) of the women belonged to the lower social classes IV and Va, based on the classification by Barker and Hall (1991).

Of the 417 women in the study population, 92 (30%) reported having been beaten by their male partner during their period of marriage or cohabitation. The prevalence of wife beating reported by women during the *year preceding* the study was 22%. There was no significant difference between wife beating and ethnicity of the study population. The study was also not able to identify a definite association between wife beating and a particular age group of either the batterer or the victim.

An early age at marriage of *less than 18 years* for women, showed a significant association ($\chi^2 = 14.98$, df = 1, $p < 0.05$) with wife beating. There was a significant inverse relationship between domestic violence and the level of education of both the batterer ($\chi^2 = 13.75$, df = 1, $p < 0.05$) and the victim ($\chi^2 = 14.17$, df = 1, $p < 0.05$). Wife beating was also found to be more common among families with a low-income (*less than* 3,000 Rupees) ($\chi^2 = 6.13$, df = 1, $p < 0.05$), low standard of living index (SLI) of *less than* 3, based on the classification by Ayad *et al* (1996) ($\chi^2 = 13.75$, df = 1, $p < 0.05$) and in families with a greater number of children ($\chi^2 = 7.33$, df = 1, $p < 0.05$).

The commonly assumed link between alcohol and domestic violence was supported by the findings of this study, which showed a significant association ($\chi^2 = 87.18$, df = 1, $p < 0.05$) between wife beating and alcohol consumption by the batterer. Furthermore 53% of women also reported that they were assaulted only when their husbands were drunk. Locally brewed illicit liquor (called *kassipu*) was identified by most women (82%) under study as the predominant factor instigating and aggravating wife beating.

Contusions were found to be the commonest type of injury (65%) suffered by battered women with injuries typically distributed in the region of the head, face and neck (60%). The majority (87.5%) of women had been manually assaulted without the use of weapons. Twelve percent of women had been assaulted or threatened with an assortment of weapons ranging from household furniture to knives and clubs.

When questioned on the most extreme reaction or response of the beaten wife to the assault, 50% stated that they had remained passive while only 10% had temporarily left the husband. Only six of the 92 abused women had complained to the police and just one had sought help from the local women's organization dealing with battered wives. A majority (81.5%) of women, irrespective of their level of education and employment status had placed the welfare of their children as the prime reason for continuing to stay in an abusive relationship with the batterer. Contrary to the general belief, financial dependency was not considered to be a decisive factor influencing the decision by the beaten wife not to leave the husband. Although over three quarters (79%) of the women in the study population held the belief that men were "superior" to women, a majority (81.5%) of beaten women were of the opinion that wife beating is never justifiable on any grounds.

DISCUSSION

Seventy percent of women in the study population reported that they have never been beaten during their period of marriage. Only 30% claimed to have been physically abused within the period of their marriage while 22% reported having been assaulted during the preceding year. Other studies which have explored the prevalence of domestic violence in Sri Lanka, found figures ranging from 27% (Perera, 1990) and 32% (Samarasinghe, 1991) to as high as 60% (Deraniyagala, 1992). The current study finds the prevalence of reported wife beating in the Kantale MOH area to be in the

lower range of the spectrum. However, this study excluded women separated from their spouses. Therefore, the actual prevalence may be higher than reported, since some severely abused women may have separated from the batterer as a result of the abuse. Moreover, under reporting is a serious problem in sensitive issues such as this and it is believed that the true prevalence of domestic violence might be double the existing estimates (Browne, 1997).

Some western studies saw no significant difference in race and religion between battered and non-battered women (Parker and Schumacher, 1977; Rounsaville *et al*, 1979). Our study too did not find a statistical difference (χ^2 = 5.11, df = 2, p > 0.05) between wife beating and the ethnicity of the sample population. Socio-demographic data pertaining to domestic violence in Sri Lanka is not uniform and literature review did not identify any study which has found an association between race, religion and wife beating.

The mean age of beaten wives was 31.1 ± 8 (mean ± SD) years and the mean age of the batterer was 36.2 ± 9.4 (mean ± SD) years. Another Sri Lankan study places the mean age of women victims at 35 years and that of the batterers at 39 years (Perera, 1990). The current study finds that both the perpetrator and victim were younger in comparison. However, a definite association between a particular age group of either the batterer or the victim and wife beating was not identified.

