National Report on Violence and Health in Sri Lanka

Ministry of Healthcare and Nutrition

World Health Organization
COUNTRY OFFICE FOR Sri Lanka

Ministry of Healthcare
and Nutrition

National Report on Violence and Health in Sri Lanka

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Message from the Ministry of Healthcare and Nutrition, Sri Lanka

Violence in any form causes devastating consequences to human beings. It causes physical, mental, reproductive and sexual health problems as well as unfavorable social outcomes to millions of persons every year. Even the limited information available is sufficient to take appropriate action to control and prevent violence.

Although the primary responsibility of preventing violence does not lie within the health sector, it has an important role to play in preventing violence and helping victims. This is because of the fact that irrespective of the place where it occurs, the victims of violence end up in health care facilities. This is a considerable burden to our country as health care is provided free of charge. In addition, the indirect costs and other socioeconomic consequences are enormous.

Whilst, appreciating the efforts taken by different stakeholders to minimize violence, the efforts of all concerned parties should be coordinated to implement and promote a multi-sectoral and evidence-based response to this important issue in Sri Lanka.

I believe that the information contained in this "National Report on Violence and Health" will be useful for planning a comprehensive programme for prevention of violence in Sri Lanka.

Nimal Siripala de Silva
Minister of Healthcare and Nutrition

Preface from the WHO Centre for Health Development

Violence, defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation", pervades the lives of many people around the world and is a crucial public health issue globally, nationally and locally.

In 1996, the Forty-Ninth World Health Assembly adopted Resolution WHA49.25 citing violence as a major and growing public health problem. In this resolution, the Assembly drew attention to the serious consequences of violence and stressed the damaging effects of violence on health. Member States were urged "to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it."

The World Report on Violence and Health provided for the first time in 2002 a global overview of what was known about the magnitude, causes and risk factors for violence and violence-related deaths and injuries; the scope and effectiveness of strategies for preventing different forms of violence, and the scope and effectiveness of services to mitigate the effects of violence for victims. The report made a huge impact to our understanding of violence and its effects, highlighting the simple message that violence can be prevented using a public health approach. A key recommendation and next important step then was to call on countries to develop national reports on violence and health.

In response to global efforts on violence and health and consistent with its mandate to address broad determinants of health, violence as a public health problem has been high on the research and policy advocacy agenda of the WHO Kobe Centre. In 1999, the Centre published a Global Atlas on Violence and Health illustrating the form, magnitude, associations and spatial distribution of violence and associated indicators globally.

In 2005, in collaboration with the WHO Department of Injuries and Violence Prevention in Geneva, respective WHO Regional Offices and Country Offices, the WHO Kobe Centre lent support to five Member States to develop national reports on violence and health. These Member States are Malaysia, Mongolia, Nepal, Sri Lanka and Thailand.

These five national reports on violence and health provide important information bolstering the case for policy and action to improve health. Moreover, the relationships and partnerships that were built in the process of developing the reports have paved the way for continuing collaboration in addressing violence as a public health problem that needs our urgent attention.

Dr Jacob Kumaresan
Director
WHO Centre for Health Development, Kobe, Japan (WHO Kobe Centre)

Message from the Ministry of Healthcare and Nutrition Sri Lanka

In the past, health personnel were primarily concerned about infectious diseases. It has now been recognized that non-communicable diseases and injuries are responsible for a majority of deaths at present. Though the most common cause of injury is road traffic accidents, different types of violence remain a major contributing factor for injuries.

Violence and its consequences are a problem all over the world. Even in Sri Lanka there is an increase in the number of deaths categorized under suicides, homicides and war casualties.

There is also a less visible aspect of violence. For instance, the suffering of children who are abused by the individuals who are supposed to protect them, women injured or humiliated by their partners, and elderly maltreated by their own children.

It is believed that violence is an inherent part of the society and that victims have to live with it. But it should not be so. Violence can be prevented or countered. If there is a will, governments, communities, families and individuals can make a difference.

The *National Report on Violence and Health* is an invaluable document for all those working towards a violence-free society in Sri Lanka.

Dr. H.A.P. Kahandaliyanage
Secretary, Ministry of Healthcare and Nutrition Sri Lanka

Foreword from the World Health Organization

When the *World Report on Violence and Health* was published in 2002, it provided a first global overview of what was known about the magnitude, causes and risk factors for violence and violence-related deaths and injuries; the scope and effectiveness of strategies for preventing different forms of violence, and the scope and effectiveness of services to mitigate the effects of violence for victims. The report's launch was widely covered by media in all regions, and drew attention as never before to the many violence prevention opportunities awaiting government and nongovernment agencies willing to take up the challenges of extending a public health approach to such seemingly intractable problems as child maltreatment, youth violence, intimate partner violence, sexual violence, elder abuse, self-directed violence and war. As a consequence, the handful of health and other government ministers that in 2001 appreciated the links between health and violence had by early 2006 increased by many orders of magnitude, with nearly 100 WHO Member States having officially appointed health ministry focal points for the prevention of violence.

A key recommendation of the World Health Assembly Resolution 56.24 *Implementing the recommendations of the World Report on Violence and Health* calls on countries to develop national reports on violence and health. As the World Report created awareness at the international, regional and country levels about how much more can be done to prevent violence, so country reports can draw attention on the part of ministries, nongovernmental agencies and civil society groups at central, regional and local government levels. Like the World Report, country reports are an opportunity for taking stock – of what's known about the problem; of the adequacy of information systems for monitoring the problem; of the nature and effectiveness of existing prevention programmes, and of the nature and effectiveness of existing victim services. Like the World Report, country reports are an opportunity for looking ahead, and for allocating prevention roles and responsibilities to agencies on the basis of their mandate and capacity. Unlike the World Report, national reports are able to be much more specific and by addressing particular local realities can serve as the basis for national plans of action.

WHO's Global Campaign for Violence Prevention works to promote and support national- and local-level violence prevention initiatives. The WHO Centre for Health and Development in Kobe played an important role in the Campaign by supporting this set of national violence and health reports from countries in the WHO South-East Asia and Western Pacific regions. While violence is prevalent in rural and urban settings alike, the evidence points to it occurring with greater frequency and higher severity in urban settings, which in the years ahead are set to be a focus of the WHO Kobe Centre's project to optimize the impact of social determinants of health on exposed populations, and therefore a continuing opportunity to deepen and expand public health programmes for the prevention of violence. I hope that the reports will serve as a stimulus to initiate violence prevention activities and a solid basis from which to develop national plans of action.

Etienne Krug
Director, Department of Injuries and Violence Prevention
WHO, Geneva, Switzerland

Message from Dr Agostino Borra, WHO Representative to Sri Lanka

A few decades ago, violence was not considered a priority concern for international public health. Knowledge and awareness about the seriousness of various types of violence and the long-term consequences to the victims have gradually gained ground. Today, violence is widely recognized as a public health and human rights issue, which affects all members in the community, and is a special burden for women's health and well-being.

The release of the *National Report on Violence and Health* is an important benchmark. It outlines the current manifestation and scope of violence in Sri Lanka, and the progress made in taking up the issue on the national agenda. This publication is a follow-up product of a worldwide endeavor against violence: in 2002, WHO launched the first ever *Global Report on Violence and Health*. Violence happens all over the world, and is not a novelty or a nationally-confined phenomenon. Hence, we are challenged to see violence as a complex problem, linked to patterns of behavior and rooted in a multitude of forces within our families and communities.

Sri Lanka has followed the trend of positive changes, and violence-related problems and consequences are today recognized and discussed openly. This is reflected in the way experts are determined in preparing the ground for durable solutions and bringing victims of violence out from suffering in silence. The present report represents the tremendous joint effort by these specialists, and is probably the most comprehensive report published on the issue to date. Furthermore, it is a valuable support to the partners who work together to tackle violence in the country: it will help collaborative efforts, such as the WHO Health as a Bridge Towards Violence Prevention and Reconciliation initiative and the UN joint programme on gender-based violence, bring together groups who are dedicated to violence prevention, and to promote values of a society free from violence. Seeing so many actors working together towards the same goal to prevent violence is not a coincidence, but a result of deliberate efforts and serious concern for the well-being of the nation.

Dr Agostino Borra
WHO Representative to Sri Lanka

Message from the Director General of Health Services

Violence has been regarded mainly as a Police, Legal or Social Problem. The Health Sector has historically played a role of care provider for affected persons.

Though the prevention of violence is the responsibility of several other sectors, Health Sector should also play a key role since the Health Ministry is forced to bear the brunt of consequences of all forms of violence in the society.

Already, there are several organizations working independently to prevent different forms of violence. These efforts should be coordinated in order to obtain better results and also to prevent duplication. The Ministry of Health recognizes the prevention of violence as a responsibility of this Ministry. The compilation of the *National Report on Violence and Health* will help understanding the magnitude of the problem and also identifying the key players related to the prevention of different forms of violence.

I congratulate the Editorial Committee for their efforts in providing an overview at National level about this important issue. I hope that the report will generate public interest and propagate action.

Dr. Ajith Mendis
Director General of Health Services
Ministry of Health Care and Nutrition

Preface from the Editorial Committee, Sri Lanka

This report, while being comprehensive and the first of its kind, is only a beginning. It is hoped that the report will stimulate discussion at local and national levels and provide a platform for increased action towards preventing violence.

This report provides a foundation for understanding various types of violence and the roles and responsibilities of various stakeholders in its prevention, identification, investigation, assessment, and treatment. Further, we hope that this report will serve as a valuable resource for building knowledge, promoting effective practices, and enhancing community collaboration.

It is important to understand that paucity of information in some of the sensitive subject areas makes it difficult to cover all aspects. However, we would appreciate the readers' comments regarding any aspects of the contents of this document.

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Executive summary

The occurrence and recognition of violence in a country is dependant on a number of issues at macro and micro levels. The epidemiological dimensions are not well known or not often discussed openly. Many issues involving violence in Sri Lanka are not understood completely as violence has always been considered a police, legal, personal or family problem and not as a health problem that needs detailed epidemiological analysis. Sri Lanka has experienced political and communal conflicts for more than two decades.

This Report on Violence and Health is the first national report ever published on this important problem. This report analyses available data to understand violence in the local context and its impact on the country. It attempts to assess the magnitude of the problem and describes different aspects of violence in Sri Lanka. Whilst most of the issues regarding violence in Sri Lanka are similar to the rest of the world, there are significant differences in certain areas due to many local factors including the protracted conflict situation.

This report too confirms the fact that violence should be considered as multifactorial in its origin. Therefore, there should be collaboration among different stakeholders in the prevention of violence. This report identifies the ways for collaboration among them.

The Ministry of Health, as the organization carrying the burden due to morbidity and mortality attributable to violence, should take the lead role in facilitating coordinated action by all stakeholders concerned. It is timely that due attention is given to this important public health problem, and it initiates a coordinated action by all relevant stakeholders.

1. Introduction

Where violence is prevalent, health is seriously compromised. Violence is recognized as one of the leading causes of deaths, non-fatal injuries and other adverse health consequences worldwide. Like many health problems, violence is unequally distributed across population groups or countries.

Violence can be self-inflicted, interpersonal or collective. The World Health Organization defines violence as: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (1).

The forty-ninth World Health Assembly (1996) declared that violence is a major and growing public health problem across the world (Resolution WHA 49.25). In this resolution, the Assembly drew attention to the serious consequences of violence – both in the short-term and long-term – for individuals, families, communities and countries. It also recognized the growing consequences of violence for health care services everywhere and its detrimental effect on scarce health care resources for countries and communities.

Traditionally, violence is considered as within the domain of the criminal justice system – a law and order issue. However, given the huge and often complex cause structure behind violence, it needs the involvement of all sectors in preventive efforts.

Situation in the South-East Asia region

Violence kills more than 1.6 million people every year, out of which one-fifth belong to South-East Asia. For every death due to violence, another 20 to 40 persons require medical care, resulting in a considerable burden on the health system. In year 2000, violence accounted for an estimated 317 000 deaths in South-East Asia. These violent deaths account for more than six times the deaths caused by malaria and half the number of deaths due to tuberculosis. The evidence shows that violence is a major health issue in South-East Asia, irrespective of age or sex (2).

Situation in Sri Lanka

Violence in Sri Lanka is mainly considered as a police, legal, personal or a family problem. Currently there is no comprehensive national plan that deals with every form of violence. The response to violence is mainly from the Police Department with only limited strategic cooperation with other authorities, departments and NGOs to help reduce its incidence.

Lack of aggregated information on violence is a major obstacle to planning the prevention of violence. Most acts and consequences of violence remain hidden and unreported. Consequently, there is insufficient data on which to form coherent policy responses. Reliable data on violence are crucial not only for setting priorities, guiding programme design and monitoring progress, but also for advocacy.

Hence, it is important to carry out a situation analysis and to prepare a national report on violence prevention. This national report contains information drawn from the analysis of the following types of violence:

- Child abuse and neglect
- Youth violence
- Domestic violence
- Gender-based violence
- Elder abuse and neglect
- Self-inflicted violence – suicides and attempted suicides
- Fatal violence – homicides
- Collective violence

Purpose and overview

This report addresses the definition, scope, causes, and consequences of different types of violence. It also presents an overview of preventive efforts so far. While this report aims at providing comprehensive information on major issues, it cannot reflect all the detailed information related to this complex problem. It is intended, therefore, to be a starting point of a violence surveillance mechanism.

This report answers the following questions:

- What is violence?
- What is the scope of the problem?
- What factors contribute to violence?
- What are the consequences of violence?
- What can be done to prevent violence?
- Which laws and policies guide public intervention in the prevention of violence?
- Who should be involved in the prevention of violence at the community level?

Though the information on violence is scarce, the interest in the subject is growing. Therefore, initiatives should be taken to launch a comprehensive violence prevention programme in Sri Lanka. This report will serve as a useful tool for advancing violence prevention initiatives and help identifying gaps and develop a national programme to address the problem of violence in the country.

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2. Data sources and limitations

It is difficult to obtain information related to violence from any single organization in Sri Lanka. Data related to different aspects could be extracted from various reports provided by the Ministry of Health, the Police Department, the Registrar General's Department and other relevant authorities. Information also could be obtained by studying the hospital records and other information documents related to management of patients. The main sources of data in respect of homicides and suicides are the police records and the records of the Registrar General's Department.

Detailed information regarding certain types of violence is available with non-governmental organizations involved in violence prevention activities. However, such information does not cover the entire country and is often limited to certain identified geographical locations. Some organizations also have information derived from surveys and research carried out directly by themselves or by others with their financial support. The limitation of such information is that they are restricted by the period of the survey and may not represent the overall picture. There is no formal surveillance system related to violence in general or specifically for any particular type of violence in Sri Lanka.

Organizations which provide information related to violence are as follows:

Gender-based and domestic violence

Women's Bureau of Sri Lanka, Ministry of Women's Affairs
National Committee on Women, Ministry of Women's Affairs
Women in Need (WIN)
Centre for Women's Research (CENWOR)
Women's Education and Research Centre
Action Network for Migrant Workers (ACTFORM)
Sri Lanka Women's NGO Forum (SLWNGOF)
Suriya Women's Development Centre (SWDC)
Centre for Women's Development (CWD)
Affected Women's Forum
Sri Lanka Campaign to End Violence against Women
Women and Development Centre

Child abuse and neglect

National Child Protection Authority
Department of Probation and Child Care Services
Children's Secretariat, Ministry of Social Welfare
Save the Children Fund
Child Protection Society of Ceylon

Youth violence

National Youth Services Council

Elder abuse and neglect

National Secretariat for Elders
Help Age, Sri Lanka
NGO Forum on Ageing

Self-inflicted violence

Sumithrayo
Sahanaya

Collective violence

Presidential Committee on Ethnic Violence
Ministry of Relief, Reconstruction and Rehabilitation

Others

Family Health Bureau, Ministry of Health Care and Nutrition
Human Rights Commission of Sri Lanka
Police Headquarters
Lawyers for Human Rights and Development (LHRD)
Human Rights Documentation Centre
International Centre on Ethnic Studies
Sarvodaya
Department of Social Services
Department of Labour

Though organizations have been listed under a particular type of violence, it is possible that these organizations provide information on more than one type of violence. There may be other organizations not covered here that are providing information about violence on a limited scale.

The main sources of data on homicides and suicides are the Registrar General's Department and the Police Department (1, 2). However, the deaths of the cadres of the militant groups resulting from violence are not available from the police. It is doubtful whether these deaths are registered with the Registrar General's Department. The details of such deaths could only be surmised from press statements issued by the respective militant groups. The accuracy of such reports is debatable.

Registrar General's reports are issued according to the period of registration rather than the period of occurrence. However, this may not affect the analysis as the interval between the occurrence and the registration in most instances is very short. But when it comes to deaths due to homicide, there can be a large time gap between the occurrence and the registration. For instance, some homicide deaths are registered long after the time of death because of the delays in the process of magisterial inquiry. As a result, the number of homicides indicated in the Registrar General's reports each year may not reflect the actual values for the particular year. In the past there had been periods of social unrest where some people were killed by unidentified persons or groups and most of these victims may not have been identified. They were considered

as "disappeared". In those cases the government has allowed registration of such deaths after a lapse of a certain period by enacting an Act of Parliament from time to time. Since the Registrar General's reports are based on the time of registration, there can be huge discrepancies related to homicides when such laws are enforced. Homicides reported by the Inspector General of Police in Annual Administrative Reports can be considered as fairly accurate. In these reports homicides are classified into two groups:

1. Homicides classified as reportable crimes
2. Homicides resulting from terrorist activities

Generally, the second group includes the deaths of police personnel and members of the armed forces. It could also include some civilians who die of terrorist activities such as bomb blasts. The details of the Liberation Tigers of Tamil Elam (LTTE, and often referred to as "Tamil Tigers") deaths were obtained for this report from a Tamil newspaper (3). Deaths of the members of other militant groups such as the EPDP, EROS, PLOTE, TELO and EPRLF are unfortunately not available.

Table 2.1: Number of homicides from 1991 to 2004 as reported by different sources

Year	Police and other sources				Registrar General Data for comparison (Data adjusted to the year of occurrence)
	Homicides under reportable crimes (IGP)	Homicides related to terrorist activities (IGP)	Homicides involving LTTE cadres (from newspapers)	TOTAL Homicides Based on police & other sources	
1991	1556	1630	1614	4800	4307
1992	1294	1733	788	3815	2529
1993	1286	591	925	2802	2005
1994	1245	415	1505	3165	1689
1995	1297	2190	Not available	3487	2214
1996	1775	1663	1376	4814	1589
1997	1637	1752	2106	5495	959
1998	1919	1808	1793	5520	1022
1999	1797	1167	1545	4509	1028
2000	1711	1968	1980	5659	-
2001	1576	782	759	3117	-
2002	1347	26	38	1411	-
2003	1310	-	-	1310	-
2004	1377	105	-	1482	-

The Registrar General's statistics on homicides correlate well with the total homicides from the Police and other sources during the period 1991–93. Thereafter this figure is much lower than the total reported by the police and the other sources. The reason for this discrepancy may be due to the fact that some homicides that took place after 1994 may not have been registered up to the time of collection of data in 2005. The above table also shows that there had been very few homicides related to the civil strife situation after the signing of the ceasefire agreement (CFA) in April 2002 and for a period of about two years.

Another problem with data provided by the Registrar General's Department is the inaccuracy due to classification errors. Both Inquirers of Sudden Deaths and the Registrars of Births and Deaths in most instances are laypersons. The Inquirers of Sudden Deaths use the findings of the medical personnel and the police, and take decisions related to the cause of deaths which are thereafter registered by the lay Registrars. Although registration of deaths in Sri Lanka is considered complete according to the United Nations definition, the certification of the cause of death is not always reliable due to the above reason. In 2002, for example, 3.7% of deaths were attributed to symptoms, signs and abnormal laboratory findings (4). These symptoms and signs ranked as the eighth-highest cause of hospital deaths. At least some of them should have been assigned to specific diseases or causes. When the suicide figures of the Registrar General's Department are compared with that of the Department of Police, there were significant differences in the numbers reported. (Please refer the chapter on self-inflicted injuries for details).

Conclusion

The above discussion indicates that there are limitations related to the data on violence. Though the data does not reflect an accurate picture of violence in Sri Lanka, it gives an indication of the gravity of the problem. Whilst all efforts are made to improve the validity of the data, the available information is provided in this report in order to use it for the planning of activities for violence prevention.

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3. Child abuse and neglect

3.1 Introduction

The term "child" is used to refer to anyone under the age of 18 years. Working with children inevitably entails dealing with issues of maltreatment in one form or another. It is a global phenomenon. It may take place within the context of the family, or outside the family setting, for example, in institutions, at work, on streets or in war zones.

Background

A decade ago, child abuse was not discussed publicly in Sri Lanka. In fact its existence was denied. Traditionally, children have been perceived as an economic asset at the disposal of the family in times of need and society justified child labour and corporal punishment.

Over the years, changes in the lifestyle have profoundly affected the manner of providing parental guidance and fulfillment of parental responsibilities. The structure and the functions of the family as a basic social unit have undergone significant changes. The extended family, which was part of the Sri Lankan culture and tradition, is being replaced by the nuclear family, mainly due to social factors such as urbanization, higher levels of education, economic hardships and the internal mobility of the population (1).

For more than two decades, Sri Lanka was affected by a bitter conflict due to clashes between the Government and the Tamil Tigers, a militant group. As a result of this protracted conflict, the education and health of the children have suffered immensely in the affected areas. Sri Lanka painfully accepts the fact that war violates the rights of a child.

Sri Lanka now faces another monumental challenge in the aftermath of the catastrophic December 2004 tsunami, which claimed tens of thousands of lives. Property damage was extensive, and hundreds of thousands of people have fallen into poverty after losing homes and jobs, particularly in areas already affected by the armed conflict. Taking measures to protect children in the tsunami zone from exploitation, abuse, and trafficking has become an added responsibility for the nation.

Defining child abuse and neglect

There is no single, universally applied definition of child maltreatment. Many countries have developed their own legal definition of what constitutes child abuse and neglect. Despite the differences, there are commonalities across various definitions. In 1999, the WHO Consultation on Child Abuse Prevention drafted the following definition (2): "Child abuse constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power."