The mean age at marriage of the beaten women was 19.1 ± 3.7 (mean ± SD) years, which is a relatively young age at marriage for women in Sri Lanka, the national mean figure being 25.5 years for women. Moreover, a third of the women who were married on or before the age of 18 years reported being beaten by their husbands. The wife's age at marriage of *less than 18 years* appears to have a significant association (χ^2 = 14.98, df=1, p<0.05) with wife beating when compared with older (*>18 years*) age groups.

Contrary to the belief that a greater intimacy and understanding among spouses can be established proportionate to the duration of marriage, it was observed that wife beating was quite common (31.1%) among marriages of long duration (*>15 years*). However, it may also be possible that *reporting* of wife beating may be greater among those women who have been subjected to repeated abuse over a long marriage, in contrast to women who have been in an abusive relationship for a relatively shorter period and are likely to be hesitant to disclose marital discord and violence to an outsider. Other researchers also found domestic violence to prevail in marriages of long duration. For instance, a third of women in a local study had been married for over 20 years (Deraniyagala, 1992).

It is a common belief that wife abuse is more prevalent in large families. This study also revealed that abuse was most common (35%) in families with five children. The chi-square (χ^2) test revealed a significant association (χ^2 = 7.33, df = 1, p < 0.05) between wife beating and number of children in the family. At this stage, it is reasonable to consider the possibility that the association of wife beating with large families and its association with a younger age at marriage may be linked to the fact that a younger age at marriage of women provides the opportunity for having large families.

Most of the families under study were nuclear families, which may indicate the breakdown of the typical, traditional extended family structure common to the sub-continent, even among the rural communities. Another home study also noted that over 70% of families studied were nuclear (Samarasinghe, 1991). However, statistical analysis showed no association (χ^2 = 0.05, df =1, p>0.05) between the type of family structure and wife beating. This evidence is in contrast to other studies on domestic violence which found that the absence of an extended family might deprive wives of their natural allies in marital conflicts and so leave them vulnerable to wife beating (Scott, 1974).

Furthermore, of the reported instances of wife beating among extended families, it was seen that beatings were less common when the

extended family comprised of members from the husband's family (13%) rather than from the wife's family (30%). This is surprising, given the trend in the Indian sub-continent, where members of the husband's family sanction and or partake in abuse towards the wife (Rao, 1997). It is also possible that the instances of *reporting* of wife beating may be greater, when the extended family includes members of the wife's family, since their presence may provide emotional and physical support for the victim in the event of retaliation by the perpetrator.

The study reveals an inverse relationship between domestic violence and the level of education of both the batterer and the victim. Statistical analysis showed a significant association between wife beating and a lower level of education of the batterer ($\chi^2 = 13.75$, df = 1, $p<0.05$) and also the victim ($\chi^2 = 14.17$, df= 1, $p<0.05$) when considering the sample under two categories of level of education (*primary education* and *secondary education*). The current study is consistent with the findings of western studies in identifying an inverse relationship between the husband's level of education and degree of wife abuse (Gelles, 1972; Parker and Schumacher, 1977; Hofeller, 1982).

The majority of the families were found to fall into the income group of less than 3,000 Rupees. Moreover, less violence was noted among families earning an income above 3,000 Rupees. There was a statistically significant difference between the levels of violence among these two income groups ($\chi^2 = 6.13$, df = 1, $p < 0.05$). More than a third (37%) of women in the category of a low standard of living index (SLI <3) reported being beaten by their husbands. There was a statistical difference in the level of domestic violence between the lower and medium standard of living indices ($\chi^2 = 13.75$, df = 1, $p < 0.05$) and between the lower and upper standard of living indices ($\chi^2 = 6.13$, df = 1, $p < 0.05$).

These findings are consistent with studies which found that spousal abuse is more likely to occur in families of lower socio-economic class (Gelles, 1972) and low-income group families (Perera, 1990; Mathew, 1996). However, others have concluded that relative poverty alone does not distinguish violent and non-violent relationships (Schuler *et al*, 1996). In addition, it is possible that wife abuse in the upper socio-economic classes is under reported, due in part to the upper strata of society having greater access to resources, which assist them in keeping their abuse private.