It is defined in Sri Lanka, as stated in the Child Protection Authority Act No. 50 of 1998, "all acts of sexual violence against children; cruelty to children; use of children in obscene publications; use of children in exploitative labour; use of children in illegal activities; nonconformity to compulsory education regulations; and involvement of children in armed conflict" (3).

There are four commonly recognized forms of child maltreatment: physical, sexual and emotional abuse, and neglect (4,5). Although any of these forms may be found separately, they often occur in combination. All forms of abuse and neglect have a psychological impact on child development.

3.2 Extent of the problem

Several factors inhibit voluntary reporting of child abuse and neglect. Hence, it is difficult to attain a reliable measure of the number of people who are abused at some time in their childhood (i.e. the prevalence of child abuse) or to estimate the number of children who are abused in a single year (i.e. the annual incidence of child abuse).

In the recent years, there is increasingly reliable information on the number of child abuse cases handled by child protection agencies including the Police, but the number of children suffering from undiscovered and unreported abuse could only be estimated.

Global situation

It is difficult to estimate the global dimensions of the problem or meaningfully compare rates between countries. According to the WHO, there were an estimated 57 000 deaths attributed to homicides among children under 15 years of age in 2000. However, there is general agreement that fatalities from child abuse are far more frequent than official records suggest (2).

In the United States, the rate of victimization per 1000 children in the national population was 12.4 in 2003. While the rate for white children was 11.0/1000 children of same race, rates for American Indians and African-Americans were 21.3 and 20.4 respectively, showing disparities between different ethnic groups. More than 60% of child victims experienced neglect. Almost 19% were physically abused, 10% were sexually abused, and 5% were emotionally maltreated. Children aged from birth to three years had the highest rates of victimization at 16.4 per 1000 children of same age group. Girls were slightly more likely to be victims than boys. The majority of victims were maltreated by a parent. While mothers were more frequently identified as perpetrators of neglect and physical abuse, fathers were more identified as the perpetrators of sexual abuse (4).

Findings reported in international studies conducted since 1980 reveal a mean lifetime prevalence rate of childhood sexual victimization of 20% among women and of 5–10% among men (2). Data on the extent of emotional abuse in different cultures and parts of the world are extremely scarce (2). This is the most difficult form of child maltreatment to identify, assess and substantiate as the effects of emotional abuse usually become evident during the later developmental stages of the child's life.

Sri Lankan situation

Information on child abuse and neglect, including information on children affected by the armed conflict, child domestic labour, and street children is inadequate. Some statistics are available, but it is uncertain how accurate they are, as many cases go unreported. Further, researchers use varying methods to measure and define abuse and neglect, making it difficult to compare findings across studies.

Reported crimes

Though the quality and coverage of information is questionable, some national statistics on reported crimes were available from Police records and also recently from the National Child Protection Authority. According to these statistics, in all districts of the North and East Provinces except for Ampara (i.e. Jaffna, Vavunia, Mannar, Killinochchi, Mullaitivu, Batticaloa and Trincomalee), comparatively few offences against children were reported (6). Underreporting, due to the collapse of the civil administration including policing in those conflict areas, is the apparent reason behind those unexpected figures.

Police statistics on minor offences against children: The number of reported offences against children, classified as minor in nature, was in the range of 700 to 900 per year during 2000–2002 period. However, there was a 65% increase in the number of minor offences in 2003 compared to that of year 2000 (from 900 to 1488) (Table 3.1). The minor offences of sexual nature (sexual abuse, sexual exploitation, child prostitution, and forced participation in pornography and obscene publications) contributed between 60% to 70% of the total minor offences reported during 2000–2002 period (i.e. 68.6% in 2000, 67.4% in 2001 and 60.8% in 2002) (Table 3.1). However, this proportion has fallen drastically in year 2003 to 34.7%. A very high number of offences (60.1%) recorded under the category of "others" in 2003 may be the reason behind above changes in the trend in the year 2003. This should be explored further.

Table 3.1: Reported minor offences against children, 2000–2003

Type of offence	**Year**			
	2000	**2001**	**2002**	**2003**
Minor physical Injuries	14	1	-	-
Sexual abuse	585	462	466	512
Sexual exploitation	29	23	22	4
Child prostitution	0	0	2	0
Forced participation in pornography	1	0	0	0
Used in obscene publications	2	2	2	0
Employing children in domestic labour	128	112	86	72
Employing children for begging	26	20	19	5
Denying education	11	7	10	1
Others	104	96	202	894
Total	**900**	**723**	**809**	**1488**

Source: Women and Children's Bureau, Police Headquarters (6)

Police statistics on major offences against children: Homicides, attempted homicides, grievous injuries and grave sexual abuses are classified as major offences against children. The term "grave crimes" is also often used synonymously in police records. From 2000 to 2004, there was a 50% increase (from 1288 to 1933) in the number of reported grave crimes against children (Table 3.2). Crimes under the broader category of sexual abuse (rape, incest, and other grave sexual abuses) contributed between 65% to 70% of the grave crimes reported to the police during this period (i.e. 65.1% in 2000, 67.0% in 2001, 68.4% in 2002 and 68.9% in 2003) (Table 3.2).

Table 3.2: Reported major offences against children, 2000–2003

Type of offence	Year			
	2000	2001	2002	2003
Homicides	44	51	60	43
Attempted homicides	20	17	16	8
Grievous hurt / injuries	56	56	46	128
Subjected to cruelty	28	91	73	35
Abduction / Kidnapping	301	329	357	387
Rape	608	685	714	753
Incest	10	26	24	6
Unnatural offences and grave sexual abuse	221	393	458	573
Total	**1288**	**1648**	**1748**	**1933**

Source: Women and Children's Bureau, Police Headquarters (6)

Fatal abuse: In Sri Lanka, information on the number of child victims of homicide comes primarily from police records. The number of child homicides reported to the police during the period of 2000 - 2003 in Sri Lanka varied between 43 and 60 (Table 3.2). This small range indicates that there was no significant change in the child homicide rate over recent years.

A total of 47 child homicides (0.85 per 100 000 children*) were reported in 2004 (7). Out of these victims, 28 (59.6%) were males. By age group, 25 (53.2%) were less than 6 years old, while 5 (10.6%) were in the 6–11 years age group and 17 (36.2%) were in the 12–18 years group.

There is grossly inadequate data on child fatalities of war / civil conflict, except for a few documented cases. The police statistics on crimes do not include these figures. On 25 October 2000, at a rehabilitation centre situated in Bindunuwewa (Uva province), 27 inmates were killed by an unruly mob. The majority of the victims were children. The youngest victim was 12 years old at the time of his death (8). According to a 2003 report, 20 children were killed by landmine explosions in the civil conflict areas (3).

Statistics from the National Child Protection Authority: In 2002, 14 complaints of grave crimes and 50 complaints of minor offences against children were reported to the National Child Protection Authority (NCPA) (9). In 2003, this unit received a total of 551 complaints pertaining to crimes against children (classification by provincial level: Western - 143, Southern - 82, Central - 58, Northwestern - 57, Uva - 45, North central - 45, Sabaragamuwa - 39, and Northeast - 26). In 2004, there were 26 complaints of grave crimes (sexual abuse - 24 and procreation / trafficking - 2) (10). In 2005, 196 cases of child sex abuse were reported to the NCPA. Grave incest by members of the family, including extended family, amounted to 43 cases while 128 cases of grave sexual abuse by outsiders were also reported (11). The NCPA has also detected the commission of child abuse by foreign nationals and has referred these cases to the Interpol and relevant embassies for further action. As the definitions and procedures for recording differ, it is difficult to link the NCPA statistics with those of Police records.

Child sexual abuse is generally considered a hidden crime. However, among the reported crimes, sexual abuse was the most frequent form of child abuse (6). This significant proportion may be due to more reporting because of heightened public awareness through media and increased vigilance by the government.

Data from various reports, studies and surveys on different types of child maltreatment and the magnitude and features of some other issues affecting children in Sri Lanka are highlighted in the following sections.

Sexual abuse: A study conducted in the early 1990s among 899 pre-university and undergraduate students in Sri Lanka revealed that 18% of boys and 4.5% of girls had been sexually abused in childhood. Most of the perpetrators were known parties such as relatives, neighbors, teachers and priests. The same questionnaire administered to girls after a lecture on child abuse increased the numbers from 4.5% to 12.3%, divulging the abuser as a brother, uncle or father (12). Sexual molestation by a stranger, although foremost in the minds of many people, actually represents only a small percentage of cases.

In a 2005 study, UNICEF reported that the prevalence of sexual abuse among 10-13 years old was 10% (among boys 14% and girls 8%). The same study found that among 14-19 year olds, 14% had been sexually abused with little difference in the prevalence among boys and girls (13). Another study conducted in the district of Anuradhapura in 1998 found a prevalence of 16.8% for sexual abuse among adolescents (13).

Neglect: Malnutrition among children continues to be a serious health issue, and a social problem in Sri Lanka. According to the Demographic and Health Survey conducted in the year 2000 (excludes Northeast Province), the proportions of preschool children (under 5 years) who were stunted, wasted and underweight stood at 14%, 14% and 29% respectively. Malnutrition was at its worst in the estate (plantation) sector with the percentage of underweight children as high as 44% (14).

Traditionally, among rural Muslims and in the estate sector, girls are either not allowed to receive higher schooling or else are kept at home to look after their siblings or assist the domestic chores. In 2003, UNICEF estimated that in the rebel-controlled areas of the Northeast, one third of children (an estimated 50 000 children) have dropped out or have never attended school (15,16).

However, by definition neglect can occur only in cases where reasonable resources are available to the family or caregiver and hence, such situations should be distinguished from circumstances of poverty (2).

Special issues

Corporal punishment: The Committee on the Rights of the Child has underlined that corporal punishment is incompatible with the United Nations Convention (2). Though there are different views among professionals, generally moderate discipline of children is not agreed to be abusive in many countries. In Sri Lanka, corporal punishment is permitted in schools for disciplinary purposes, subjected however to strict limitations. Regulations made under the Education Ordinance of 1939 permit corporal punishment only for grave misconduct or habitual idleness and only when other methods of punishment have been tried without effect. Further, it allows only the school Principals to inflict it. It can be inflicted only on the palm of the hand and the cuts must not exceed four (1). As to whether corporal punishment violates Article 11 of the Constitution is yet to be judicially determined. The recent judgment punishing some teachers involved in a harsh corporal punishment case at a leading school in Colombo was an eye-opener to many. However, most of the Principals and teachers are keen that some disciplinary measures should be made available to them. Corporal punishment is also widely prevalent in some homes.

Child labour: It occurs mostly in the informal sectors of small, unregistered concerns such as family farms, crafts, small trade establishments, eating houses, repair workshops, and private homes. Most children in the labour force are from remote or disadvantaged villages, tea estates and conflict areas.

An unofficial survey conducted by the International Labour Organization (ILO) showed that nearly 35,000 children were employed in shops and small industries. According to this survey, one of the most destructive forms of child labour in Sri Lanka prevails in the fishing industry (15). Children were recruited in fishing "vaadiyas" most of which were situated in remote areas and they were kept in conditions of virtual slavery.

The commonest form of child labour in Sri Lanka is domestic labour. There are an estimated 100,000–150,000 child domestics in the country (17). Besides being emotionally abused, many of these children are physically and sexually abused too. A rapid assessment survey was recently conducted on the prevalence of child domestic labour in selected areas of the country. A purposive sample from communities representing estate areas, conflict-affected areas, rural areas and inner city slums, which were identified as providing child labour, was selected for this survey. Analysis of survey data indicated that among these areas, the estate area had provided the largest number of child domestics (3).

The National Child Protection Authority records a 10–15 fold reduction in child labour following intensified action by authorities and a broad media campaign against domestic child labour (15). Using children as domestic servants has become a taboo today following the media awareness campaign.

Child prostitution: One of the most degrading and serious forms of child labour involves commercial sexual exploitation of children. In the recent years, most of the local and international publicity has focused on children exploited by foreign pedophiles. This consists mainly of sexual exploitation of boys between approximately 8–14 years of age. It is now well known that Sri Lanka is part of an international commercial sex tourism network. The exact number of affected children is unknown. NGOs have quoted figures as high as 30,000 whilst some studies indicate the numbers to be in the 2000–2500 range (1). The problem first manifested in the 1980s and has since grown particularly in the tourism areas along the seacoast in the South and in places such as Negombo. In a pilot study done among 145 school children aged 13-17 years from a poor neighborhood in a high-risk beach area, 6% of the respondents agreed that they had done "sexual things" with adults for money (18).

Child conscription: Under international law, 18 years is set as the minimum age for all participants in hostilities, and any recruitment or use of children under the age of 15 is considered a war crime (8). According to Article 38 (3) of the Convention on the Rights of the Child (1989), any recruitment or use of children under the age of 15, whether enforced or voluntary, is considered a war crime (1, 8). The Convention on Elimination of the Worst Forms of Child Labour (1999) declared the use of children under the age of 18 in armed conflict as one of the worst forms of child labour (8). However, it is a well-known fact that the Liberation Tigers of Tamil Eelam used children for both gathering intelligence and engagement in combat.

Many organizations, including the United Nations Children's Fund (UNICEF) and the Sri Lanka Monitoring Mission, have documented both forced and voluntary recruitment of children for military purposes. Militant groups often pressure Tamil families to provide a son or daughter for "the cause." When families refuse, they may be harassed or threatened, and

the children taken by force. Some children join the cadres because they come from poor families, are orphaned, or have no access to schooling. Some have experienced abuse by government forces. Children are typically 14 or 15 years old when they are recruited, though some are as young as 11 years (19).

In June 2003, the LTTE and the Sri Lankan government agreed to a formal Action Plan on Children Affected by War. Under the Action Plan, the LTTE agreed to end their recruitment of children and to release children from their forces, either directly to the children's families or to new transit centers that were constructed specifically for this purpose. The UNICEF, as of 31 July 2005 has documented 5081 cases of underage recruitment, since the signing of the Cease-Fire Agreement in February 2002 (8, 20). Out of this, 2106 (41%) were girls. The highest were from Batticaloa district (2356), followed by Jaffna (749), Trincomalee (471), Ampara (412), Killinochchi (232), Mullaitivu (212) and Mannar (184). Since the signing of "Action Plan" in 2003, LTTE has formally released more than 1400 child soldiers to UNICEF. Some child recruits have been released directly to parents or to the LTTE's Secretariat on Human Rights. The total released so far is considered to be 1480, with 821 running away, 1825 returned and 16 deceased. As of August 2005, UNICEF had 1209 outstanding cases of child recruitment (20). These are the known and documented figures. Similar to other protection issues related to children, the actual numbers could be considerably more. It is not possible to know the full extent of the problem of underage recruitment since not all parents are aware of existing reporting mechanisms.

At the same time, the Human Rights Commission (HRC) of Sri Lanka expressed its concern about the lack of protection for LTTE runaways who surrender to the security forces (8). Children who have been released or have run away are in a vulnerable position and in need of protection. According to the HRC, there are reports that these children are regularly harassed and when taken into custody, are sometimes subjected to repeated questioning and videotaping.

The child combatants are not only at risk of injury, disability and death, but are also vulnerable to long-term and serious psychological problems, deprivation of education and worst of all, denied the right to a life with their families and communities.

Street children: There are also street children who live in cities such as Colombo. Numbers are estimated to be around 20,000 (1). They too are deprived of basic needs in health, nutrition, and education. They work, live, learn, and play in the streets. They are also in danger of being subject to violence and abuse. A preliminary study conducted among street children in Colombo has found that 84% of them were having family ties and family disintegration was the cause for life on the streets. Among the respondents, child labour was reported by 38%, 16% admitted to being sexually abused and 20% were tobacco smokers (21)

Institutionalized children: According to a recent report, 15,068 children live in children's homes in Sri Lanka. Many are sent to these institutions because they have been abused; have got into trouble with the Police; their parents are no longer able to care for them; or they are orphaned (22). For this report, researchers spoke to about 2000 children from 329 state-run or volunteer-run homes to find out their problems. The strongest testament about the quality of care in the institutions came from the children themselves, who spoke out against the lack of privacy, dignity and individuality.

Sexual abuse as well as other forms of abuse has also been reported from institutions that are poorly supervised and monitored. Counseling services were provided in only 16% of state-run homes. In the Northeast, where a protracted civil strife has affected lives for decades, 34% of the institutions had no beds for the children and there was no playing area in 40% of the homes, depriving children of their right to leisure (22).

3.3 Factors associated with child abuse and neglect

Child abuse and neglect occurs across socioeconomic, religious, cultural, racial, and ethnic groups. What makes it frightening as an issue is that there is no established pattern and there is no single known cause. Every person who has experienced abuse is unique, and each has a unique combination of risk and protective factors that have influenced, and continue to influence, the effects in his or her life. It is also almost impossible to draw up characteristics or traits of a potential perpetrator or say who is at more risk.

However, research has recognized a number of risk factors or attributes commonly associated with maltreatment. Usually, maltreatment results from a combination of such factors. The most widely adopted explanatory model is the ecological model quoted in the World Report on Violence and Health. This model considers a number of factors including the characteristics of the individual child, those of the perpetrator, nature of the local community, and the social, economic and cultural environment (2).

Individual characteristics

Though children are not responsible for the abuse inflicted upon them, certain child characteristics have been found to increase the risk or potential for maltreatment. Differences existing between individual children and between groups of children may result in discrimination, exclusion and marginalization. Factors such as disability, gender and ethnicity have particular significance in relation to the welfare and protection of children (5).

Evidence suggests that age and gender are predictive of maltreatment risk. Younger children are more likely to be neglected, while the risk for sexual abuse tends to rise after puberty (2). Fatal cases of physical abuse are found largely among young children in Sri Lanka (7). Global estimates of child homicides also suggest that infants and very young children are at greatest risk, with rates for the 0–4 years old age group more than double that of 5–14 year olds (2). Young children are also at risk for non-fatal physical abuse, although the peak ages for such abuse vary from country to country.

Statistics show that female children and adolescents are significantly more likely than males to suffer sexual abuse (23), and Sri Lanka is no different. According to 2003 Police records, the majority of victims of grave sexual abuse (seduction, rape, incest and procreation) were girls (78%), especially younger children under 16 years old (7).

In Sri Lanka, among both younger and older children, mostly girls were employed as domestics, though the difference was small among younger children. In the older age group (between 16 and 21 years), almost all the domestics were females (7). Boys are exploited more in child prostitution, theft and the sale of drugs (1,7).

Information on characteristics of the perpetrators of child maltreatment is lacking in Sri Lanka. However, some data were available on fatal abuse. According to 2004 Police statistics, the perpetrators were blood relations of the victims in 43% of child homicides. It

should be noted that only in 13% of cases, perpetrators were unknown parties to the victims. The sex distribution of the perpetrators shows that 64% were males. Age-wise, it should be noted that there were no “child perpetrators” recorded and that about 94% of perpetrators were in the age group of 18–48 years (7).

Family characteristics

Disintegrated families: The family is the basic social unit mainly responsible for the growth and development of children. Children without proper primary caregivers are deprived of their first source of protection. Separation from parents and family is usually detrimental to the overall well-being and development of a child.

In Sri Lanka, there are now more truncated nuclear families or single parent families. Such family units probably amount to a considerable number, although exact figures are not available. There are many reasons for their existence. There is anecdotal evidence of alcoholism, drug abuse and child abuse and neglect, which subject these families to traumatic experiences.

One reason for the rising number of families experiencing trauma is the conflict in the country and the increasing number of war widows (1). Many children are displaced and abandoned. Children separated from their families are vulnerable for conscription. They are also easy prey for “job placement agents” who pick them up on the streets in villages or even from within the refugees camps and then sell them for employment, most commonly for domestic work.

Another reason is the migration of young married women to the Middle East countries for employment since early 1980s. These women are usually between the ages of 20 to 35 years. The number of women migrant workers abroad is estimated to be more than 800,000 (1). This exodus of women has led to many secondary effects on the rest of the family, especially children. The husbands who are generally not used to managing domestic affairs often indulge in alcohol abuse and the burden of looking after the children falls on grandmothers or more often on elder girls, who may have to stop school education. Information collected through law enforcement authorities and community workers indicates that an increasing number of girl children of migrant women remain unprotected and become victims of abuse even ending in incest, unwanted pregnancies and illegal abortions (24). It is a direct outcome of the absence of maternal protection.

Another group of children who are vulnerable to various forms of abuse and neglect are those who have lost their parents or have been separated from their families due to the recent tsunami. While no reliable figures yet exist, estimates based on the numbers of dead and displaced suggest that there may be hundreds of children across the country falling into this category.

Some other characteristics of the families are also linked with child maltreatment. Domestic violence and lack of parenting increase the risks of maltreatment to children (25). Intra-familial child abuse is a manifestation of a dysfunctional family. Evidence also suggests that the physical and sexual abuse of children often occurs in successive generations of families. Recent studies have established a link between having a history of childhood abuse and becoming a victimizer later in life (26).

Community factors

Violence and unemployment are some of the community-level variables that have been found to be associated with child maltreatment (23). Though child abuse cuts across all ethnic, religious, social and economic backgrounds, economic disadvantage is a major contributor to child neglect.

There is evidence to show that the children vulnerable to child labour belong to poverty groups in low-income urban neighborhoods, remote rural villages, new settlements and tea plantations (17). Children living in refugee camps in conflict-affected areas are another vulnerable group. Many are precluded by cost and the opportunity cost of education from utilizing even existing free education facilities. Some are often compelled by parental pressure to contribute to family income or to assume childcare and household responsibilities very early in their lives.

Societal factors

The least understood and studied level of child maltreatment is that of societal factors (23). Included here are those factors that create an acceptable climate for abuse.

Armed conflict: The government of Sri Lanka and the Liberation Tigers of Tamil Eelam were engaged in a brutal military conflict from 1983. Since then up to 2002, over 65,000 people were killed. This conflict has directly and indirectly affected the lives of thousands of children, particularly those living in the North and East Provinces. It also impacts on children living in threatened villages on the borders of the districts of Puttalam, Anuradhapura, and Polonnaruwa.

There are displaced communities, who have been living in welfare centres or private accommodation for over 10 years whilst some other communities continue to farm in their villages by day but hide in the jungle at night. In year 2003, of the 400,000 remaining internally displaced persons in Sri Lanka, it was estimated that 34% (136,000) were children (16). Apart from insecurity, alcoholism of fathers, migration of mothers to Middle East countries for jobs, parents away from home as "home guards", single parent and child-headed families, sexual exploitation of children and early marriages are the main issues in these isolated and close communities affecting the lives of children (27).

3.4 Consequences of child abuse and neglect

The consequences of child maltreatment depend on a variety of factors. The following were some of the factors research has shown to influence the effects of abuse and neglect of children (28):

- Intensity and frequency of abuse and how long it went on.
- Age of the child when the abuse happened.
- Who committed the abuse.
- Whether or not violence was involved, and if so, how severe.
- Whether the child told anyone, and if so, the person's response.

The effects of child abuse and neglect are profound. As an immediate consequence, abused and neglected children generally become withdrawn, quiet and avoid social settings. They perform poorly in schools. They also often experience long-term adverse effects

including permanent physical and intellectual impairment, educational and emotional failure, criminal or delinquent behavior, and the possibility that the abused child in turn becomes an abuser. These children may try to deal with stress and anxiety through substance abuse, deliberate self-harm, or other damaging types of behavior (5).

3.5 Interventions and policy responses

Most parents want to be good parents and have the strength and capacity, when adequately supported, to care for their children. When parents (or caregivers) are unable or unwilling to fulfill their responsibilities to provide adequate care and to keep their children safe, then child welfare interventions are required. Interventions however need to be sensitive to the cultures, beliefs, and customs of the community (2).

National commitment

Policy response: The Convention on the Rights of the Child was ratified by Sri Lanka in 1991. Based on it, the Children's Charter was adopted in 1992. Even after the ratification of Convention on the Rights of the Child, Sri Lanka had neither the knowledge/expertise nor the necessary infrastructure to address child abuse and neglect. To fill this void, the Presidential Task Force on Prevention of Child Abuse was appointed in late 1996 and as one of its recommendations, the National Child Protection Authority (NCPA) was set up in June 1999 under the National Child Protection Authority Act No. 50 of 1998 (3).

The mandate of the NCPA includes a broad range of authority, objectives and duties. This includes formulating policies related to child abuse and exploitation, the therapy and rehabilitation of children who are victims of such abuse, coordination of the many groups and agencies involved in combating abuse, including NGOs, monitoring research and resource mobilization (3).

The NCPA has identified advocacy, protection, rehabilitation, and legal reform as the most effective avenues and methods of bringing about the changes that are necessary for the elimination of all forms of child maltreatment (3).

Advocacy and awareness creation

To prevent abuse and exploitation, advocacy and awareness creation are important, and these are best implemented through processes that reach families and communities at grassroots level. During the seven years of its existence, the NCPA has been able to create a considerable amount of awareness among the public and the children themselves. Their poster campaign continues to be one of the most effective methods of creating awareness. Recently, UNICEF has led a mass media campaign via newspapers, radio and television to improve community attitudes, customs and practices towards children and their rights, and to promote awareness about the dangers of sexual abuse and the penalties for adults who commit it (29). A significant consequence of the above developments is the marked increase in the reporting of incidents of child abuse.

Knowledge and skills development

The NCPA has undertaken knowledge and skills development programmes for various categories of people (e.g. social development officers, police officers, labour and probation officers, medical professionals including paediatricians, psychiatrists, general

practitioners, psychologists and judicial medical officers, legal professionals including Judges, Magistrates, state counsels and attorneys, media personnel, and members of child protection committees) who are in a position to help children (3). The National Institute of Social Development has also commenced training of staff who can help to promote the recovery of abused children and their social integration (1).

Community participation

Promoting the psychosocial well-being of children living in the conflict areas and providing the necessary skills to address their needs is an important task. In this regard, in some parts of the North and East Provinces, especially in the East, action has been initiated. Community workers have been trained by NGOs to work with and address the needs of traumatized children and their families (27). As a result of this training, communities are taking their own initiatives to support children and families and sustainability is assured through the trainees being based within the community.

Protection and rehabilitation

Existing guidelines for children's homes were reviewed and steps were taken to develop necessary minimum standards for institutions that are caring for children in a residential setting for ensuring a child's safety, health and well-being. The NCPA has also formulated a project to improve the present institutional care for ex-child domestic workers, street children and child combatants (3). A new rehabilitation model with vocational training for trafficked and exploited children will be introduced in collaboration with the Department of Probation and Childcare Services shortly.

Legal reforms

It is necessary to have a legally-guided mechanism to respond to the needs of the children whenever abuse is suspected. Amendments have been made where existing laws were having negative effects on child protection.

Penal code (amendment) Act No. 22 of 1995: The highlight of this amendment was a provision strengthening the law relating primarily to sexual offences and offences against children. These amendments concentrated on: defining offences that were previously not defined or described inadequately; increasing sentences; and introducing mandatory jail sentences for some offences. Major changes relating to child abuse are summarized in Table 3.3 (1,9).

Table 3.3: Amendments to Penal Code relating to child abuse

Offence	Previous law	Amended law
Child pornography	Up to 3 months imprisonment or fine or both.	Minimum 2 years, maximum 10 years, plus fine at discretion of court
Cruelty to children	Maximum 3 years or fine	Minimum 2 years, maximum 10 years with fine and compensation at discretion of court.
Procreation of girls or women	Not described previously	Minimum 2 years, maximum 10 years with fine at discretion of court.
Trafficking	Previously defined as "slavery"	Minimum 5 years, maximum 20 years.
Statutory rape	Age of victim 12 years	Age of victim increased to 16 years, minimum sentence 7 years
Custodial rape, rape of pregnant women, rape of females less than 18 years and gang rape	Not previously described adequately	Physical injury not essential to prove lack of consent. Minimum 10 years, maximum 20 years
Grave sexual abuse	Not described previously	Minimum 7 years, maximum 20 years
Incest	Offence under marriages law	Minimum 7 years, maximum 20 years with compensation
Publication of matters relating to sex offences, identifying the victims	Previously not an offence	Up to 2 years imprisonment or fine or both for guilty media personnel

Judicature (amendment) Act No. 27 of 1998: This dispenses with the non-summary trial in the case of statutory rape (if the victim child is below 16 years). Previously in cases of rape, a non-summary trial (preliminary inquiry) in the Magistrate Court was held before an indictment was filed in the High Court. It was often protracted and led to psychological trauma to child victims of rape (9).

Code of Criminal Procedure (amendments) Act No. 19 of 1997 and Act No. 28 of 1998: In case of alleged perpetrators of child abuse arrested without a warrant, the Magistrate was given powers to make the detention order up to three days (previously 24 hours) for purposes of investigation. These amendments also made provisions for legal definition of child abuse; priority for cases of child abuse; and introduced a form of referral of victims of child abuse to institutes of care and protection pending trials (1,9).

Penal Code (amendment) Act No. 29 of 1998: Several new criminal offences with regard to child abuse were introduced through this regulation. It prohibits the use of persons less than 18 years for the following purposes: begging, procuring persons for sexual intercourse and trafficking in restricted articles (1,9).

Law of Evidence (Special Provisions) Act No. 32 of 1999: This permit in cases of child abuse, the reception of videotaped evidence of the interview of a child victim or witness (1). This prevents a child from being further harmed by the legal process. Further, this new procedure will be less traumatic and will enhance a child's freedom of expression in court proceedings.

Amendment (1999) to the Women's, Young Persons' and Children's Act No. 47 of 1956: The minimum age for employment of children was raised from 12 to 14 years by this amendment (30). The Ministry of Labour has initiated action to make payment of compensation mandatory for violating the minimum employment age requirement.

Law enforcement

In 1994, the Police Department established Women and Children's Desks in 33 main Police Stations with a view of facilitating complaint procedures in respect of violence against women and children (1). A Police hotline has been established to receive complaints of abuse. A handbook for police personnel was produced and distributed.

The Attorney General's Department established a special unit within the department to deal with child abuse prosecutions. During the past few years, judicial, investigative, and prosecution authorities have been providing mutual legal assistance in cases where foreigners have abused local children, thereby enabling foreign courts to dispense justice more effectively.

The establishment of a special Police unit at the NCPA itself resulted in an increase in the detection of child abuse cases and prosecution of perpetrators of abuse. Under the powers vested by the NCPA Act, the NCPA is in a position to carry out its own investigations on child abuse cases through authorized officers, even without a search warrant (9).

Support services

Approaches to prevention will not succeed unless there are also attempts to reduce poverty, burden of childcare, and family isolation. Several projects have been implemented recently to promote the well-being of the people living in conflict-affected areas. The government, donors, NGOs and international organizations such as the World Bank, WHO, UNDP, UNHCR and UNICEF have combined their efforts to address health, education and other protection needs (16).

Currently, the Government is in the process of developing a mechanism to address the needs of children affected by the conflict through a network of social workers in all districts of the North and East Provinces. The activities included "catch up" education programmes, refurbishing school buildings, recruitment of teachers, establishing vocational training capacity, micro-credit schemes, additional probation and child care capacity and social work support (29).

3.6 Recommendations

There should be a "child welfare system" to promote the well-being of children. Of course, this cannot be a single entity. No single agency, individual, or discipline has all the necessary knowledge, skills, or resources to provide the assistance needed by abused and neglected children and their families. There should be a multisectoral approach for the protection of children involving sectors such as health, education, law enforcement and rehabilitation. Public agencies (National Child Protection Authority, Ministries of Health, Education, Justice and Social Services, Family Health Bureau, Health Education Bureau etc.) should collaborate with NGOs and community-based organizations to provide necessary services to children and their families. Further, there should be community support and participation; otherwise the efforts will be in vain.

Most abusive parents do not consciously set out to harm their children. Parents at risk of abusing should be reached and helped. Helping in psychological recovery and social reintegration of abused and neglected children is a priority intervention. To be effective in addressing this complex problem, the combined expertise and resources of interdisciplinary

agencies and professionals is needed. More local capacity must be built in this critical area of need.

Following are some of the specific actions recommended:

- The general public should be provided with guidance on how to prevent abuse and what to do in order to protect children when abuse is suspected and how to support children affected by abuse.
- There should be efforts at local, national and international level to protect children from recruitment to militant groups and to effectively address the impact of armed conflict on children. "Push and pull" factors that lead to recruitment should be addressed.
- If there is a need, children of migrant mothers should be provided with temporary institutional care until their mothers return.
- There is an absolute need for the capacity building of professionals in rehabilitation and protection of abused children.
- Proper guidelines should be formulated for more professional institutional care. A "code of good care practices" could be introduced for all institutions on a staggered basis. A "Psycho-social audit" for children's homes should be conducted periodically.
- Strengthening the existing monitoring and surveillance mechanisms for child abuse and neglect is essential. It is necessary to develop compatible databases of abused, exploited and trafficked children with information on age, gender and ethnicity which should allow better identification of national trends and indicators. Information is the best ammunition for arresting this social menace.
- New laws and amendments to existing laws should be introduced to enforce mandatory reporting of child abuse by professionals.

3.7 Conclusion

Child abuse in Sri Lanka, as in most societies, has existed for many generations and in many forms such as physical abuse, sexual abuse and exploitation, neglect, child labour and in recent times the conscription of children by militant groups. Each community has a legal and moral obligation to promote the safety and well-being of children. Intervening effectively in the lives of these children and their families is not the sole responsibility of any single agency or professional group, but rather a shared community concern.

Compared with other South Asian countries, there are certain aspects in which Sri Lanka has achieved significant progress. For example, Sri Lankan children have access to free education. Whilst progress has been made, however, the reality remains that thousands of children are growing up in difficult circumstances and are deprived of their rights. The evil cannot be obliterated overnight, but it can be prevented. Never have the challenges been greater.

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4. Youth violence

4.1 Introduction

Violence involving young persons, typically children, adolescents, and adults between the ages of 10 and 29 is called youth violence (1). This has been cited as one of the most visible forms of violence in many countries. The young person can be the victim, the perpetrator or both. Youth violence can be aggressive behavior such as verbal abuse, bullying, hitting, slapping, shooting, cutting or fist fighting. This behavior has significant consequences on health, notably fatal and non-fatal injuries. Most of these do not generally result in serious injury or death. Youth violence also includes serious violent and delinquent acts such as aggravated assault, robbery, rape, and homicide, committed by and against youth.

Adolescents are an important segment of youth. They can experience violence within the context of a dating relationship. This may occur when one person in a relationship uses abusive behavior to demonstrate power or control over the other person. Dating violence includes physical violence, sexual assault, and verbal or emotional abuse. It is continued to be occurring commonly among youth in Sri Lanka and several instances were reported among university students and frequently published in the print media.

In terms of public health importance, it is worth analyzing the consequences of youth violence in depth. In addition to causing injury and death, youth violence can cause an increase in the cost of health care, reducing productivity, decreasing property values, and disrupting social life.

4.2 Extent of the problem

It is important to reveal the challenges and issues faced by the Sri Lankan youth when they enter adulthood from adolescence in order to understand the background or the specific context of their problems and also situations that lead to violent behavior. Sri Lanka with its successful welfare system has one of the highest literacy rates in the world. Access to free education since the second quarter of the twentieth century has resulted in a high enrollment rates for both girls and boys. Significant numbers also enter tertiary education. This has led to the comparatively good social indicators Sri Lanka has in the field of health and education. Moreover, it also contributed to the widespread perception in Sri Lanka that education is the most important means for upward social mobility.

Despite the educational opportunities afforded by the free education system, the number of unemployed youth has increased over the years due to the mismatch between the educational and employment opportunities available to youth. Also, the problems faced by school leavers, particularly of those who failed to enter university, is another issue for youth in Sri Lanka (2).

A survey carried out in 2000 among the age group 15-24 years revealed that the main issues young people in Sri Lanka are concerned with were unemployment, alcohol and drug abuse, and poverty/high cost of living. Dealing with information technology and war and violence/ militant groups were other issues mentioned, but to a much lesser extent. There were no significant gender differences in these perceptions, which indicated that the young people who answered this question identified themselves more strongly by their age rather than gender (3).

Sri Lanka has been seriously involved in political and communal conflicts for about two decades. Consequently, homicides have been a major problem in the country and now the Police Department statistics show a decline in this aspect. In 2001, homicides were the second leading cause of death in the group of 15-24 years at a rate of 114 per 100 000 population (4).

Suicides were the third leading cause of death in the 15-24 years age group with an age-specific incidence rate of 42 per 100 000 population in 2001 (5). Suicide rates are high in late adolescence and early adulthood in Sri Lanka. They decline somewhat in middle adulthood, to rise again in elderly. The common method of committing suicide is poisoning. Easy access to poisonous substances like organophosphate compounds and plant extracts is said to be a factor for attention in intentional poisoning. The trend of suicide is currently declining in Sri Lanka.

Trends in youth violence

Homicides: The data from the Registrar General's Department is not available for recent years. The available data for the past are for 1992 and 1995. Table 4.1 shows that 53% and 52% of the total number of victims fall into the category of age group 10–29 years respectively for both years. Only 37.4% of the total population belongs to the 10-29 year age group. This indicates that young adults are more vulnerable to homicide. The majority of the victims are males compared to females. Accordingly, 86% and 80% of the homicide victims among youth are males for 1992 and 1995 respectively.

Table 4.1: Distribution of youth homicide victims by age and sex in 1992 and 1995

Age groups	1992				1995			
	Male	**Female**	**Total**	**%**	**Male**	**Female**	**Total**	**%**
< 1 yr	8	3	11	00.43	1	2	3	00.14
1-4 yrs	34	33	67	02.65	12	13	25	01.13
5-9 yrs	26	27	53	02.10	21	14	35	01.58
10-14 yrs	75	33	108	04.27	41	28	69	03.12
15-19 yrs	275	52	327	12.93	205	77	282	12.74
20-24 yrs	464	63	527	20.84	377	75	452	20.42
25-29 yrs	335	45	380	15.03	302	45	347	15.67
All >30 yrs	881	175	1056	41.75	839	162	1001	45.20
Total	**2098**	**431**	**2529**	**100**	**1798**	**416**	**2214**	**100**

Source: Registrar General's Department

Suicides: Table 4.2 shows that males are more susceptible to suicidal events than females in all age groups. Hence, this becomes a strong demographic factor.

Table 4.2: Distribution of youth suicide victims by age and sex 2000-2002

Age group	2000		2001		2002	
	Male	Female	Male	Female	Male	Female
8 – 15	124	78	102	84	61	76
16 – 20	234	197	233	155	206	157
21 – 25	351	179	388	163	344	180
26 – 30	351	164	371	155	304	130
31 – 35	414	136	368	102	385	101
36 – 40	411	126	421	112	360	69
41 – 45	432	89	401	69	409	65
46 – 50	359	81	310	58	372	59
51 – 55	381	56	343	71	351	48
56 – 60	292	69	246	72	248	34
>60	685	203	595	136	627	106
Total	**4034**	**1378**	**3778**	**1177**	**3667**	**1025**

Source: Police Department

Tables 4.3 and 4.4 shows Police Department data on grave crimes among young persons charged and victims.

Table 4.3: Number of youths (up to 25 years) charged for grave crimes, 2000–2004

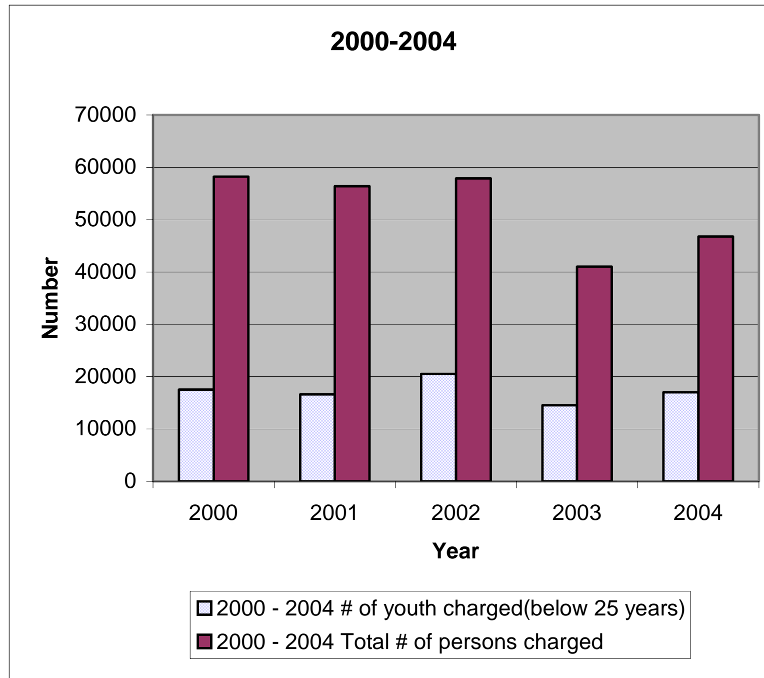
Year	Number
2000	17 543
2001	16 606
2002	20 500
2003	14 563
2004	17 011

Table 4.4: Number of youth (up to 25 years) victims of grave crimes, 2002–2004

Year	Number
2002	13 133
2003	9668
2004	11 829

Figure 4.1 illustrates the serious crimes committed by youth as a proportion of total serious crimes committed by all age groups. It shows a somewhat similar proportion every year with minor fluctuations.

Figure 4.1: Grave crimes committed by youth below 25 years as a proportion of total, 2000–2004



4.3 Factors associated with youth violence

The data collected by several departments, organizations and agencies are useful for understanding the extent and types of youth violence in Sri Lanka (6, 7, 8, 9).

Risk factors

Various risk factors for youth violence in Sri Lanka have been noted, based on the focus group discussions with the Police Department, National Child Protection Authority, Department of Probation and Child Care services, Children's Secretariat of the Ministry of Social Welfare and National Youth Services Council. Risk factors for violent behavior can be viewed mainly in four domains: individual, family, school/peer group, and neighborhood/community factors. There could be a complex relationship between the various risk factors, and the relative importance of each is not yet fully understood, as sufficient research on the qualitative aspect of this problem is not available in the country.

Individual Factors

Attention deficit/hyperactivity
Antisocial beliefs and attitudes
History of early aggressive behavior
Involvement with drugs, alcohol or tobacco
Early involvement of general offences

Low IQ
Poor behavioral control
Social cognitive or information-processing deficits

During childhood, the strongest individual risk factors include committing serious (but not necessarily violent) criminal offences and substance use. Other individual childhood risk factors include hyperactivity and physical aggression. It is evident from available data that male gender is also a risk factor.

Family Factors

Authoritarian childbearing attitudes
Exposure to violence and family conflict
Harsh or inconsistent disciplinary practices
Lack of involvement in the child's life
Low emotional attachments to parents or caregivers
Low parental education and income
Parental substance abuse and criminality
Poor family functioning
Poor monitoring and supervision of children

According to the case studies discussed at the National Child Protection Authority in Sri Lanka, living in poverty and parental criminality in childhood can be considered as moderate risk factors. Other risk factors include poor parent-child relations exemplified by harsh, lax, or inconsistent discipline. Children with divorced, separated, or never-married parents are at a slightly increased risk of violence. Child abuse and neglect are consistent predictors of later violence, although most children who are abused do not become violent. In adolescence, most family risk factors diminish in importance, as the influence of peers increases. Inadequate supervision and low parental involvement confer a small risk of violence among adolescents.

Peer/School factors

Association with delinquent peers
Involvement in gangs
Social rejection by peers
Lack of involvement in conventional activities
Poor academic performance
Low commitment to school and school failure

Research conducted in other countries has revealed important findings in relation to the peer group factors (10). Young children are not strongly influenced by peers but adolescents are. Adolescents with antisocial or delinquent peers are at high risk of violent behavior. Although social isolation is not a risk factor for violence, adolescents who are unpopular and uninvolved in conventional school activities can turn to antisocial peer groups for acceptance. Gang involvement is a strong risk factor for violence. These three peer group factors – weak ties to conventional peers, antisocial peers, and gang involvement – have independent effects but appear to cluster together. They are each powerful predictors of violence in adolescence.