Research has correlated domestic violence with alcohol abuse by the husband (Gayford, 1975). Sri Lankan studies also found drunkenness as a major problem among husbands of battered women in 80% of the study population (Saravanapavananthan, 1982). In our study, almost half (47%) of the men who abused their wives were in the habit of alcohol consumption. Alcohol consumption by the husband and wife beating showed a strong association ($\chi^2= 87.18$, df = 1, $p < 0.05$) when alcohol users were compared with those who were not. Although, the current study supports the commonly assumed link between wife beating and alcohol abuse by the perpetrator, the relationship between alcohol use and spousal abuse is not invariable. For instance, one home study found that over two thirds of battering incidents occurred independently of alcohol consumption (Silva, 1994). Indeed, alcohol addiction may often co-exist with wife battering rather than cause it (Scott, 1974). It is also possible that alcohol may not be a direct causal agent of domestic violence but rather drunkenness may provide a socially acceptable explanation for wife beating where alcohol and not the husband is blamed (Gelles, 1972).

An increase in frequency and severity of abuse with increase in level of alcohol use has been reported (Roy, 1977). Sri Lankan studies have also stated that over half of drinkers had assaulted their wives only when drunk (Saravanapavananthan, 1982; Perera, 1990). In the current study, 48 of the 57 alcohol drinkers had abused their wives only when under the influence of alcohol.

Over half (53%) of the beaten women did not report any demonstrable external injuries. Contusions were found to be the commonest

type of injury (65%) inflicted. Contusions remain the commonest type of injuries reported in other studies as well (Saravanapavananthan, 1982; Perera, 1990). In keeping with reported patterns of injuries sustained by abused women in previous studies, most of the injuries (61%) sustained by the women in this study were seen in the region of the head, face and neck.

Most of the battered wives (88%) reported that their husbands assaulted them with their hands or feet while only (12%) reported the use or implied use of weapons and one victim claimed she had been burned. However, other authors have identified a more widespread use of weapons in domestic violence with more than half of the women in their studies reporting that the batterer had used weapons to intimidate them (Saravanapavananthan, 1982; Deraniyagala, 1992). The arsenal of weapons used by the perpetrator included household furniture, firewood, knives and clubs.

It has been reported that during or even after an assault, victims usually offer little or no resistance to minimize the threat of injury or renewed aggression (Browne, 1993). Similarly, in our study over 50% of abused women said that they had remained passive during the beatings. Only six of the 92 abused women had complained to the police and just one had sought help from the local women's organization dealing with battered wives. This may reflect the common trend of battered wives to shun outside intervention, especially from the police or help agencies. In addition to the perceived shame of exposing marital discord to outsiders and fear of retaliation from the batterer, the lack of awareness of the existence of helping agencies may contribute to their reluctance to seek outside help.

Ironically, it has been found that a majority of abused women continue to remain in abusive relationships. One local study found that only 21% of battered women left their husbands following abuse and that too as a temporary measure (Perera, 1990). The current study finds that only 10% left their homes temporarily. Furthermore, a majority (81.5%) of women, irrespective of their level of education and employment status placed the welfare of their children as prime reason for continuing to stay in an abusive relationship with the batterer. This was also reported by other authors who found that two thirds of abused women remained in a violent relationship on account of their children (Perera, 1990; Mathew, 1996).

Financial dependency was not considered to be a major factor influencing the decision by the beaten wife to leave the husband. This is in contrast to a western study where over half of the victims had stated that financial considerations forced them to remain in the marriage (Hofeller, 1982). However, it must be taken into account that social and cultural differences exist between the west and the Indian subcontinent where married women are more likely to maintain ties with their parental family and hence may have access to financial, logistic and emotional support from them, unlike their sisters in western nations. Therefore, financial dependency on their husbands may not be total or to an extent which may force them to stay on in an abusive marriage.