It is found from the sample surveys carried out in Sri Lanka that the signs of possible gang involvement could be (11):

Sudden poor grades and lack of interest in school
Withdrawal from family activities
Sudden change in friends
Evidence of drug use
Use of hand signs
Having a new nickname
Having a bad attitude toward family, friends, etc
Wearing special haircuts or tattoos
Gang graffiti on walls, school books

Neighborhood/Community Factors

Diminished economic opportunity
High levels of family disruption
Low community participation
Socially disorganized neighborhoods

In childhood, community-level risk factors are not strong predictors of violent behavior among youth. Once a child reaches adolescence however, community factors become more important. Social disorganization - characterized by economic instability, high residential turnover, and single-parent families - presents a small risk factor for violent behavior among youth. Adolescents exposed to violence in their communities are at higher risk of violent behavior. Other risk factors include the presence of crime and drugs in the neighborhood and neighborhood adults who are involved in crime (12).

There has been much concern about the effects of media violence on the risk of violent behavior among youth. There are many forms of media violence, including movies, video games, television, music, music videos, and the internet. To date, evidence shows that exposure to media violence increases the risk of verbally and physically aggressive behavior in the short-term, and some studies suggest there might also be long-term effects on aggressive behavior. However, little is known about the short- and long- term effects of exposure to media violence on serious violent behavior. It is not yet possible to know which types and lengths of exposure and which ages and types of children are most seriously affected by exposure to violence in the media as research done in this regard is scarce in the country.

According to a research carried out in the USA in 1999, it is found that, as children develop, some risk factors become more important while others become less important. Risk factors tend to appear in clusters within individuals, and young people with many interrelated risk factors are more likely than other youth to exhibit violent behavior. It is realized that the total number of risk factors or the balance between risk and protective factors is most important in predicting whether violent behavior occurs. Many of the known risk factors might not be causal but perhaps function as markers of groups at high risk for violent behavior (13).

It is important to mention that lack of job opportunity compared to high average level of education due to free education as described in the sub-section on “extent of the problem” in Sri Lanka in this chapter is an important community factor that affects Sri Lankan youth. This has been given as a major root cause for delinquency among youth in Sri Lanka by analysts.

Protective factors

Protective factors are aspects of the individual and his or her environment that moderate the effect of risk. Identifying and understanding protective factors are equally as important as researching risk factors. Research on protective factors for violent behavior among youth is insufficient, but little research has specifically addressed factors that protect against violent behavior. More research is needed to identify protective factors and to determine when in the course of a child's development they most effectively buffer risks.

Individual protective factors

Intolerant attitude towards deviance
High IQ
Positive social orientation

A strong individual-level protective factor is an intolerant attitude toward deviance. School achievement and success also are protective against delinquency and violence. Other individual factors to buffer risk factors for violence include high IQ, female gender, and the adoption of traditional social values.

Family protective factors

Stress-free family background
Caring parents

Protective factors in the family include an emotionally supportive parent who provides consistent rules and supervision and a caring adult who supports conventional behavior.

Peer/school protective factors

Commitment to school
Involvement in social activities

Commitment to school has been found to buffer the effects of risk factors for violent behavior. Proposed protective factors include conventional friendships and peers who disapprove of violence.

4.4 Conclusions and recommendations

Sri Lanka has limited information on different types of violence when compared to unintentional injuries. The available data most of the time are confined to the quantitative aspect and little or no data are recorded on the qualitative aspect.

The country's concern on youth is considerable and cannot be underestimated though a comprehensive and concerted programme is not yet launched at the national level. The government has established various institutions to address the different aspects of needs of the youth. The National Youth Services Council is a good example of the country's attention on youth. There are many programmes conducted specially designed for youth to develop their abilities on different vocational activities in this Council. Also, recreational activities like drama, sports involving youth are being organized by this Centre.

The different programmes conducted by the Department of Probation and Child Care Services and the Children's Secretariat of the Ministry of Social Welfare are targeted at persons up to the age of 16 years, which is an important fraction of youth. The National Child Protection authority also looks into the legal aspect of children's needs up to the age of 18 years.

In Sri Lanka, a separate Ministry of Youth affairs has always existed in the history of the political system in the country to address the needs of the youth. Sometimes this Ministry has also had jurisdiction over sport.

As a good infrastructure already exists in the country, it is suggested that a systematic and comprehensive programme targeting youth violence be initiated in Sri Lanka.

The following recommendations can be derived by analysis of existing data and the situation pertaining to the problem of youth violence in Sri Lanka:

1. Develop a national action plan for violence prevention initiated with due priority for youth violence;
2. Improve the response for victims and management of substance abuse;
3. Introduce a system of easily accessible counseling services and create a positive environment for rehabilitation;
4. Promote qualitative research on youth violence enabling in-depth analysis of the problem;
5. Integrate violence prevention into all relevant policies at the national level.

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5. Domestic violence

5.1 Introduction

Domestic violence cuts across racial, ethnic, religious, educational, and socioeconomic strata. Though the term "intimate partner violence" is often used synonymously, strictly speaking, intimate partner violence is only a component of domestic violence, a category which also includes child abuse and abuse of elderly committed by family members. As there are different chapters on child abuse and neglect (Chapter 3) and elder abuse and neglect (Chapter 7), this chapter deals exclusively with intimate partner violence.

Intimate partner violence occurs between people in an intimate relationship. It has many forms, including physical violence, sexual abuse, emotional abuse, intimidation, economic deprivation or threats of violence. Although women can be violent in relationships with men, as the overwhelming burden of intimate partner violence is borne by women, the focus of this chapter will be mainly on violence against females by their male partners.

Some cultures have beliefs, norms and social institutions that propagate intimate partner violence. These cultural justifications usually follow from traditional notions of the roles of men and women in family settings. Women are often expected to show their husbands obedience and respect. Fortunately Sri Lanka does not have many such institutions. A common notion is that the purpose of domestic violence is not primarily to harm the victim but it is to gain or maintain power and control over the victim (1).

<u>Background</u>

Domestic violence in Sri Lanka could be realistically understood only if the background of the Sri Lankan society in which the women live is considered first. Traditionally, women in families are respected to varying degrees in the rural and urban societies. The majority of the people are religious-minded with strong beliefs in cultural norms and deeply rooted prejudices. However, some of the socially and culturally accepted practices seen in other South Asian countries such as female genital mutilation, “sati” or widow burning are mostly unknown in Sri Lanka. This may lead to a misconception that domestic violence is not an important issue in this country, and denial of the existence of this problem.

When the issue of domestic violence was raised initially in early 1980s in Sri Lanka, it was brushed aside as a western idea that was likely to disrupt the family unit. Now, society as a whole is much more aware of this problem. More and more victims now seek the help of support groups and the legal system. Domestic violence is an important area of action for both governmental and nongovernmental organizations concerned with women and their welfare, even though the rudiments of the concept that it is an imported notion remain in the minds of a few individuals.

The cultural values inculcated in the minds of Sri Lankan women on the institution of marriage seem to result in women continuing their marriage in spite of an abusive relationship. Recent studies carried out in Sri Lanka have shown that 60% to 80% of women remained with their abusive husbands or partners (3,4). Another study revealed that 38% of the women who experienced violence left home, but returned and continued to experience violence, as they did not consider leaving as a permanent solution (5).

Defining domestic violence

Domestic violence, broadly defined, is violence largely between family members and intimate partners, usually, though not exclusively, taking place in home (6). The first formal definition for domestic violence could be found in the United Nations Declaration on the Elimination of Violence against Women in 1993 (7):

> **Article 2**
>
> Physical, sexual, and psychological violence occurring in the family, including battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices, non-spousal violence and violence related to exploitation….

The British annual crime survey defines intimate partner violence as: "Any violence between current or former partners in an intimate relationship, wherever and whenever the violence occurs. The violence may include physical, sexual, emotional and financial abuse" (8).

5.2 Extent of the problem

Documenting the prevalence or incidence of domestic violence is an extremely difficult and sensitive task that poses many ethical dilemmas. The task is rendered particularly difficult owing to the reluctance of women affected to report the violence or abuse. They are forced by social conventions and other pressures to keep silent. They may fear that reporting the abuse will jeopardize their safety and destroy their means of support and they may stay in the relationship hoping that the situation will improve. Further, the woman's family background, as well as her cultural and religious beliefs, influence her perceptions of abuse (7). According to a UNHCR study, which was conducted in 12 sites across Sri Lanka in 2004, 80% of incidents of violence against women were not reported to authorities (9).

The extent, validity and reliability of the data on domestic violence are crucial in determining the magnitude of the problem and in identifying priority areas for intervention. Data from Police records give only numbers of women affected badly, and are not very useful in assessing the prevalence or incidence rates. Population-based surveys and special studies are other sources of data. These studies, however vary in the sample size, the methodology, the definitions used, and in the parameters, which can range from physical abuse alone, to physical, sexual and psychological abuse combined (1,6). Because of these factors, most prevalence figures on intimate partner violence from different studies cannot be compared directly.

Global situation

Different types of abuse often coexist in the same relationship. However, most of the studies on intimate partner violence have concentrated on physical violence as it is more visible, and hence it can be more easily conceptualized and identified. According to a review of population-based surveys from around the world, between 10% and 69% of women reported being physically assaulted by an intimate male partner at some point in their lives (6).

Scientific prevalence studies were conducted initially in countries like the United States, Canada and the United Kingdom. In the United States, 2.4 million women are battered each year and it is the leading cause of injury among women in the reproductive age (10). About one fourth of women reported at least one episode of physical violence from their partners in the United States and in the United Kingdom (1). Reducing physical abuse directed at women by male partners was one of the United States' year 2000 health objectives, with an important target group being pregnant women (11).

The Council of Europe also found in a 1992 study that one quarter of women experience domestic violence over their lifetimes and that 6–10% of women suffer from domestic violence in any given year (12). Every minute in the United Kingdom, the Police receive a call from the public for assistance against domestic violence. However, they estimate that only around 35% of domestic violence is actually reported (8).

According to the World Report on Violence and Health, intimate partner violence accounts for a significant number of deaths by murder among women. Studies from Australia, Canada, Israel, South Africa and the United States show that 40% to 70% of female murder victims were killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship (6).

This contrasts with the situation of male murder victims. In the United States, only 4% of men murdered between 1976 and 1996 were killed by their wives, ex-wives or girlfriends (6). In England and Wales in 2000-2001, 42% of all female homicide victims compared with 4% of male homicide victims, were killed by current or former partners (8). According to other statistics, in the United States, men kill their female intimate partners at about four times the rate that women kill their male intimate partners. Further research has found that when males were killed by their female intimates, the women in those relationships had been abused by their male partners about 75% of the time (12).

In developing countries, prevalence studies with representative samples of populations are relatively new. Nevertheless, many studies have been carried out in parts of Africa, Asia and South America. Prevalence of abuse seems to be higher in this part of the world compared to the West. Studies conducted in Indian states such as Punjab, Karnataka, Uttar Pradesh and Tamil Nadu have shown that the prevalence of wife beating varies from 22% to 75% (13,14,15).

Sri Lankan situation

At present, there is no systematic mechanism for data collection in relation to the prevalence, causes and consequences of violence against women and there are no disaggregated statistics available concerning intimate partner violence. However, records of complaints to women's organizations assisting women affected by domestic violence, Police statistics and newspaper reports suggest a higher prevalence of intimate partner violence. Recent studies on this subject estimate the prevalence to be between 18.3% and 60% in Sri Lanka.

One of the earliest studies done in 1991 recorded a prevalence of 54% in Colombo, 71% in Halmillawa, 60% in Nochchiya and 72% in Pitakanda. Except Colombo, all other areas were rural. For this study a total of 515 households were interviewed and the researcher herself commented that these figures were outrageously high but should not be ignored (16). A recent cross-sectional study done in the Trincomalee district found that the prevalence of

wife-beating among ever-married women was 30% and the prevalence of wife beating in the year preceding was 22% (4).

A study done by a general practitioner among his clients (n = 800 women) on domestic violence in 1992 found a prevalence of 27% of physical violence with 9% of them experiencing severe battering (17). Another study done in the same year among 200 low-income urban women found that 60% of them had been physically abused by their male partners during the period of marriage or cohabitation (5). Most of the abused women (98%) had been beaten more than once during this period.

In 2002, a UNFPA sponsored study, women attending antenatal and gynecological clinics of a hospital in Anuradhapura were screened for domestic violence (18). Out of the respondents, 36% had been beaten but had no external injuries and an additional 11% had been beaten resulting in injuries. Another study done in the same year on physical abuse among pregnant women in Badulla district found that 18.3% of women had been abused sometime during their entire period of cohabitation, 10.6% of women had been abused during the last year and 4.7% of women had been abused during the current pregnancy (19).

A survey at the Outpatient Department of the Teaching Hospital in Ragama, a semi-urban area in the suburbs of Colombo, found that 40.7% of women had been abused by their partners. The abuse was physical, emotional, and sexual, and most women reacted in a submissive manner (20). A detailed study of 62 rural women victims of violence identified 14 cases of "marital rape" (21). The same study recorded verbal and emotional abuse among 27 out of 62.

According to the Women's Rights Watch Report that dealt with the press reports of violence against women in 1998, out of a total of 1096 incidents reported, 291 incidents (27%) occurred in the home environment (22).

Reported homicides: Table 5.1 describes the relationship between the victim and the perpetrator of homicides reported to the Police during the period 1998 to 2002 in Sri Lanka. Though the sex of neither victim nor perpetrator was revealed in this table, partner (spouse, co-habitant or lover) had been the perpetrator in 8.0% to 27.6% of homicides during the period of analysis. When the motive for killing was analyzed for the same period, it revealed that 5.3% to 23.0% of homicides were due to family disputes (23).

Table 5.1: Relationship between the victim and the perpetrator of homicides reported, 1998–2002

Relationship	1998		1999		2000		2001		2002	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Spouse	114	5.9	99	5.5	86	5.0	195	12.4	82	6.1
Co-habitant	34	1.8	25	1.4	70	4.1	128	8.1	34	2.5
Lover	15	0.8	20	1.1	29	1.7	112	7.1	11	0.8
Parent	38	2.0	39	2.1	44	2.6	131	8.3	32	2.4
Son/Daughter	44	2.3	42	2.3	46	2.7	141	8.9	33	2.4
Other blood relation	198	10.3	139	7.7	109	6.4	204	12.9	98	7.3
Other	405	21.0	182	10.1	131	7.6	286	18.2	152	11.3
No relationship	1071	55.8	1255	69.7	1196	69.9	379	24.0	905	67.2
Total	**1919**	**100**	**1801**	**100**	**1711**	**100**	**1576**	**100**	**1347**	**100**

Source: Administrative Reports of the Inspector General of Police, Sri Lanka (23)

According to an analysis of reports of homicides published in the print media in 1998, 129 murders were committed inside homes and the husbands were allegedly responsible for the murder of their wives in 83 cases (64%) (22).

5.3 Factors associated with domestic violence

The current research base for domestic violence in Sri Lanka is inadequate for the task of identifying fully the factors associated with intimate partner violence. Most of the studies recorded what the victims perceived as the cause of violence, which may not be the actual cause of violence. The current research base in many countries is highly skewed towards investigating individual factors rather than community or societal factors that may affect the likelihood of abuse (6). Several important factors may be missing because no studies may have examined their significance, while other factors described below may prove simply to be correlates of partner aggression rather than true causal factors.

Individual factors

A Sri Lankan study has found that certain groups of women are to be at a higher risk of abuse: women who marry at an early age, women with a higher number of children, women living with their extended families especially with in-laws, women with a low level of social skills and women with certain personality types (anxious, impulsive etc.). According to this study, mean age of abused women was 25 years (24).

A recent study on pregnant women of different ethnicities reported that younger women were more prone to physical abuse than older women (the mean age of abused women was 25 years) (24).

Two studies placed the mean age of victims of intimate partner violence at 33 years and 35 years respectively (25,26). A recent study on pregnant women of different ethnicities reported that younger women were more prone to physical abuse than older women (mean age of abused women was 25 years) (24).

Stereotypical masculine behaviors – aggression, risk-taking, and the consumption of drugs and alcohol – are often linked to a man's likelihood of abusing an intimate partner. Men with a history of violent acts outside the home are more likely to physically abuse their partners (24). Male dominance and gender hierarchy are in themselves inadequate as explanatory factors for violence against women. They do not explain why some men indulge in violence and others don't, even though all men are exposed to the same social and cultural values that vest them with the right to control women's behavior.

Alcohol use by men: In Sri Lanka, consumption of alcohol is mostly confined to males. According to a study quoted earlier, low-income urban women attributed alcohol abuse among their husbands as one of the leading causes of domestic violence (5). Most rural women also identified alcohol abuse by men as the predominant factor for instigating and aggravating wife beating (4). Some other studies have found use of alcohol as a problem in over 70% of wife abusers (3,24,25). However, one study has reported wife beating, independent of alcohol consumption by the husbands (27). The study in the province of Anuradhapura where a direct question was asked whether the perpetrator was under the influence of alcohol no relationship was found (18).

Adverse childhood experiences: Exposure to domestic violence at a young age may desensitize a child to its terrible consequences and these children may take violence for granted, subconsciously assuming that it falls into the accepted norms of behavior. According to a study done in the Badulla district, a woman's and her husband's experience of abuse during childhood seemed to have a significant association with intimate partner violence (24). Another study on second-generation violence in Sri Lanka corroborates this view (28). However, though children raised in violent homes are at increased risk for perpetrating or experiencing violence in adulthood, not all abusive partners or abused women were exposed to family violence while growing up (29).

Relationship factors

At an interpersonal level, the most consistent marker to emerge for intimate partner violence is marital conflict or discord in the relationship (6). The prevalence of abuse was high in families where the husbands suspect their wives of extramarital relationships (24).

Community factors

The prevalence of intimate partner violence varies substantially between neighboring areas. It was found to be high in the estate sector (32.2%) where the majority are Tamil Hindus of Indian origin (24). This finding was comparable to the abuse prevalence of 30.4% in the estate sector reported in another study done in 1991 (16).

In Sri Lanka, incidents of violence against women are more visible in low-income groups in both rural and urban society than in the middle class and privileged groups (4). Studies from various countries show that, while physical violence against partners cuts across all socioeconomic groups, women living in poverty are disproportionately affected (6). However, some researchers point out violence to be part of all income levels and that they are not confined to a particular socioeconomic status (30). According to them, it is not that domestic violence does not take place in higher income groups, but rather it is not allowed to become public. It should be noted that in Sri Lanka, most of the studies to record prevalence of violence have been conducted mainly among low-income groups (5,16,24).

Two studies (4,24) found a significant inverse relationship between domestic violence and the level of education of both the perpetrator and the victim. Another study (25) found that half of the men who beat their wives had low educational levels and were unemployed or unskilled.

Societal factors

Studies done elsewhere suggest that domestic violence occur most often in societies in which men have economic and decision-making power in the household, and where adults routinely resort to violence to resolve their conflicts (6). It has been argued that partner violence is more common in places where war or other conflicts are taking place. Where violence has become commonplace and individuals have easy access to weapons, social relations – including the roles of men and women – are frequently disrupted, and the situation in Sri Lanka is no exception (6).

In Sri Lanka, women have equal rights as men in the General Law but discriminatory provisions exist in varying degrees in the family law of each community pertaining to areas such as marriage, divorce, property and financial transactions (31). Unlike in the neighboring

country India, studies done in Sri Lanka have not identified "dowry issues" among the leading causes of domestic violence. The National Crimes Bureau of India recorded 6995 "dowry related deaths" which accounted for 4.9% of crime (32). It is interesting to note that dowry was not mentioned as a cause for violence against women among estate workers in Sri Lanka, who are generally Indian descendants (24).

Why women stay in abusive relationships: The reasons for staying in abusive relationships are many. Cultural conditioning and socialization processes may be contributing to this situation (30). According to a study done in a semi-urban area, 79% of abused women had stayed in their marriages for more than 10 years. The researchers attribute this to the submissive behavior of the abused due to lack of means to leave their husbands and live independently and the fact that society looks down upon such women (20). One of the earliest studies also found that illiteracy, unemployment and the consequent dependency on their husbands for existence as reasons for staying in the abusive relationships (3). These findings suggest that economic considerations carry more weight than the emotional ones. In a study in Eastern Sri Lanka, it was found that most women regardless of their level of education and their employment status stayed in an abusive relationship because of the welfare of their children (4). Other studies have shown that an overwhelming majority opt to stay in an abusive relationship because of children (25, 26).

5.4 Consequences of domestic violence

Living in an abusive relationship takes a tremendous toll on a woman's physical and psychological well-being. The World Bank estimates that rape and domestic violence account for 5% of the healthy years of life lost to women aged between 15 and 44 in developing countries (33).

Obviously, violence can lead to injuries, disability and death. The long-term physical health consequences of intimate partner violence include chronic debilitating pain, gynaecological symptoms, likelihood of getting sexually transmitted diseases including HIV/AIDS, unwanted pregnancies leading to illegal unsafe abortions, and adverse pregnancy outcomes such as premature birth, growth retardation, and bleeding during pregnancy (1,11,34,35). Intimate partner violence also accounts for a substantial but largely unrecognized proportion of maternal mortality in India and Bangladesh (6).

A study by a General Practitioner analyzed the physical health consequences to some extent (27). According to this study, 26% of the victims reported loss of consciousness or fainting, 8% reported emergency admission to the hospital and 35% reported emergency attendance. It should be noted that according to this study, 22% of the victims were prevented from going to the doctor by the perpetrators.

Far more difficult to capture than physical health consequences is the damage to women's mental health. Intimate partner violence creates fear and undermines the security and self-esteem of women, diminishes their capacity to cope and makes them vulnerable to a range of mental disorders. It can lead to common emotional trauma such as depression, anxiety, panic attacks, sleeping and eating disturbances, substance abuse and post-traumatic disorders (1). The psychological dysfunction associated with experiencing violence may also have fatal consequences by inducing suicidal behavior, and suicide is one of the extreme consequences of intimate partner violence. Based on several studies, a close correlation between intimate partner violence and suicides has been established (1). In Sri Lanka, the suicide rate was 47 per 100,000 population in 1991 – the highest in the world – but it started

coming down from 1995 (36). The exact contribution of intimate partner violence to these suicides is difficult to quantify. According to a report, the number of recorded female suicides or attempted suicides due to disputes with their partners ranged from 172 in 1987 to 210 in 1991(37). In another study, 21% of severely battered women claimed that they attempted suicide at least once (17).

The impact on children: Children are usually forced to watch acts of domestic violence. In many instances children are also the victims of abuse along with the mother. According to a study, in 29% of families where a woman was battered, children were also battered (5). Children, who have witnessed domestic violence or been abused, exhibit health and behavior problems, including problems with their weight, eating habits and sleep. They may have difficulties at school and may find it hard to develop close and positive friendships. They may run away or even display suicidal tendencies (1). The worst effect is, because violence is a learned behavior, the children are more likely to become abusers or victims of abuse in later life (24). Also children, especially males, subconsciously or consciously learn to regard women as physically weaker and therefore subordinate to men (28).

5.5 Interventions and policy responses

The response to domestic violence is a combined effort mainly between the police, judiciary, health and social service and NGOs. The role of each has evolved as domestic violence has been brought more into public attention. However, the experience has repeatedly shown that without sustained efforts to change culture and practice, legal and policy reforms have little effect (6). It is a complex problem and there is no single strategy that will work in all situations. A multi-layered strategy that addresses the structural causes of domestic violence while providing immediate services to victims is possibly the strategy that has the most potential to eliminate this scourge (1).

Awareness creation

The need to establish a broader public awareness on domestic violence is greater today than ever before. Society in general should be made aware of the fact that domestic violence is a social issue and not a private one. There is a need for systematic and comprehensive awareness-raising among women themselves on their rights and the remedies available to them. Programmes to create awareness amongst women regarding their legal rights and the procedures for securing these rights are being presently conducted by the Women's Bureau and the National Committee on Women (38).

Judiciary

In Sri Lanka, the Penal Code does not criminalize domestic violence. Prosecution of domestic violence therefore has to be undertaken under other general sections such as Section 324 (assault) or Section 311 (causing grievous hurt). These provisions are however rarely used, as social conditions prevent women from reporting incidents of domestic violence and even when they do, the complaints are often not taken seriously by the authorities or informal mediation mechanisms are utilized to settle the cases. Family disputes, particularly in relation to domestic violence are generally considered as cases that have the potential to be settled out of court in Mediation Boards. These Mediation Boards, appointed by the Ministry of Justice under the Mediation Board Act, obviously circumvent the law and usually the parties are reconciled without resorting to court action. Family and social peers also often pressurize women into compromise. Most women do complain of being forced to settle their disputes

and feel disadvantaged (21). For the 291 cases of domestic violence reported in the press in 1998, only 11 sentences were handed down (22).

Prevention of Domestic Violence Act, No. 34 of 2005: The backbone of the act is its provisions empowering the court to grant interim orders and protection orders where they are deemed to be necessary to prevent an aggressor from inflicting harm to persons within the home environment. A protection order may prohibit the aggressor from committing acts of domestic violence and entering the victim's residence and may impose other prohibitions. The act provides only a civil remedy and the issue of a protection order will have no bearing on the normal criminal law jurisdiction. Thus where an offence has been committed, the normal criminal justice process of investigation, prosecution and punishment will follow (39). While domestic violence legislation in many other countries permits a wider base of intervention in court, it is notable that the Sri Lankan act does not go so far.

Law enforcement

Women and Children's Desks staffed by female Police Officers have been established at a number of Police Stations throughout the island. Their function is to receive complaints from female and child victims of violence and give them guidance and protection referral to relevant departments concerned. At present, there are about 40 such desks in the country (23). However, very few women appear to have an opportunity to appear before the judiciary to make use of the laws, in spite of coming to what is the first-level state institution. The laws will be of no avail if the law enforcement authorities do not implement them effectively. It is hoped that knowledge of the magnitude and gravity of the problem and the newly-enacted bill on preventing domestic violence will help to bring about a shift in this attitude.

Support services

Shelters: There are very few centres which provide shelter and counseling to victims of domestic violence in Sri Lanka. A few women's organizations such as the Women in Need and the Women's Development Centre in Kandy run private shelters, and offer counseling and legal assistance as well (40). It is a pressing need and the government needs to address this.

5.6 Recommendations

Advocacy and awareness creation: An ideal entry point for community intervention is at school level as a strategy of primary prevention. Schoolchildren should be taught life skills such as coping with stress and non-violent forms of conflict resolution. Schoolchildren, a captive audience, can be used as an effective tool to communicate these skills to their families as well as to the community. In addition, community-based programmes should be carried out for adolescents on the implications of negative cultural practices such as early marriage, which may lead to a compromise on education and economic independence, in turn associated with marital disharmony (24). Already some organizations such as Dam Rivi are conducting programmes for the couples planning marriage as a method of preventing domestic violence.

Role of the media: Given that the media is a powerful tool of communication, the state machinery should access it to create greater public awareness. The media has played an important role in drawing attention of the public to some aspects of domestic violence, though it was not part of a balanced or a focused campaign but tends rather to be involved for

the sensational value of incidents. The media should play a responsible role and take care not to dramatize brutal incidents of domestic violence.

Knowledge and skills development: Historically, law enforcement agencies and the courts have treated domestic violence as a personal problem of minor consequence (6). Those within the system frequently share the same prejudices that predominate in society as a whole. The State should ensure that Police Officers are gender-sensitized and take the crime of domestic violence seriously. Women and Children's Desks at Police Stations should be expanded to cover all major towns and officers stationed at them should be educated and trained with regard to proper procedures to be followed in intervening and handling complaints. The Attorney General should develop and adopt guidelines for officials prosecuting domestic violence cases.

Identification of victims: Identifying abused women in the community for intervention purposes is necessary as most victims prefer to suffer in silence rather than tell someone about it. The health infrastructure at community level is well established in Sri Lanka and it can take up the challenge of identifying abused women. However, the health sector has not yet offered tangible support to such victims.

Most women visit a health facility at some point in their lives – for pregnancy, or for health care for themselves and their children. An ideal time to screen women for partner abuse is during pregnancy, as this is the only time that healthy women come into repeated contact with the health care services. For the purpose of screening, an instrument has been developed by a group of local researchers which could be used routinely in the antenatal clinic setting (19). Grassroots-level primary health care workers such as Public Health Midwives (PHM) can administer this screening instrument, and in some areas the PHMs have been trained for this purpose.

Other health service interventions: Recognition of domestic violence as a health issue and documenting its prevalence and health consequences, providing special care for women seeking medical help following an episode of violence, including referral to other support services and the sensitization of health care providers are some other urgent tasks for the health sector.

Support services: The paucity of available state services in terms of crisis centres, shelters, legal support and counseling services is a serious shortcoming in fulfilling the state's obligations to victims of domestic violence. Although some NGOs have a few centres, considering the number of cases being referred to and addressed by these crisis centres, it is evident that many more such centres should be set up (40). As an immediate course of action, support groups can be promoted to help victims. Setting up telephone hotlines or non-residential crisis centres is an option, as running a shelter in all areas is not possible.

Legal reforms: In many situations of domestic violence, women complain of being forced into unwanted intercourse by husbands. However, the State does not recognize marital rape. Rape within marriage is specifically excluded from the ambit of Section 363 of the Code, which criminalizes rape (41). This clearly has implications for the ability of women to protect from unwanted pregnancy and sexually transmitted diseases. The 1995 amendment to the Penal Code recognizes marital rape as an offence only in cases of spouses living under judicial separation (41).

Campaign against alcohol abuse: Alcohol use by perpetrators was a significant factor associated with intimate partner violence in many studies. Persistent campaigns against alcohol consumption should be carried out across the community and be given top priority. Special programmes on prevention of alcohol and drug abuse should be conducted for schoolchildren. Tailor-made preventive programmes are needed, especially targeting the estate sector.

Empowerment: Women need to be empowered through education, employment, and the right to inheritance. The State and NGOs should provide knowledge and training for skills development among women so as to promote income generation such as self-employment and provide women with access to credit, which will enhance the women's capacity to be economically independent and empowered.

Coordination and integration: Interventions should cover and be coordinated between different sectors working at community and national levels. It will be more effective if the programmes on intimate partner violence are integrated with other programmes such as those dealing with youth violence, substance abuse including alcohol abuse, and other forms of family violence.

Data collection and analysis: The lack of comprehensive data is one of the major problems that have to be dealt with if the issue of domestic violence is to be taken seriously by the State. Gender-disaggregated and cause-specific data should have to be systematically maintained, especially in hospitals and police stations.

5.7 Conclusion

Domestic violence is a health, legal, economic, educational, developmental and human rights problem with devastating consequences for women, children, families, and communities. In the recent years, there has been a greater understanding of the problem of domestic violence, its causes and consequences. An immediate change towards its reduction would be extremely difficult, as it is an extremely deep-rooted problem. It can be prevented and eliminated only when the underlying causes are addressed and cultural norms and attitudes are challenged.

Box 5.1: Health consequences of violence against women

Non-fatal outcomes

Physical health outcomes:

- Injury (from lacerations to fractures and internal organs damage)
- Unwanted pregnancy
- Gynecological problems
- STD including HIV/AIDS
- Miscarriage
- Pelvic inflammatory disease
- Chronic pelvic pain
- Headaches
- Permanent disabilities
- Asthma
- Irritable bowel syndrome
- Self-injurious behaviors (smoking, unprotected sex)

Mental health outcomes:

- Depression
- Fear
- Anxiety
- Low self esteem
- Sexual dysfunction
- Alcohol abuse
- Eating problems
- Obsessive compulsive disorder
- Post traumatic stress disorder

Fatal outcomes

- Suicide
- Homicide
- Maternal mortality
- HIV/AIDS

Source: "Violence against women", WHO Consultation, 1996

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6. Gender-based violence

6.1 Introduction

The term gender is not merely a biological concept but a term indicating the incorporation of social and cultural norms. Patriarchal thoughts and attitudes have encouraged a host of discriminatory social, cultural, religious and legal practices to take root. Violence against women forms the core of gender-based inequalities, with far-reaching consequences for women's development and well-being.

The male psychology of dominance may not be biological but a direct consequence of "man-made" social arrangements. It is acknowledged that the group in any society which has more power than others determines who can exert acts of gender-based violence. This is not restricted to economic power, but is very much rooted in the notions of power in social power, and hierarchies used to exercise such power.

The focus of this chapter is on various forms of violence against women within the general community – including workplace violence, and violence perpetrated or condoned by the state. Domestic violence which is gender-based, is dealt separately in Chapter 5.

Background

The situation in Sri Lanka could be realistically understood only if the background of the Sri Lankan society in which these women live is considered. The island nation has a population of 19.2 million with a sex ratio of 101.2 women to 100 men (1). The ratio of girls to boys in primary and secondary education was 102.8% in 2002 and the female literacy rate is 83.8% against a male literacy rate of 90%. The mean age at marriage is 25.3 for females and 27.9 for males. There were only 22 per 1000 births for women aged 15-19 years. The total fertility rate (TFR) has come down below 2.0 (1.9 in 2004) and under-5 mortality is 16 females to 30 males. The life expectancy at birth was 75.9 for females and 69.9 for males (1,2).

There are women working in the agricultural and informal sector and in export sectors with a vital financial impact on the economy such as the garment manufacturing industry, the plantation industry and in expatriate labour. The share of women employed in the non-agricultural sector was 43.2% in 2003. Enrolment in universities is high, with comparatively high rates of employment at executive levels. High literacy rates have resulted in high standards of maternal and childcare, placing Sri Lanka high in the Human Development Index.

In contrast to these relatively favorable indicators, negative factors too exist. There are nearly 350,000 internally displaced persons, and women are especially vulnerable to gender-based violence in areas close to conflict-affected areas (3). It is estimated that there are nearly 40,000 war widows (4). It is found that one out of every five households in Sri Lanka is headed by a woman (5).

Sri Lanka has produced the world's first woman Prime minister and the world's first elected woman President. The first woman cabinet minister was appointed in 1956. However, the female presence in the Parliament and other administrative bodies remain low. Female representation is 5.3% in the Parliament and that in the administrative and management level is only 16.9% (6).

Peace is the first and foremost precondition for the cause of women. It is women and children who suffer most from wars and armed conflicts. Sri Lanka has experienced a number of armed conflicts, which had both direct and indirect effects on women. The armed insurrections in the south of the country occurred in 1971 and in 1980. The armed conflict in the Northeast part of the country continued for more than 20 years and mercifully minimized by the 2002 Ceasefire Agreement, which again is in a delicate balance at the moment.

We should measure and judge the advancement of women not in isolation but in relation to how they stand in all aspects of life with their male counterparts.

At the international level, Sri Lanka is a party to all seven Covenants and Treaties dealing with Human Rights, including the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). However, much remains to be done to fully implement all these covenants and treaties.

Definitions

There is no precise definition for gender-based violence. Definitions are steadily broadening since the time Women's Rights began to be recognized in the early 1980s. The first formal definition could be found in the United Nations Declaration on the Elimination of Violence against Women in 1993 (7):

> **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 deprivation of liberty, whether occurring in public or private life.
>
> **Article 2**
>
> (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution.

Gender-based violence is also defined as "any act of commission or omission by individuals or the state, in private or public life, which brings harm, suffering or threat to girls and women, and reflects systematic discrimination-including harmful traditional practices and denial of human rights because of gender" (8).

6.2 Extent of the problem

In Sri Lanka, gender-based violence ranges from sexual harassment in public places including public transport to acts of violence within the privacy of the home or at workplace. Research data indicates that gender-based violence is found everywhere in the country across all ethnic communities. In the majority of the cases the perpetrators are known to the victims. Most victims are between the ages 20 and 44 years and the majority of the perpetrators were males (9).

Migrant work has become a family survival strategy for Sri Lankan women (10). Foreign employment comprised mostly of women employed as housemaids is one of the main sources of foreign exchange (table 6.1). Reports of violence perpetrated against these Sri Lankan women workers overseas often appear in the media (11). In 2001, the Sri Lanka

Bureau of Foreign Employment received 7927 complaints of which 92% were for non-payment of wages (68% from female migrant workers). There were two murders reported to the Bureau, both were women and 11 suicides were reported, out of which 10 were women (91%). These statistics show how vulnerable these women are to severe forms of violence and stress resulting from them (10).

Table 6.1: Distribution of migrant workers by sex in 2001

Type of job	Males	Females	(%) of Females
Professional jobs	1070	69	6
Middle level jobs	3199	571	15
Administrative jobs	4629	1382	23
Skilled jobs	25220	11482	31
Unskilled jobs	25627	7822	23
Housemaids	-	102811	100
Total	**59,745**	**124,137**	**68**

Source: Ministry of Labour

Another group of women who need to be taken into consideration in Sri Lanka is the Free Trade Zone workers. This group is comprised mainly of a female workforce. They suffer abuse of different kinds at workplace as well as at their lodgings, which are often substandard.

In situations of armed conflict, women and children become vulnerable to all forms of gender-based violence. Though it is difficult to give statistics, rape and other forms of sexual harassment, torture, assault, forced prostitution and increased domestic violence are some of the forms of violence experienced by vulnerable groups, especially females.

Another repercussion of the armed conflict is the loss of male breadwinners and the emergence of female-headed households. There are an estimated 40,000 “war widows” in Sri Lanka (4) and most of them are young with small children. They are at the mercy of various officials in their efforts to get due compensation and other services. This situation often makes them vulnerable to various kinds of gender-based violence such as forced sex. A study of 120 of female-headed households in the Batticaloa district has found that the vast majority of household heads were below 35 years of age and had preschool children; some had elderly dependents as well (11). The Sri Lanka Demographic Survey in 2000 found that females headed about 20% of the households. Though not purely due to armed conflict, no one can deny the fact that it has contributed to this situation to a large extent.

Unlike in the rest of South Asia, there are few reports of large scale trafficking of women for commercial sexual exploitation in Sri Lanka. However, studies and reports show that trafficking for sex and exploitative forms of labour does exist internally and externally, specially where Sri Lankan women travel out of the country to the West and East Asian countries to work as domestic aids or in garment factories. Within the country, trafficking of women has been found to take place in situations where women seek work in factories, where people lure women with the promise of such employment and press them instead into sexual slavery in the cities. However, some forms of gender-based violence such as female genital mutilation and honor killings do not exist in Sri Lanka.

6.3 Factors associated with gender-based violence

The factors associated with gender-based violence are many and complex and vary with the type of violence. Domestic violence being the commonest type of gender-based violence, most comments made are meant for this. A host of deep-rooted discriminatory social, cultural, religious and legal practices are the main contributory factors for gender-based violence. The protracted armed conflict in the country and the resultant socioeconomic problems also further contribute to this situation. Most of the factors associated with gender-based violence are discussed in the chapter on domestic violence in detail.

6.4 Consequences of gender-based violence

When one talks of gender issues, there should not be a narrow selective focus purely on human rights. High social, health and economic costs to the individual and society are associated with violence against women. It causes serious physical, psychological, economic and social sequelae for the affected women and their families. These are well documented in world literature. Unfortunately, most of the studies done in Sri Lanka have not addressed the consequences of gender-based violence and are limited to domestic violence.

6.5 Interventions and policy response

State commitment

For over two decades the government of Sri Lanka has been actively committed towards gender equality and the advancement of women including working towards reducing gender-based violence. The state commitment to issues particular to women came about during the United Nations Decade for Women (1975 – 1985) and specifically as a result of the International Women's Year in 1975.

Some important milestones in Sri Lanka:

- 1931 - Women gained the right to vote to represent them in the Parliament at the same time as their male counterparts.
- 1978 - The Article 12 and 12 (2) of the Constitution of 1978 guaranteed equal rights to men and women without discrimination on sex. Article 12 (4) of this constitution further provides for affirmative state action for the special advantage of women.
- 1978 – The Women's Bureau of Sri Lanka, the first ever national machinery for women in the country, was established.
- 1981 - Sri Lanka ratified the National Convention on the Elimination of all forms of Discrimination against Women (CEDAW).
- 1983 - Ministry of Women's Affairs was established.
- 1993 - Sri Lanka signed the Vienna Declaration on the Elimination of Violence against Women. Reaffirming its commitment at the international level to address the issue of gender-based violence.
- 1993 - Women's Charter, the main policy statement of the government was adopted by the State.
- 1993 - Establishment of National Committee on Women.
- 1995 - Amendment to the Penal Code.
- 1996 - The National Plan of Action was adopted by the State.
- 2000 - Establishment of Women and Children's Desks at Police Stations.

- 2004 - Establishment of "Diri Daru Piyasa”.
- 2005 - Domestic Violence Bill was passed in Parliament.

The mission of the Women’s Bureau was identified as to work towards the improvement of living standards and empowerment of Sri Lankan women by providing knowledge, opportunities and resources for them to utilize their full potential and reap benefits through ensuring their equal rights in the educational, socioeconomic, political, legal and cultural spheres.

Recognition of the subject of Women’s Affairs as a ministerial portfolio demonstrates the state patronage for gender and development in Sri Lanka. The Ministry of Women’s Affairs is the national focal agency for promotion of gender-equity in Sri Lanka. Eliminating gender-based violence is clearly identified and makes up a specific item in its list of objectives. This includes formulating, implementing and monitoring policies, programmes and projects for the empowerment of women and combating violence against women and networking with government, NGO’s, media and donor agencies on activities connected with violence against women.

The amendment to the Penal Code in 1995 drastically updated archaic laws and resultant practices that discriminated against women victims of rape for over a hundred years. The new laws are extensive and carry a mandatory minimum sentence of seven years with enhanced punishment for gang rape, custodial rape, and rape of a woman of unsound mind or in a state on intoxication and of pregnant women. The law also recognizes statutory rape at 16 years. This amendment to the Penal Code introduced two new offences that criminalized two forms of gender-based violence, sexual harassment and incest. Sexual harassment, which remains largely unacknowledged as a crime in Sri Lanka, is now dealt in the Penal Code. It recognizes sexual harassment in the public sphere including in employment and in public transport. The setting up of the National Child Protection Authority has also had an important impact in creating an avenue for such offences to be brought to court.

In 2005 the Parliament passed the Domestic Violence Act which is important as this legislation recognizes domestic violence as an offence and gives the opportunity to the victim to obtain a restraining order from the court. Subsequently, many NGOs and the national women council are doing advocacy programmes to ensure that women get the benefit.

The Women’s Charter is the main policy statement by the government, regarding the rights of women, expressing the state’s commitment to remove all forms of discrimination against women and address crucial areas relevant to women. The charter aims at eradicating sex based discrimination and at achieving gender equality and establishes standards to be observed in seven broad areas: political and civil rights, rights within the family, the right to education and training, the right to economic activity and benefits, the right to health care and nutrition, the right to protection from social discrimination and the right to protection from gender-based violence. One of the critical areas of the Charter is violence against women. Yet, more than a decade after its adoption, the Charter is yet to achieve its full potential.

The National Plan of Action (NPA) for Women was adopted by Sri Lanka following the World Conference on Women (Beijing, 1995) in May 1996, and has been developed based on the Global Platform for Action on Women. The NPA is a collaborative effort between the government and the NGO sector in Sri Lanka and looks at violence against women and armed conflict as two of its main sectors. The NPA, in each area of concern identifies the problem faced, measures necessary to address the problem, and identified state

and non-state agencies responsible for the implementation of identified measures. For the State, the National Committee on Women takes responsibility to ensure the fulfillment of the NPA.

The most significant introduction to state machinery to work towards the rights of women made by the Charter was the setting up of the National Committee on Women (NCW), a Presidential Committee, which is facilitated by the provisions of the Charter, which requires the establishment of a fifteen-member committee to monitor the rights under the Charter. The mandate of the NCW falls into three broad categories: to entertain, scrutinize, and take action against complaints of gender discrimination, to promote research into gender issues and to advise the Minister in charge of Women's Affairs when advice is sought or when the NCW considers it necessary. NCW had been very active, conducting training in many aspects to ensure empowerment of women. One of the innovative experiences has been the training of a group of women for the purpose of entering the field of politics as contestants in local government bodies.

Commitment of NGOs

The NGO sector has been active in addressing the issue for nearly two decades. There are over 50 organizations (NGOs and universities) working in the sphere of violence against women, with the majority focusing on domestic violence (12). There are a number of non-governmental organizations and community based groups which have programmes on awareness raising, training, research and mobilizing the public, or who advise policy-makers on measures against gender-based violence. Some NGOs have collaborated with state sector attempts to address the issue by providing resources in terms of their expertise and inputs to planning and documentation of the issue.