As to the justification of domestic violence as part of normal family relations, even the battered women themselves stand divided in opinion (Goodstein and Page, 1981). However, this study found that a majority (82%) of women, irrespective of their level of education, were of the unwavering opinion that wife beating is never justifiable on any grounds. About 90% of women in another study also felt that wife beating was widespread in our society and reiterated that domestic violence is not justified (Deraniyagala, 1992). But surprisingly, many women (77%) in this study population, irrespective of their level of education, held the belief that men were superior to women, validating the general gender bias towards a male dominant society widely prevalent in the Indian subcontinent.

Illicit liquor was implicated by over 80% of women in the study population as the predominant factor instigating and aggravating instances of wife beating. In contrast, another study of domestic violence in an urban, low-income group in the Colombo district records

that only 18% of abused women saw alcohol as being directly responsible for violence in the family (Deraniyagala, 1992). The influence of the husband's family members constituting the extended family structure and marital arguments related to household chores, financial and children's matters were other reasons seen as contributing to marital discord and wife beating.

In conclusion, wife beating is an important health and social problem which requires urgent preventive and intervention measures in key issues such as lack of awareness of the extent and nature of wife beating in the society, societal norms sanctioning gender bias, alcohol addiction, lack of pre-marital counseling and conflict resolution programs targeting young adults and an inadequate infrastructure to support battered women.

Although wife beating is a common problem worldwide, it must be acknowledged that when compared with the west, where the push for gender equality has empowered women with greater freedom, much is left to be desired in the South Asian subcontinent. The study identifies an urgent need to establish broader public awareness on domestic violence and gender equality as a crucial step in addressing this problem. Awareness among the community at large is as important as among the victims if any progress is to be made and it should be borne in mind that the approach to the issue should be tailor-made to the community, religious group or sub-culture that the message is intended to reach. A "social marketing" campaign, in the form of a television sitcom, such as the highly successful campaign adapted by the Leprosy Campaign in Sri Lanka a few years ago, may be expected to have satisfactory impact.

State and non-governmental community based organizations need to intensify their *assistance programs* for abused women in terms of dealing with abusive situations. It is imperative that every attempt be made to encourage victims of abuse to speak out, not only to seek assistance for themselves, but also to highlight the extent of the violence within the society and motivate affirmative action from an otherwise complacent society. The provision of temporary shelters for battered women is a service which is lacking and may need consideration. The importance of counselling in domestic violence cannot be overemphazised. However, counselling must be made available at community level with easy accessibility to the facility, in addition to ensuring continuity of services, for better receptiveness among the population. In addition, counselling should also encompass pre-marital counselling for prospective spouses on key issues pertaining to marital harmony, including conflict resolution, non-violent parenting and mutual responsibility in managing the family.

The management of alcoholism among men in the community, both individually as well as at society level is a priority in attempting to curtail wife beating. Rehabilitation for volunteers should be encouraged and necessary support provided with the co-operation of the medical officer of health and the local hospital. Strict enforcement of existing laws pertaining to illicit liquor is needed to curb the source of cheap, easily accessible source of alcohol.

Community awareness must also be raised with regard to negative societal practices and cultural influences, which encourage teenage marriages of the girl-child. Poor coping skills to handle situational stresses of family life, poor socio-economic status due to large unplanned families, compromise on education and employment opportunity for the young wife are possible consequences of early marriage which may contribute to marital discord. Moreover, reproductive health programs on family planning, birth spacing and reproductive health, targeting young couples are recommended as an intermediate and long-term approach to preventing marital discord as a result of the economic and emotional burden of large families.

A role for primary health care workers in the prevention of domestic violence appears to be a useful strategy to employ as was evident from the close rapport seen between the public

health midwives and the local women, during data collection for this study. The training and sensitization of primary health care workers on the issue of marital violence may enable them to detect early signs of domestic violence among the families they serve. Consequently, reporting of wife beating will be expected to improve and necessary intervention could be made possible without delay.

Given the current situation in Sri Lanka where a civil war has been ravaging the country for over 17 years, an important, unexplored aspect in this study is the relevance of war violence to wife beating. That background violence in the husband's family is associated with domestic violence is well established and the possibility exists that war violence could also be an important factor propagating wife beating. This is an interesting area for future research.

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