6.6 Recommendations

Awareness raising

Since gender-based violence is an extremely deep-rooted problem, an immediate change towards its reduction would be extremely difficult. However, "awareness" of the problem could open up a definite dialogue towards change. The need to establish a broader public awareness of gender-based violence is greater today than ever before. Any effort to raise awareness should invariably include issues on gender equality in the family as well as in the community.

Awareness and intervention programmes could target three specific groups: firstly the community on the extent, nature and risk factors of gender-based violence; secondly, abused women and lastly, perpetrators. An ideal entry point for community intervention could be at school level. It is encouraging to note some billboards targeting young boys as future perpetrators close to boys schools in the city as a primary prevention strategy. In addition, community-based programmes should be carried out for adolescents on the implications of negative cultural practices such as early marriage which may lead to a compromise on education and economic independence, and marital disharmony.

Given that the media is a powerful tool of communication, the state machinery could access it to create greater public awareness. Media-based intervention is critical. The media has proved to be an effective tool in curbing social deviances and could be used to educate victims of abuse as well as the perpetrators. The media should play a responsible role and

take care not to dramatize brutal incidents of gender-based violence. There should also be sensitization programmes to include the highest level policy-makers including parliamentarians and other politicians, departmental heads and other government officials. Already the staff of the Ministry of Health, key police officers including the supervising officers have been trained.

Training

- The State and NGOs provide training and skills development to women so as to promote income generation such as self employment and provide women with access to credit, which will enhance women's capacity to be economically independent and empowered.
- When an abused person files a report or seeks treatment, she used to contend with Police Officers who have not been trained to respond adequately. In-service sensitisation programmes have already been started with the help of the NCW and large numbers of police officers alone with their superiors have participated to overcome the attitudinal problems prevalent among them and also to instil in them the gravity of the issue.
- The Judges' Training Institute includes gender sensitization courses as a part of its curriculum. The Law Commission has already arranged seminars and discussions regarding the newly passed domestic violence act.
- The education system should ensure that the curricula and teaching methods do not include gender stereotyping and biases. Schoolchildren should be sensitized regarding gender issues.
- Gender issues including detection and prevention of gender-based violence should be integrated into all the basic and in-service training programmes of officers of the health care system including the preventive and curative sectors, so as to improve their knowledge, attitudes and skills in handling gender-based issues. The Ministry of Health has already included this topic in the curriculum of midwives and nurses.

Provision of health care and other support services

Recognition of gender-based violence as a public health issue and documenting its prevalence and health consequences, and providing special care for women seeking medical help following an episode of violence, including referral to other support services and the sensitization of health care providers, are some of the urgent tasks for the health sector. The state should establish and maintain shelters and homes for the victims, which also provide counselling and rehabilitation services and legal aid for them. However, the provision of counselling which is of crucial importance is neglected in a busy hospital catering to a wide spectrum of health problems. In addition, the overcrowding of hospitals denies the essential requirement of privacy to victims of gender-based violence.

Very few shelters are available at the moment and nearly all of them are managed by NGOs. This is a dire need identified at the moment.

Some of the services piloted in the Ministry of Health:

(1) The Ministry of Health has arranged with the assistance of NGOs such as Women In Need to establish a 'Help Desk' at some of the hospitals such as accident services of the National Hospital, De Soysa Maternity Hospital.
(2) The Ministry of Health carried out a pilot project in Anuradhapura with NGOs in 2002 to screen and provide services for victims of gender-based violence.
(3) A centre has been established by the name of "Liya Sevana" at the Kurunegala Teaching Hospital with the assistance of an NGO.
(4) Currently the Ministry of Health has set up a centre Matara General Hospital by the name of "Mithuru Piyasa" providing dedicated counselling and medical services for the victims of gender-based violence. A core group of health personnel has especially trained and are involved in training and sensitization activities of the other care providers in the hospitals. This activity is linked to a field component involved in training and sensitizing medical officers of health, public health midwives, public health inspectors who would refer victims to the centre based at the hospital.
(5) To ensure sustainability of such activities, it is important to mainstream gender-based violence in the Ministry of Health activities. It is heartening to note that gender focal points had been identified and is very active in the Family Health Bureau.

Legal assistance

Judicial intervention is a priority and is the cornerstone of prevention of abuse. Like in many other countries, the legal resources available to combat violence against women in the domestic as well as the non-domestic spheres are very limited in Sri Lanka, even though the law is in place. The judiciary itself is perhaps not sensitive enough to gender specific crimes and some of the meager sentences handed out to perpetrators bear testimony to this. Perhaps knowledge of the magnitude of the problem and the newly enacted bill on preventing domestic violence would help to bring about a shift in this attitude.

Responsibility of the nongovernmental organizations

The collective voice of NGOs needs to be articulated to address gender-based violence through coordination and not through competition. NGOs should strengthen their skills and capacity to continuously carry on lobbying and advocacy campaigns.

Management of an information system

Gender-disaggregated data should have to be systematically maintained, especially in hospitals and police stations, which would be helpful in planning and implementing programmes to address the victims as well as the perpetrators.

6.7 Conclusion

Since gender-based violence is an issue from time immemorial, it has inevitably resulted in the conscious and subconscious subordination of women. Any primary prevention programme to prevent violence against women will require creating an entire generation of individuals who see violence against women as inappropriate. To achieve a genuinely equitable role for women, we need to ensure that they are empowered and become equal partners in the decision-making processes in families, in villages, in political parties, in the business sector and in the civil society as a whole. They should not be passive participants in the process, but an integral part of the machinery of power. In short, what is needed is a social upheaval where women would be perceived as equals.

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7. Elder abuse and neglect

7.1 Introduction

Neglect and abuse of the elderly dates back to ancient times. It gradually emerged as a public health issue and a social welfare problem at the beginning of the last century and subsequently as an ageing issue during the past few decades. The abuse and neglect of the elderly like other forms of domestic violence is a human rights violation and is ethically unacceptable. Education and awareness programmes and the enactment of appropriate legislation and enforcement are necessary to combat the problem. In Sri Lanka, with the gradual shift from extended to nuclear family system and the erosion of social values and modernization, and the ageing of the population, the problem of elder abuse has emerged as a subject of public discussion in recent years.

Background

In Sri Lanka, the age structure of the population shows a shift towards the adult age intervals, with the proportion of children declining rapidly. The aged population defined as those 65 years and above is on the increase, and has been estimated as 7% of the household population in 2000 (Table 7.1).

Table 7.1: Elderly population and dependency ratio for the elderly

Year	Elderly population (%)	Dependency ratio for the elderly
1971	4.2	7.5
1981	4.3	7.2
1993	6.1	9.6
2000	7.2	10.7

Source: Census of population (1971 & 1981), Demographic and health survey (1993 & 2000)

Definition of elder abuse

The definition developed in the United Kingdom is as follows: "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" (1). Elder abuse can be divided into the following categories: physical abuse; psychological abuse; financial abuse; sexual abuse; and neglect.

7.2 Extent of the problem

There is no empirical evidence of the extent of the problem of elder abuse in Sri Lanka. However, enquiries from relatives and friends visiting selected State and NGO homes for the elderly revealed that the disabled elderly are being abused mainly physically and emotionally. It was also evident that most workers in these institutions are not properly trained to handle the elderly. It is also seen that in homes run by religious authorities, the extent of abuse is very much less.

Physical abuse

Physical abuse is more likely to take place in institutions than at home. The most common forms are assault and neglect in providing medical care. As mentioned in Chapter 2, there is no routine surveillance system related to elder abuse and neglect in Sri Lanka. There are no studies documenting physical abuse. However, it is believed that such abuse is

prevalent both in institutions and at home. A study on the ageing issues in an urban slum and a fishing village showed that about 84% of the elders in the sample, required long-term medication for one or more illnesses and that the elders were not satisfied with the medical treatment they received (2).

Neglect

Neglect is more common among elders who live alone and in poor households. In a focus group discussion it was revealed that about half of the respondents received no financial support from non-resident children (3). In another study, it has been revealed that only about 47% of the elderly are regularly visited by relatives (4).

Homicide and Suicides

Homicides as well as suicides of elderly have been on the increase. The underlying cause of some of the suicides has been the result of abuse at the household level. 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 in comparison to the younger ages. The corresponding rate of 20.0 for females was also relatively high compared to other ages (5).

According to unpublished data of the Registrar General's Department, in 1995 there were 133 deaths due to homicide among males over the age of 60 years with a rate of 16.0 per 100 000 population and 47 deaths due to homicide among females in the same age group, giving a rate of 5.8 per 100 000 population (6). The homicide death rate over 60 years for both males and females combined was reported at 11.0 per 100 000 population for the year 1995.

7.3 Consequences of elder abuse and neglect

Very little research has been undertaken on a global scale on the short-term and long-term consequences of elder abuse. In Sri Lanka, such studies have not been undertaken. However, personal communication with a psychiatrist revealed that depression and psychological distress occur as a result of elder abuse. Moreover, the health conditions resulting from such abuse take a considerably longer time to heal. The economic impact of elder abuse has not been assessed. However, it can be considerable given the fact that those who are reaching the age of 60 today are more educated and skilled as a result of six decades of free education in the country.

7.4 Factors associated with elder abuse and neglect

Sex and age are seen as risk factors. Elder women are more likely than men to be abused. Similarly, much older or the 'old-olds" are more likely to be abused than the "young olds". Disabled elderly are also more likely to be abused both at institutions and at home. This is perhaps because more data are available from institutions.

Elders who do not have any financial assets and are entirely dependent on the children are more likely to be abused than those who have some means of support. This is because those who do not have any means on their own are at the mercy of their children.

In the urban setting, abuse could be even more prevalent due to the fact that most of the household members go to work including the female members. Therefore, the elders who are left behind at home tend to be neglected.

As a result of demographic ageing this problem can be further aggravated in the future. For instance, in Sri Lanka, the rise in life expectancy and the decline in fertility over the past three decades have brought about changes in the population age structure. The population aged 60 years and over is projected to increase from 1.9 million in 2001 to 4.7 million in 2031 (7). With higher female life expectancies, females will outnumber males at older ages. In 1971 there were about 122 males to every hundred females aged 60 years and over. This ratio is expected the decline to 84 in 2041 (7,8). With higher life expectancies at older ages, the duration of co-residence of elderly with their children will further increase.

7.5 Interventions and policy response

Primary prevention of elder abuse in institutions is given priority in intervention programmes. The elderly population needs to have opportunities for self-fulfillment in society. An important way of achieving this objective is to create community awareness through education and training. Health care and social workers are an important target group for such education and training to detect and prevent elder abuse. Therefore, in state elderly homes this aspect is given priority. On the other hand, the print and electronic media are also powerful tools for raising awareness of the problem among the general public. The Media Forum of the Health Education Bureau, Ministry of Health has initiated action to give publicity to this aspect of the problem.

As long as the elderly are marginalized by society, they will suffer from loss of self-identity and remain vulnerable to discrimination and abuse. Therefore, it is necessary to formulate effective policies and preventive strategies based on objective evidence. The Sri Lanka National Policy on Elderly has addressed this issue.

7.6 Conclusions and recommendations

Given the rising elderly population and the rudimentary evidence about elder abuse and neglect in Sri Lanka, it is necessary to undertake studies to objectively assess the extent of the problem and enact laws and formulate policies to eliminate or minimize the abuse and neglect of the elders. Given the current state of knowledge, the following recommendations are made.

- Train “young olds” to help the “old-olds”.
- Build “social networks” of older people in villages and neighbourhoods.
- Focus attention on poor households where older widowed women live.
- Make jobs and training facilities available for the “young – olds”
- Encourage the media to promote positive image of ageing.
- Support active ageing programmes among general public so that the in future elders will have less problems.
- Promote the private sector and NGOs to participate in the provision of services and protection of older persons.
- Establish services for victims of abuse and rehabilitation arrangements for abusers.
- Include older persons as a target group in poverty alleviation programmes with emphasis on high-risk groups including women.
- Enact legislation and strengthen legal efforts to eliminate elder abuse.
- Provide counselling services to the elderly, particularly to those who are in need of such services.
- Encourage the building of social capital through neighbours and friends.

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8. Self-inflicted violence – suicides and attempted suicides

8.1 Introduction

Self-inflicted violence can be considered as a specific act of violence where both the perpetrator and the victim are the same. This is essentially a phenomenon peculiar to mankind. Self-inflicted violence can result in deaths, but suicides are only a part of this serious problem. Many more survive attempts to take their own lives but live to suffer the consequences.

In contemporary society, suicide and attempted suicide are considered a major form of deviance. The social reactions to suicide however, have shown wide variations from society to society and in different periods of human history. In Sri Lankan historical anecdotes, there were instances where suicide is described as a heroic sacrifice or an act by which a person's pride is preserved. In some other oriental cultures also suicide was an acceptable behavior under certain circumstances: "sati" in India and "hara-kiri" in Japan are two examples. Western European and American societies, in contrast, have traditionally been strongly opposed to suicide.

Definitions of suicidal behavior

The World Health Organization has defined suicide as an act with a fatal outcome that is deliberately initiated and performed by the person himself or herself in the knowledge, or expectation, of its fatal outcome (1). Suicidal acts with a nonfatal outcome are labeled as attempted suicides. It can be defined as behavior with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill himself / herself (2). A suicide attempt may or may not result in injuries.

The term "parasuicide" covers behavior that can vary from what are sometimes called suicidal gestures and manipulative attempts to serious but unsuccessful attempts to kill oneself (3). Some prefer the term parasuicide than attempted suicide or suicide attempt since it makes no reference to intention. The reason is that the intention cannot be used as a criterion since the person's motive may be too uncertain or too complex to ascertain readily (3).

Suicidal ideation refers to any self-reported thoughts of engaging in suicide-related behavior. They are cognitions that can vary from fleeting thoughts that life is not worth living, through very concrete, well thought out plans for killing oneself, to an intense delusional preoccupation with self-destruction (4). Presently, many use the concept of suicidal behavior to cover suicidal ideation, attempted suicide and suicide (5).

From an epidemiological point of view, the two populations that complete suicide and those who attempt suicide differ. More males complete suicide while more females attempt suicide. Suicide completers use more lethal methods than suicide attempters, although whether a person survives or not following a suicide attempt depends on a number of factors. The lethality of the method (objective dangerousness) used, perceived lethality (subjective dangerousness) of the method, intervention by others, availability of medical facilities, and attitudes of health care workers are among the factors that determine survival following a suicide attempt (6). Hence, it is the practice to describe suicide completers and suicide attempters as two separate but overlapping populations (7).

8.2 Extent of the problem

Global situation

Suicide is the 13th leading cause of death worldwide. In the year 2000, an estimated 815,000 people (14.5 per 100,000 population) died from suicide around the world. The incidence of suicide varies significantly from one society to another as well as among subgroups within a particular society. Generally high rates are found in East European countries (e.g. Lithuania 51.6 and Russia 43.1 per 100,000) and low rates are found in Latin American (e.g. Colombia 4.5 per 100,000) and in some Asian countries (e.g. Philippines 2.1 and Thailand 5.6 per 100,000). Suicide rates below 5 per 100,000 population are generally considered as low while rates above 15 are considered high (8). Suicide rates vary over time, and while some currently show an increasing trend (e.g. Ireland, Norway), others report a decreasing trend (e.g. United Kingdom, New Zealand).

Globally, suicide rates tend to increase with age and this is notable among both sexes, but is more marked among men. Due to demographic distribution, although suicide rates are higher among older people, the absolute number recorded is higher among those under 45 years than among those over 45 (9). The rate of suicide is almost universally higher among men compared to women by an aggregate ratio of 3.6 to 1, with few exceptions like rural parts of China where more females commit suicide than males (10). The global suicide rates for males and females are 24.7 and 6.9 per 100,000 population respectively (11).

Sri Lankan situation

The quality of data on suicide mortality is to a considerable degree associated with the procedure underlying the ascertainment of a suicide (12). In Sri Lanka, this is being done by a Coroner who is most often a lay person, with the supporting findings of an autopsy and the evidence coming from the relatives and friends of the deceased. Deaths are registered by the local Registrar of Births and Deaths, again most often a lay person. Although registration of death in Sri Lanka is considered complete according to the United Nations definition, the certification of the cause of death is not very reliable (12). In 2002, for example, 3.7% of deaths were attributed to symptoms, signs and abnormal laboratory findings (13). This ranked as the eighth leading cause of hospital deaths. When the suicide figures of the Registrar General's Department are compared with the other official source of suicide data, the Department of Police, it shows a significant difference of reporting between 1987 and 1996 (Table 8.1). Therefore, all conclusions should be made within this limitation in ascertainment of suicide.

Table 8.1: Reported number of suicides by the Registrar General's Department and the Department of Police

Year	Reported number of suicides		Difference in number
	Registrar General's Department	Department of Police	
1981	4808	5069	261
1982	5416	5719	303
1983	6068	6270	202
1984	6236	6609	373
1985	6217	6133	- 84
1986	5740	6084	344
1987	5993	7165	1172
1988	6042	7531	1489
1989	6063	6657	594
1990	Not available	7075	---
1991	5925	7411	1482
1992	5379	7505	2126
1993	5401	7364	1963
1994	5460	7394	1934
1995	5515	8449	2843
1996	5519	7344	1825
1997	5887	6418	531
1998	5518	5839	321
1999	5619	5907	288

Sources: Registrar General's Department and Department of Police (Unpublished information)

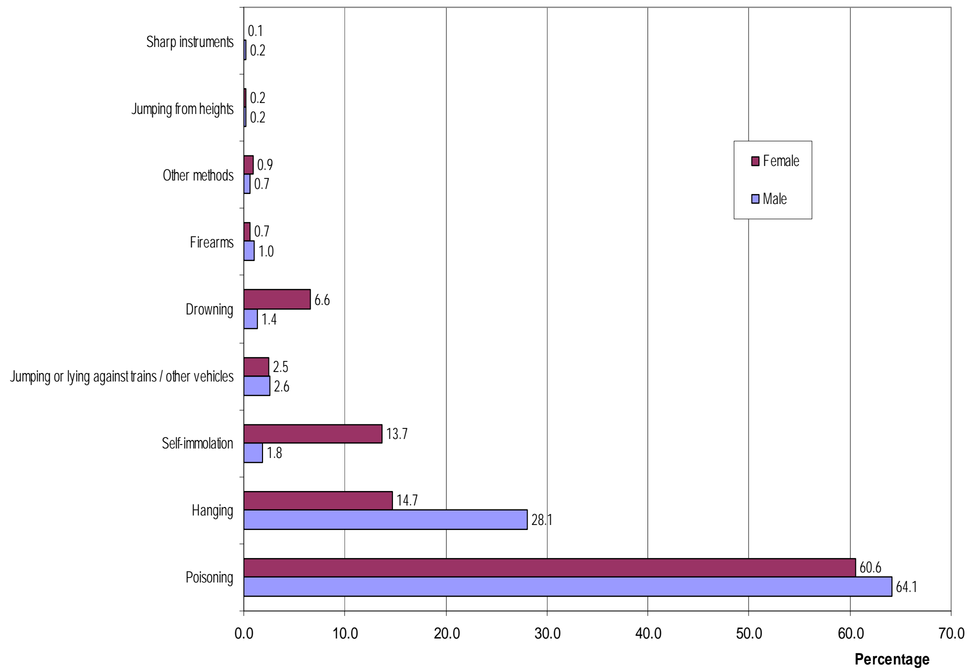
The districts of Vavunia, Polonnaruwa, Kurunegala, Jaffna, Mannar and Anuradhapura in Sri Lanka had high district suicide rates for the decade 1971–1980, all above 30 per 100,000 population. Meanwhile Colombo, Kalutara, Galle, Matara and Kegalle districts recorded low suicide rates, fewer than 18 per 100,000 population (8). All the districts with high suicide rates except Kurunegala, are in the dry zone of the country.

Methods of suicide: In Sri Lanka, over the time common methods used for suicide has been changing. During the period 1880-1950, hanging was the method most frequently employed. This accounted for more than 70% of all suicides during the period of 1880-1889. This proportion gradually reduced to 55% during the period of 1940-1949. In 2004, only 25% of suicide victims resorted to hanging (8). The second most popular method during the early period was drowning.

During 1940-1949, only 13% of total victims used poison as the method to commit suicide. However, during the past four and a half decades the proportion of cases committed suicide by taking poison has increased substantially to reach 63.4% in 2004. Presently, poisoning, especially ingestion of pesticides or herbicides, is the most common method resorted to by both males and females to commit suicide (Figure 8.1). Organophosphates, organochlorines and paraquat are the most commonly used pesticides and herbicides for this purpose in Sri Lanka. Seeds of the yellow oleander plant are also widely used (13). Use of substances available at homes or in close environment for acts of deliberate self-harm is very common (14). Almost all of the hospital admissions due to toxic effects of pesticides in Sri Lanka are following an act of deliberate self-poisoning (13). In 2002, there were a total of 17,364 hospital admissions due to toxic effects of pesticides with a case fatality rate of 8.3%, making them the seventh leading cause of death. Organophosphate poisoning cases occupied 41% of the medical intensive care beds in the General Hospital, Anuradhapura (15). In Sri

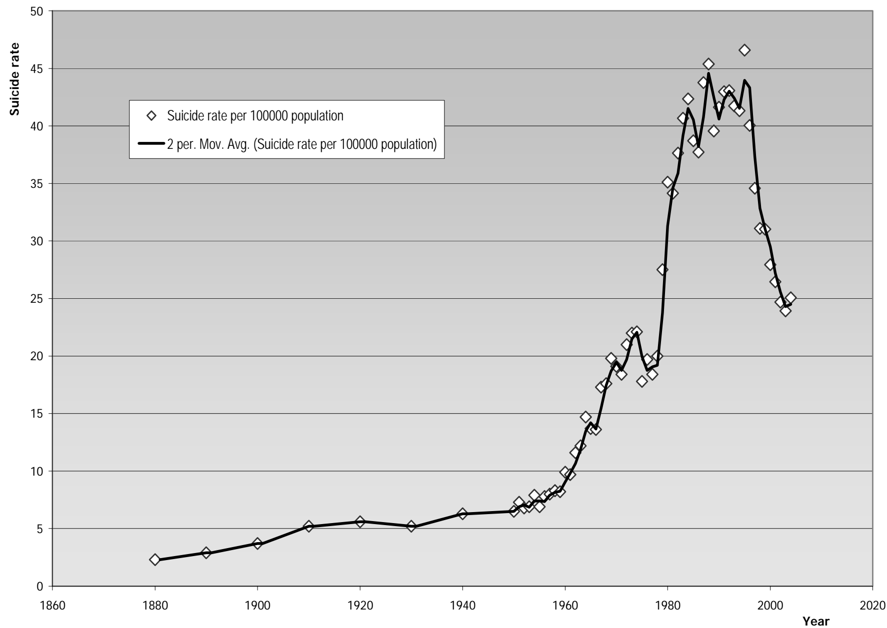
Lanka, the case fatality rate of self-poisoning is 12.7%, which is very high compared to the 1–2% reported in the UK (6, 15).

Figure 8.1: Methods of suicide in Sri Lanka in 2004



Source: Unpublished information, Department of Police.

Figure 8.2: Suicide rates and the trend in Sri Lanka, 1880–2004



Source: (16,17,18)

Trend in the suicide rate: The trend in Sri Lanka has varied from time to time (Figure 8.2). In 1880, the reported suicide rate in Sri Lanka was 2.3 per 100,000 population. During the period 1960 to 1974, there was an accelerated increase in annual suicide rates, compared with the gradual, slow increase for the period of 1880 to 1959 (16). There was a very sharp increase in the rates for the period 1979 to 1995 (17). The suicide rate in 1995 was 46.6 per 100,000 population, which was a 20-fold increase over 1880. Since 1996, there has been a steady decline in the suicide rate with an estimated suicide rate of 26.5 per 100,000 population in 2001 (18). However, this is still high and is among the highest national rates in the world.

The dramatic changes in suicide rates, observed since 1950s were attributed to the rapid socioeconomic and demographic changes which have taken place in the country (19). Resettlement or new settlement schemes (colonization) were set up in the dry zone of the country since 1940s. People living in the South-Western Wet Zone were resettled in the North-Central and Eastern Provinces under irrigation schemes like Gal-oya and Mahaweli. After the independence of the country in 1948, the colonization process was accelerated, causing considerable internal migration. In one way, this process contributed to the overall agricultural development of the country. However, there were social consequences (19). There was very rapid population growth in the settlement areas. Due to the disproportionate migration, the sex ratio of these districts reversed the female preponderance pattern. The traditional Sri Lankan family norms and customs were also threatened. Problems related to housing facilities, drinking water, basic sanitation, education, and the dispute between the man and the animal especially wild elephants were among many hardships that these communities had to face. Failure to pay adequate attention to the social integration and cultural aspects of these communities brought adverse outcomes. The enormous stress that was caused by all these factors may be the reason for the steady rise in suicide rates from the 1950s to the 1970s.

The sharp increase in the suicide rate of the 1980s was also preceded by significant changes in the political and economic spheres of the country. Up to the latter part of the 1970s, the economy of the country was centralized with strict government control. In 1978, major economic and political reforms were introduced and the economy was liberalized. A high degree of mobility of the population coupled with these changes caused rural to urban and overseas migration, especially among the young population. This brought a significant impact on the social infrastructure (20). The traditionally valued extended family structure was broken into nuclear units. This left the elderly population isolated in rural areas. Moreover, this caused changes in the lifestyle and responsibilities of the young. High mobilization of females also occurred in the form of internal migration to free trade zones and external migration to Middle Eastern countries for employment. Disintegrated families, pre/extra-marital sexual activities, and unwanted pregnancies are some of the adverse consequences of this process. The increased events of suicidal behavior suggest that a quite higher proportion of the community could not cope with this stressful life.

Attempted suicides in Sri Lanka: Unlike for suicide, figures for attempted suicide are not readily available. There are no large community-based studies attempting to measure the incidence of attempted suicide. Studies in other countries suggest that there will be as many as 10 attempted suicides per completed suicide (21). In Sri Lanka, this figure may be as high as 16 per completed suicide (22).

Ingestion of poison or taking an overdose of drugs with suicidal intent accounts for more than 80% of suicide attempts (6). Ingestion of the organophosphorus chemicals was the

most frequent method used, accounting for 60% of attempts. Carbamate and yellow oleander seeds are also among poisons commonly used in attempted suicide. Gender variation in the methods of attempted suicide was reported in a study conducted in Jaffna (23). Agrochemicals and insecticides or the organophosphate groups were used predominantly by males, while the females used medically prescribed drugs or other chemical agents and plant poisons.

According to a hospital based retrospective study on suicide and attempted suicide, in Sri Lanka nearly 1% of hospital admissions were related to suicide attempts (6). In 2002, there were 3,584,816 hospital admissions and out of these admissions 35,848 were attributed to self-harm (6, 13). In the same year, there were 48,359 hospital admissions due to poisoning and the majority of those could be attributed to deliberate self-harm (15).

The male to female ratio of hospital admissions following attempted suicides was found to be 1.9:1 in 2000 (6). A study done at the General Hospital, Jaffna found that in 1984 almost an equal number of males and females were admitted after suicidal attempts (23). Generally the incidence of attempted suicide is higher for females (24). This does not reflect the hospital data reported above and could mean that more females make less serious suicide attempts that do not require hospital admission. Also the situation in Jaffna would have been special at that time.

There are several factors that determine the case fatality following a suicide attempt. The time gap between the suicide attempt and reaching a health care facility is one of the main determinants. Although there may be a time gap between executing the act and its detection by others, the main factors that increase the time gap include distance to the health care facility, availability of transport and road conditions. The capacity of the curative health services to deal with these cases is another important factor that determines the case fatality rate.

8.3 Factors associated with suicidal behavior

The factors that place individuals at risk of suicide are complex and interact with one another. Identifying these factors is vital to prevent suicides. A majority of research has found that suicidal behavior is associated with some form of underlying psychopathology (25,26,27,28). However, suicidal behavior cannot simply be attributed to psychopathology. There are a wide range of demographic, social, economic, environmental, genetic and other biological factors that increase the risk of suicidal behavior and in most instances, suicidal behavior is multi-factorial (9). This may be the reason that we observe distinct differences in the epidemiology of suicidal behavior across countries in the world as well as among sub-populations within a country.

However, some argue that behind many suicides there is probably no real intention to die (29). If there is no farewell letter, it may sometimes be very difficult to ascertain the reason for a suicide and whether it was a deliberate act or an accidental death. Even if it is determined as a deliberate act, to determine the actual intention to die will be difficult.

Although Sri Lanka has one of the highest suicide rates in the world, opportunities for researching suicidal behavior within the context of the Sri Lankan culture are limited. A larger proportion of studies are hospital-based. There are some studies that have explored the sociological aspects of suicide. Community-based studies and intervention studies on suicidal behavior in particular are very limited. However, the available evidence and the routine data

provide some information to understand the magnitude of the problem and its major correlates.

Demographic factors

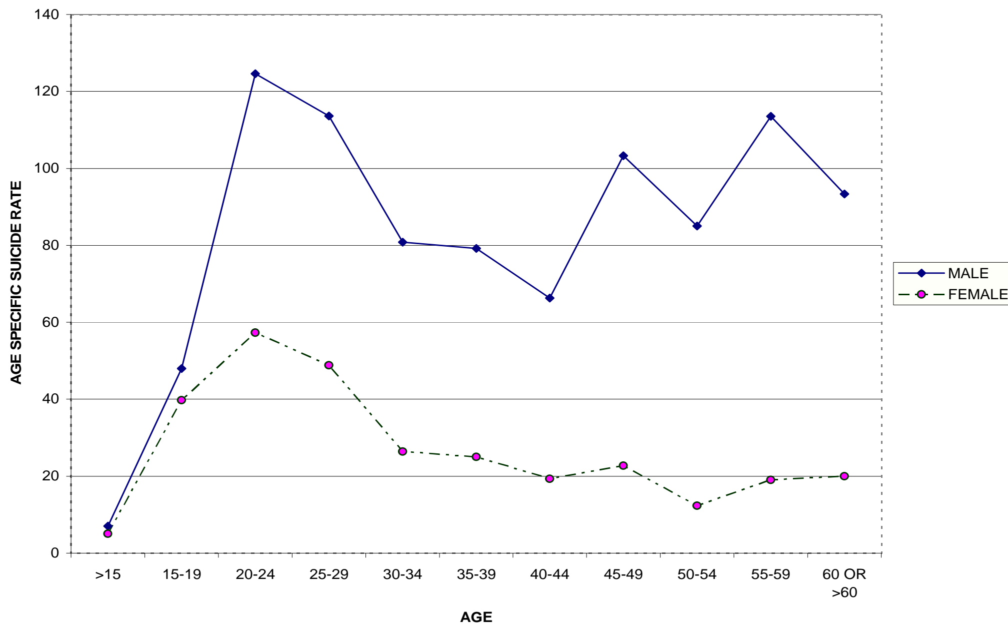
More males commit suicide than females. In 2004, 3803 males and 1073 females committed suicide in Sri Lanka. This makes a male/female ratio of 3.5:1. This is consistent with the global estimate of 3.9:1 made by the WHO (11).

During the period 1950 to 1978, the suicide rate for males increased from 8.3 to 24.8 per 100,000 population. A sharp increase in the male suicide rate was observed in 1979, the rate rose from 24.8 in 1978 to 58.4 in 1979. The female suicide rate showed a similar pattern, rising from 4.4 in 1950 to 25.7 per 100,000 population in 1984. When the hospital admissions for self-harm in 2002 were analyzed, the male to female ratio was found to be 1.9:1 (6).

Districts with high suicide rates for one sex have had high rates for the other sex and vice versa. However, the range of suicide rates observed for districts is much greater for females than for males. In 1980, the highest suicide rate for both sexes was recorded in Mullaitivu district and the lowest in Gampaha district. For males, the Mullaitivu rate was six times that of Gampaha while for females it was 19 times more.

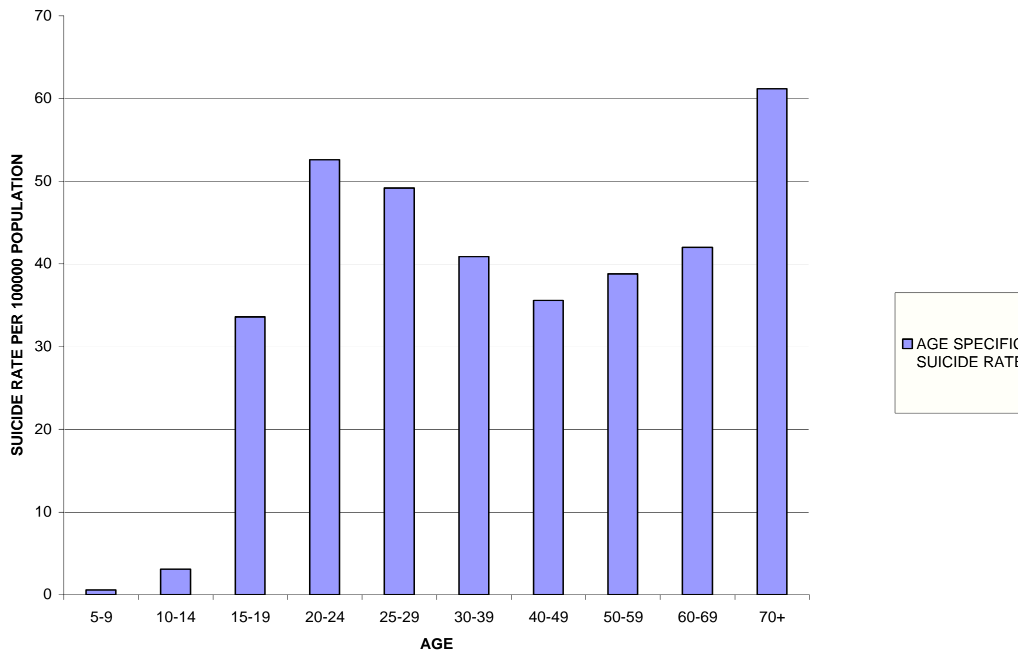
In many countries, suicide is more common among the elderly population and a steady increase in suicide rates is seen with the increasing age. However, in Sri Lanka, suicide rates show a bimodal pattern. In late adolescence and early adulthood suicide rates are high for both males and females. They decline somewhat in middle adulthood, to rise again in the elderly. This decline in middle years occurs sharply for females and more gradually for males. As shown in Figure 8.3.1, in 1986 the age specific suicide rates gradually increased with age to reach a peak in the 20–24 age group, 124.6 and 57.3 per 100,000 population for males and females respectively. Thereafter, suicide rates decline gradually up to the 40–44 years age group and then tended to increase again to reach the second peak in the 55–59 years age group, where the rate reaches 113.5 for males and 19.0 per 100,000 for females (17). This bimodal pattern was again demonstrated in 1996 showing high suicide rates for both the 20–24 and the 70 or above age groups (30) (Figure 8.3.2).

Figure 8.3.1: Age-specific suicide rates by sex in Sri Lanka in 1986



Source: (17)

Figure 8.3.2: Age-specific suicide rates in Sri Lanka in 1996



Source: Department of Health Services (30)

In 2000, 60% of all hospital admissions due to self-harm were in the 16–25 years age group and 11.2% of cases were aged 40 years or above (6). Almost identical age distribution for hospital admission following deliberate self-harm was reported from the General Hospital, Jaffna also (23).

Ethnicity is another important factor in the epidemiology of suicides. The highest suicide rate is observed among Indian Tamils, while Moors have the lowest. In 1981, suicide rates for Sinhalese and Indian Tamils were 36.6 and 37.8 per 100 000 population respectively, both of which were above the national rate of 34.2 (8).

The districts in Sri Lanka which recorded a high incidence of suicide are characterized by rapid population growth rates (> 4.0), an excess of male population, high positive lifetime migration rates and large proportions of in-migration, while districts with low suicide rates are characterized by considerable net out-migration, high rates of labour force participation, higher literacy rates and more balanced sex ratios (8). Jaffna is an exception where there was a sizable net loss of population by out-migration and a nearly balanced sex-ratio, but it has consistently recorded high suicide rates.

Social and environmental factors

Individuals from disadvantaged or dysfunctional family backgrounds, characterized by poor parental care, poor parental relationships, parental psychopathology, family history of suicidal behavior, exposure to physical or sexual abuse, economic disadvantage and high residential mobility, were at higher risk of suicidal behavior (31). Socializing in a home of frequent abuse and family violence, entrapment of women in traditional roles in an abusive environment, a culture of accepting suicidal behavior, aggression when faced with problems, and low value for life are among potential risk factors for deliberate self-harm according to a Sri Lankan study (14). This study has also found that involvement of extended family in interpersonal conflicts was also a potential risk factor.

Marriage has a protective effect on suicidal behavior. Living alone was about twice as common among the suicides as in the general population both for men and women (32). Connectedness to others, responsibility for dependent children, and fears based on religious beliefs have played as protective factors against deliberate self-harm. However, poor marital relationships as reflected by divorce or separation and spousal abuse were common among suicide victims in Sri Lanka (22).

There is consistent evidence to suggest that a family history of suicidal behavior is associated with increased risk of suicide (26). It is not only the family history but also the exposure to suicidal behavior of others by means of witnessing them or nursing suicidal victims that increases the risk of suicidal behavior (22).

A low educational achievement increases risk of suicidal behavior. Both active suicidal ideations and suicide were associated with less formal education (22). Employment provides not only the financial support, but also a social network to interact with. It also determines an individual's position within a society. Unemployment is a risk factor for both suicide and suicide attempts. Those who engage in full time work have the lowest suicide risk (22).

There are some differences in the suicide risk with the nature of the employment, suggesting a class ladder in suicide mortality. Among men, those holding higher positions have the lowest suicide rates. Suicide rates increase with every successive step down the ladder and are highest on the lowest rank and among unskilled workers. However, among women, this pattern is different with higher suicide mortality among both lowest and highest positions being observed (33). Lowest suicide rates are reported among those in middle positions.

Psychiatric factors

Mental illnesses are one of the major risk factors for suicidal behavior. Suicidal behavior is more common among people with mental illness than among the general population. Depression is the commonest psychiatric illness that increases the risk of suicide in a person (28). Common mental disorders, alcoholism, and schizophrenia are other known psychiatric illnesses that increase the risk of suicidal behavior (27). A Sri Lankan study has found that depression and a lifetime history of alcohol abuse or dependence were associated with suicide (22).

A history of past suicide attempts is one of the most powerful predictors of eventual suicide. It is estimated that about 10–15% of persons in contact with health care services as a result of their first suicide attempt do eventually die by suicide (34). The highest risk appears during the first three years, especially in the first six months after an attempt (35).

Method as a risk factor for suicide

The method chosen for a suicide attempt depends on a number of factors. The most proximal factors are the availability and the accessibility to the method and its familiarity. Perceived lethality of the method (subjective danger) and the level of suicidal intent also have an influence on the choice of the method. Ready availability of potent pesticides and other poisons in homes in agricultural areas makes it the preferred method of deliberate self-harm. It was reported that 53% of males and 78% of females used substances available at home in causing deliberate self-harm (14).

Suicide as a weapon

Amidst high numbers and rates of suicide, Sri Lanka has experienced another form of suicide over the last two decades. The Liberation Tigers of Tamil Eelam, a militant group fighting for a separate state, has launched repeated suicide bomb attacks, resulting in the sacrifice of a total of 261 cadres (up to November 2004). The suicide bombers included 77 "land tigers" (59 males and 18 females) and 184 "sea tigers" (133 males and 51 females) (36). These suicides are in stark contrast to the other forms of suicides discussed above. As defined earlier, suicide is a self-directed violence. The suicidal ideation, plans and its attempt are all generated within the self and activated by the individual. However, suicide as a weapon to destroy an enemy is generally not generated within the self or executed by the person in isolation. A suicide bomber is a member of an organization and he is executing an act for which the decision is usually taken by somebody else. Therefore, the psychology of a suicide bomber is completely different from other suicide victims.

8.4 Interventions and policy response

The time gap between the occurrence of active suicidal ideation in a person and the act of committing suicide varies. It could be a few minutes as in an impulsive act of suicide or may be longer, perhaps months or years. Therefore, a primary strategy to prevent the occurrence of suicidal ideations and thereby the execution of a suicidal act would be the most successful. Those who attempt suicide have a greater risk of repeating the act. Therefore, secondary prevention activities are equally important.

Specific prevention activities should be targeted at high risk groups. In addition, the general community-level activities targeted at development of coping skills and disproving

suicide as a problem-solving strategy are required. The influence of media on suicidal behavior is clearly documented. Responsible media reporting of suicide is a requirement.

It may be very unlikely that potential suiciders will attempt to compete with others to obtain mental health services, which are overstretched. Unlike in European countries, support services such as telephone services will not suit Sri Lanka for the simple reason that telephone services are still a luxury for remote rural areas where such services are most needed.

8.5 Conclusions and recommendations

In an effort to prevent suicide in Sri Lanka, a Presidential Task Force was appointed in 1996. This committee has looked into the ways of preventing suicide and made several recommendations to the government (37). Some of these recommendations are:

- Take measures to reduce the quick and easy access to highly lethal methods of harm.
- Take measures to reduce the lethality of pesticides.
- Take measures to improve the medical management of those who have attempted suicide by setting up poison treatment centres at each base hospital and by improving the existing treatment facilities in the district hospitals.
- Ensure appropriate treatment for those who are depressed and alcoholic irrespective of whether they have attempted suicide or not and for those who have survived an attempt at suicide.
- Change the present law in order to decriminalize suicide by deletion of the section 302 of the Penal Code that makes attempted suicide a crime.
- Develop a media policy that discourages the reporting of suicide in a trivial manner.

As a result of these recommendations, the Penal Code was amended by an act of Parliament in May 1998 and attempted suicide is no longer a crime. Many other recommendations, however, remain unimplemented.

Mental health services should be expanded further to facilitate access for all those who require treatment and counseling facilities. At present, the psychological support that is provided even after an act of attempted suicide is grossly inadequate (38). There is only one psychiatrist per 500,000 population in Sri Lanka (39). Further, out of the total number of psychiatrists available in Sri Lanka, almost 65% are employed in the Western Province. To ease the burden to some extent, medical officers of mental health have been appointed to 36 base and district Hospitals throughout the country after three months of intensive training (39). Encouraging private sector and voluntary organizations to participate in the provision of mental health services would help to complement the services provided by the national health care system.

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9. Fatal violence - homicides

9.1 Introduction

The mortality resulting from violence can be classified as homicides and suicides. Though a reliable database related to other forms of violence is not readily available, the data on fatal violence is usually available and fairly accurate.

Homicides may be categorized under all forms of violence such as youth violence, intimate partner violence, collective violence, child abuse and elderly abuse. As in all other forms of violence, homicides are not restricted to any geographical area, race, age or any educational or income group.

Sri Lanka at present is in the midst of an ethnic problem. The homicide rate under a war situation is obviously higher than at normal times. The police records on homicides are classified into two groups. Those homicides that are classified under routine reportable crimes belong to the first group. The second group is the homicides related to terrorist activities. However, it was observed that the police do not routinely maintain the records of deaths of the members of militant groups due to violence. The police classification is important in the sense that homicides due to terrorist activities cease to exist with the establishment of long-lasting peace in the island. The aetiology of homicides under reportable crimes is different and more concerted efforts are needed to reduce such homicides.

9.2 Extent of the problem

Global situation

According to the World Report on Violence and Health (1), death rates due to violence vary according to country income levels. In 2000, the rate of violent deaths in low- to middle-income countries was 32.1 per 100 000 population. The rate for high-income countries was around 14.4 per 100 000 population.

There are also considerable regional differences in the rates of violent deaths. These differences are evident, for example, in the WHO regions. In the African Region and American Regions, homicide rates are nearly three times greater than suicide rates, whereas in the Europe and South-East Asia Regions, suicide rates are only little more than double the homicide rates (19.1 per 100 000 as against 8.4 per 100 000 for the European Region; 12.0 per 100 000 as against 5.8 per 100 000 for the South-East Asia Region), and in the Western Pacific Region, suicide rates are nearly six times greater than homicide rates (20.8 per 100 000 as against 3.4 per 100 000).

Within regions there are also large differences between countries. For example, in 1994 the homicide rate among males in Colombia was reported to be 146.5 per 100 000 while the corresponding rates in Cuba and Mexico were 12.6 and 32.3 per 100 000 respectively. Large differences within countries also exist between urban and rural populations, between rich and poor groups, and between different racial and ethnic groups.

With regard to youth, the World Report on Violence and Health indicates that in 2000, an estimated 199 000 youth homicides (9.2 per 100 000) occurred globally. In other words, an average of 565 children, adolescents and young adults between the ages of 10 and 29 years die each day as a result of interpersonal violence.

Almost everywhere, youth homicide rates are substantially lower among females than among males, suggesting that being a male is a strong demographic risk factor. The ratio of the male youth homicide rate to the female rate tends to be higher in those countries with high homicide rates. For example, the ratio is 13.1:1 in Colombia, 14.6:1 in El Salvador, 16.0:1 in the Philippines and 16.5:1 in Venezuela. Where homicide rates are lower, the ratio is usually lower – such as in Hungary (0.9:1), the Netherlands and the Republic of Korea (1.6:1).

According to the World Report, intimate partner violence accounts for a significant number of deaths by murder among women. Studies from Australia, Canada, Israel, South Africa and the United States of America show that 40-70% of female murder victims were killed by their husbands or boyfriends, frequently in the context of an ongoing abusive relationship. This contrasts starkly with the situation of male murder victims. In the United States, for example, only 4% of men murdered between 1976 and 1996 were killed by their wives, ex-wives or girlfriends.

Sri Lankan situation

Sri Lanka is a country with high suicide rates (25-30 per 100 000 population). The Health Master Plan (2) published by the Ministry of Health, Sri Lanka with the assistance of the JICA organization in 2003 identified homicide as the second cause for death in Sri Lanka (72-122 per 100 000 population), behind only diseases of the cardiovascular system. However, a recent study (3) indicated that the above finding is inaccurate and the actual figure is around 30 per 100 000 population. This figure includes homicides related to the war situation as well. When one considers only the homicides classified as reportable crimes (Police Department Data), the homicide rate would be around 9 per 100 000 population in 2000. However, there are some disparities between the Registrar General's data (4) and the Police records (5) which have been discussed under data sources and limitations (Chapter 2).

According to the above study (3), the highest homicide rate, based on the routine reportable crimes within the past few years was observed in 1998 (10.7 per 100 000) and the lowest observed in 2003 (6.8 per 100 000). When routine reportable crimes and war casualties are taken together, the highest homicide rate was observed in 1998 (31.2 per 100 000) and the lowest was in the year 2003 after the signing of the Ceasefire Agreement in April 2002 (6.8 per 100 000 population). Even this lower value recorded in 2003 is much higher than the reported homicide rate in the South-East Asia Region (5.8 per 100 000) (Table 9.1).

Table 9.1: Homicide rates based on routine data and rates for war-related homicides, 1991–2004

Year	Total population ('000)	Routine reportable homicides		War-related homicides		Total homicides	
		No.	Rate per 100 000 population	No.	Rate per 100 000 population	No.	Rate per 100 000 population
1991	17,583	1556	8.8	3244	18.4	4800	27.3
1992	17,583	1294	7.4	2521	14.3	3815	21.7
1993	17,583	1286	7.3	1516	8.6	2802	15.9
1994	17,583	1245	7.1	1920	10.9	3165	18.0
1995	17,583	1297	7.4	2190	12.4	3487	19.8
1996	17,615	1775	10.1	3059	17.4	4814	27.4
1997	17,833	1637	9.2	3850	21.6	5495	30.9
1998	18,047	1919	10.7	3601	20.0	5520	31.2
1999	18,262	1797	9.8	2712	14.8	4509	24.6
2000	18,489	1711	9.2	3948	21.3	5659	30.6
2001	18,732	1576	8.4	1541	8.2	3117	16.7
2002	19,007	1347	7.1	64	0.3	1411	7.4
2003	19,252	1310	6.8	-	-	1310	6.8
2004	19,462	1377	7.1	105	0.5	1482	7.6

Source: Based on Police Reports on reported crimes and various newspaper reports

Age and sex distribution of homicide victims: The figures for 1992 and 1995 are compared in Table 9.2. In both years, about 20% of victims were in the 20–24 age group. However in the general population, only about 9% of people fall into this age group. This indicates that young adults are more susceptible to homicide. In both years, just over 80% of victims were males.

Table 9.2: Distribution of homicide victims by age and sex in 1992 and 1995

Age groups	1992				1995			
	Male	Female	Total	%	Male	Female	Total	%
< 1 yr	8	3	11	0.4	1	2	3	0.1
1-4 yrs	34	33	67	2.7	12	13	25	1.1
5-9 yrs	26	27	53	2.1	21	14	35	1.6
10-14 yrs	75	33	108	4.3	41	28	69	3.1
15-19 yrs	275	52	327	12.9	205	77	282	12.7
20-24 yrs	464	63	527	20.8	377	75	452	20.4
25-29 yrs	335	45	380	15.0	302	45	347	15.7
30-34 yrs	184	33	217	8.6	193	16	209	9.4
35-39 yrs	176	31	207	8.2	181	23	204	9.2
40-44 yrs	135	15	150	5.9	104	25	129	5.8
45-49 yrs	119	27	146	5.8	100	22	122	5.5
50-54 yrs	61	15	76	3.0	74	14	88	4.0
55-59 yrs	67	9	76	3.0	54	15	69	3.1
60-64 yrs	43	16	59	2.3	39	9	48	2.2
65-69 yrs	35	14	49	1.9	41	14	55	2.5
70-74 yrs	21	10	31	1.2	25	12	37	1.7
>75 yrs	40	5	45	1.8	28	12	40	1.8
Total	**2098**	**431**	**2529**	**100**	**1798**	**416**	**2214**	**100**

Source: Registrar General's Department (4)

Table 9.3: Distribution of homicide victims by sex, 1992–1995

Year	Male		Female		Total	
	No.	%	No.	%	No.	%
1992	2098	83.0	431	17.0	2529	100
1993	1681	83.8	324	16.2	2005	100
1994	1449	85.8	240	14.2	1689	100
1995	1798	81.2	416	18.8	2214	100
Total (1992 – 1995)	**7026**	**83.3**	**1411**	**16.7**	**8437**	**100**

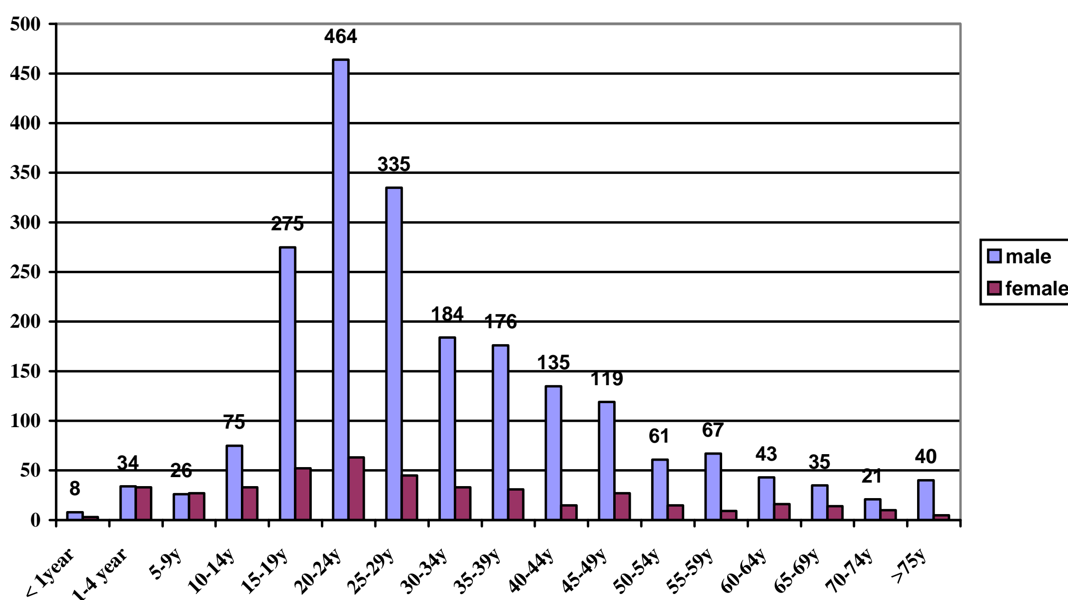
Source: Registrar General's Department (4)

Table 9.4: Distribution of youth (10–29 years) homicide victims by sex

Year	Male		Female		Total	
	No.	%	No.	%	No.	%
1992	1149	85.6	193	14.4	1342	100
1993	884	84.2	166	15.8	1050	100
1994	725	86.3	115	13.7	840	100
1995	925	80.4	225	19.6	1150	100
Total	**3683**	**84.0**	**699**	**16.0**	**4382**	**100**

Source: Registrar General's Department (4)

Figure 9.1: Distribution of homicide victims by age and sex in 1992



This report uses the World Health Report definition of youth as persons between the ages of 10 and 29 for the purpose of analyzing the youth victims of homicide. 84% of youth homicide victims are males. The youth homicides comprised of 51.9% of the total reported homicides by the Registrar General's Department. This is much higher than the expected share of youth homicides. It is only 37.4% of the total population belonging to the age group 10-29 years. Using these figures, the youth homicide rate for 2000 could be calculated as 42.6 per 100 000 population.

The calculated youth homicide rate for males is 70.5 per 100 000 population and for females is 13.4 per 100 000 population. If one considers only the homicides reported

routinely under the reportable crimes (i.e. excluding war deaths), the estimated youth homicide rate is 12.9 per 100 000 population. The youth homicide rate for males is calculated as 21.3 per 100 000 population and for females 4.1 per 100 000 population (excluding war deaths).

Table 9.5: Distribution of homicides classified under reportable crimes by place of occurrence 2000–2002

Place of occurrence (Province)	2000		2001		2002	
	No.	%	No.	%	No.	%
Western Province	394	23.0	370	23.5	443	32.9
Southern Province	243	14.2	194	12.3	234	17.4
Central Province	101	5.9	114	7.2	111	8.2
North Western Province	174	10.2	168	10.7	149	11.1
North Central Province	129	7.5	143	9.1	77	5.7
Sabaragamuwa Province	144	8.4	122	7.7	119	8.8
Uva Province	98	5.7	79	5.0	77	5.7
Northern Province	138	8.1	135	8.6	59	4.4
Eastern Province	290	16.9	251	15.9	78	5.8
Total	**1711**	**100**	**1576**	**100**	**1347**	**100**

Source: Police Department

About one fourth of the homicides classified as reportable crimes occurred in the Western Province, where the capital city of Colombo is situated (Table 9.5).

Table 9.6: Homicide rates (excluding war-related homicides) by provinces, 2001

Province	No. of homicides under reportable crimes	Total population	Homicide rate per 100 000 population
Western Province	370	5,361,000	6.9
Southern Province	194	2,277,000	8.5
Central Province	114	2,415,000	4.7
North Western Province	168	2,157,000	7.8
North Central Province	143	1,106,000	12.9
Sabaragamuwa Province	122	1,788,000	6.9
Uva Province	79	1,171 000	6.8
Northern Province	135	1,042,000	13.0
Eastern Province	251	1,415,000	17.7
Total	**1576**	**18,732,000**	**8.4**

Source: Police Department

In 2001, a homicide rate of 17.7 per 100 000 population was observed in the Eastern Province. The second highest homicide rate was registered in the Northern Province and the third was in the North Central Province. The lowest death rate 4.7 per 100 000 population was observed in the Central Province. Though the majority of homicidal deaths have taken place in the Western Province, the province's homicide rate is less than the national rate.

Weapons used for homicides: The Police records classify the weapons used for homicides in a different way than what is described in the ICD classification. However, since this is the only data available related to weapons it has been included in this report. Pointed knives and other cutting weapons are most commonly used for homicides. Use of automatic weapons such as the T-56 was also commonly seen to a certain extent from 1998 to 2000. It is likely that the present or ex-cadres of militant groups or army deserters have been involved with such killings.

Table 9.7: Weapons used for homicides, 1998–2002

Weapon	1998		1999		2000		2001		2002	
	No.	%	No.	%	No.	%	No.	%	No.	%
Pointed knife	389	20.3	330	19.1	308	18	222	14.0	310	23.0
Other cutting weapons	391	20.4	375	21.8	337	19	236	14.9	275	20.4
Club	215	11.2	177	10.2	211	12.3	125	7.9	170	12.6
Other blunt instruments	124	6.5	110	6.3	113	6.6	91	5.7	115	8.5
Shot gun	65	3.9	71	4.1	69	4.0	87	5.5	73	5.4
Rifle	14	0.7	21	1.2	8	0.5	112	7.1	16	1.1
Pistol	67	3.4	82	4.7	78	4.5	93	5.9	58	4.3
Trap gun	8	0.4	6	0.3	10	0.6	87	5.5	-	-
Automatic weapons	368	19.1	265	15.4	307	17.9	114	7.2	76	5.7
Explosives	107	5.5	77	4.4	96	5.6	118	7.2	35	2.5
Personal weapons	67	3.4	172	9.9	68	3.9	112	7.1	107	7.9
Corrosive substance	34	1.7	25	1.4	30	1.7	95	6.0	35	2.6
Others	70	3.6	90	5.2	76	4.4	84	5.3	77	5.7
Total	**1919**	**100**	**1724**	**100**	**1711**	**100**	**1576**	**100**	**1347**	**100**

Source: Administrative Reports, Inspector General of Police (5)

Relationship between victims and perpetrators: According to the study described earlier (3), in most instances there was no relationship between the victim and the suspect. The spouse had been the perpetrator in between 5% and 12.9% of homicides which occurred during the period analyzed.

Motive for killing: The commonest motive for killing is previous enmity. Other common ones include sudden provocation, land disputes and other disputes in the family. Killings due to communal reasons have come down since 2000 (3).

Occupation of victims and perpetrators: Almost all categories of employees including professionals are found among the victims as well as among the perpetrators of homicides. The proportion of unemployed is higher among the perpetrators than homicide victims (3).

Child homicides: According to the unpublished data available at the Statistics Division of the Police Department, out of the child homicides (i.e. victims aged below 18 years) more than half the victims were aged below 6 years (6). This is a very unfortunate situation as these children are helpless in such actions of the adults. Unlike in adult homicides, 70% of perpetrators of child homicides are blood / other relations (3).

Table 9.8: Distribution of child victims of homicides by age in 2004

Age group	Number	Percentage
0–5	25	53.19
6–11	5	10.63
12–17	17	36.17
Total	**47**	**100**

Source: Police Statistics Division (6)

More than 75% of child homicides were committed during the daytime. Nearly 60% of killings occured in isolated places. However, about 25% of homicides took place in the home of the perpetrator (3).

More than 60% of perpetrators of child homicides are males. But the percentage of females involved with killing of children is also unexpectedly high. Nearly 75% of perpetrators of child homicides were below the age of 40 years (3).

Table 9.9: Distribution of child victims of homicides by sex in 2004

Sex	Number	Percentage
Males	28	59.57
Females	19	40.43
Total	**47**	**100**

Source: Police Statistics Division (6)

9.3 Factors associated with homicide

Individual factors

1. Sex: Males are more susceptible for homicides than females.
2. Age: Youth are more susceptible than the other age groups. People of 20–24 years have a particularly high mortality due to homicides.
3. Certain personalities such as those who habitually involve themselves with arguments with others are more prone. Previous enmity and sudden provocation have been identified as common motives for killing.
4. Family disputes and land disputes are major causes. Those who face such disputes are more vulnerable.
5. Inadequate financial resources for individual survival/unemployment can encourage a person to engage in illegal activities.

Community factors

1. The very competitive nature of society and the rat-race people are involved in has pushed them into a money-motivated social order, subjugating the positive values. Erosion of the values of life has created a murderous mindset among some sections of the people.
2. High incidence of poverty.
3. High rate of youth unemployment.
4. War situation in North and East of Sri Lanka and communal clashes.
5. Deserters of the militant groups and state armed forces. Large numbers have left the army without following proper procedures and they are in hiding. Some of them have even kept their firearms, grenades and other hi-tech weaponry important for the armed forces.
6. Presence of underworld operatives and gangsterism.

7. The drug menace plagues society, and drug users also involve themselves in violence including killing people in search of money. In addition, drug traffickers resort to violence in establishing their business and creating a monopoly.
8. Easy access to sophisticated firearms and weaponry.
9. Absence of stringent penalties for offenders.

9.4 Interventions

Homicides could be prevented by taking action to reduce domestic violence, youth violence, child abuse and elder abuse in the society. These have been discussed in the relevant chapters.

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10. Collective violence

10.1 Introduction

This chapter discusses collective violence with special reference to Sri Lanka where collective violence inclusive of political and ethnic violence in its multi-faceted forms has plagued the country taking a heavy toll of human life. Immediately before the country gained Independence from the British in 1948, violence in any form was not common as it is today and had not assumed political or ethnic dimensions. Diverse causes that precipitated group violence too were almost non-existent and individual acts of violence – killings, rape, abductions, looting, banditry and so on were scarce with little impact on the overall social order of the country. In the pre-independence period collective violence, if at all was in the form of struggle for freedom against the foreign rulers.

Nevertheless, collective violence has emerged in the recent decades as an issue affecting the daily life of Sri Lanka. Violence and terror unleashed by groups against the State, responses of the State in return, gang warfare and underworld operations have considerably affected the Sri Lankan society. Violence in the aftermath of the clashes between the State and a group of militants in the North & East demanding autonomy has prevailed for over two decades. The easy accessibility to high-tech arms and weapons which in certain instances have fallen into the wrong hands, the army deserters in particular, has given rise to a gun culture that threatens to explode the entire social fabric of the country.

Definition

The World Report on Violence and Health (2002) defines collective violence as, "the instrumental use of violence by people who identify themselves as members of a group whether this group is transitory or has a more permanent identity – against another group or set of individuals, in order to achieve political, economic or social objectives" (1).

Forms of collective violence

Various forms of collective violence have been recognized including,

- Wars, terrorism and other violent conflicts that occur within or between states.
- State-perpetrated violence such as genocide, repression, disappearances, torture and other abuses of human rights.
- Organized violent crimes such as banditry and gang warfare.

Torture

The World Medical Association in it's Tokyo declaration in 1975, has defined torture as "deliberate systemic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the order of any authority, to force another person to yield information, to make confession or for any other reasons". However in most instances, an individual is subjected to torture as he or she is a member of a group or set of individuals (2). Accordingly, torture can also be considered as a form of collective violence. The usual victims are refugees, detainees, prisoners of war, and members of minority or even majority ethnic groups etc. Torture can also take place to a lesser extent in other forms of violence such as child abuse, youth violence, elder abuse, domestic and gender-based violence.

10.2 Extent of the problem

Collective violence is not reported on a regular manner in Sri Lanka. This type of violence has assumed political or ethnic dimensions. There have been periods of political/ ethnic violence followed by short or long periods of non-violence. Therefore, the information and data on collective violence would be presented in a historical perspective than providing data and information for each year.

Furthermore, as mentioned in chapter 2 there is no routine surveillance system on collective violence and what is mentioned here are the data obtained from documents published on this subject and by focus group discussions held in the Ministry of Health for the purpose of compiling this report. It was not possible to separate data related to collective violence from the information provided by the Registrar General's Department and the morbidity data provided by the Medical Statistician of the Ministry of Health.

A brief historical review of political and ethnic violence in Sri Lanka

Except for identified few instances, the political violence in Sri Lanka limited to pre- and post- election violence at the times of election since independence (3). It occurred in different severity at different times and now on decrease in severity. The available literature indicates that the collective violence is connected with poverty, corruption, underworld gangsterism and drug menace (3,4,5).

Political violence

Collective violence in a severe form was seen in 1971 when a group of disgruntled youths took up arms against the state. The state was taken unawares and though swift action was taken by the state it left a trail of destruction of life and property. The youth responded to a call by the government to lay down arms and surrender on conditions of complete amnesty and a process of rehabilitation was instituted (3). Temporary accommodations for them were given in the camps set up in the two universities Vidyodaya and Vidyalankara. They were gradually incorporated into the society and some of them have even held substantial posts in the social institutions.

Although the movement went underground for a reasonable period, it raised again in late 1980s with the policy of the government changed in order to devolve the power to the provinces. This time the terror tactics were more coordinated and targeted not only the state infrastructure but the members of the armed forces and their families. In addition many criminal elements of the society infiltrated the movement for their personal advantage. These activities reached a peak in 1989 when the day to day affairs of the government and the civil society was affected severely. The insurrection ended with the arrest of the leaders and many of their associates. The same movement many years later entered the mainstream politics and is in a strong position in the political arena today.

Beginning of the North / East crisis

Sri Lanka is facing the long standing and well-known instance of violence in the North and East provinces where a group has taken up arms asking for a separate state. Historically the concerted and combined effort of Sinhalese who were and still are the majority, Tamils and Moslems guided by their leaders resulted in gaining independence from the British without a struggle.

By 1950s when legislative changes regarding the use of Sinhalese as the official language the Sinhalese Only Act were made suspicion and doubt was created in the minds of the Tamils regarding the intentions and the motives of the state resulting in an environment of unease. Although there was sporadic violence occurred, it became a significant entity in 1983 when a group armed themselves and identified themselves as 'Liberation Tigers of Tamil Eelam (LTTE)' and launched violent activities demanding a separate state. According to the Presidential Truth Commission on Ethnic Violence 2002 the whiplash violence that followed the killing of 13 Soldiers by militants in the North escalated this conflict (6). Such escalations of violence occurred at different periods such as 1956, 1958, 1971, 1976, 1977 and one of the worst in 1983.

The Cease-Fire Agreement (CFA) was signed between the state and the LTTE in 2002 and there was relief from hostilities throughout the country although sporadic violations of the agreement continued, each party claiming that the opposite party made more violations.

The violations of the CFA escalated towards the latter part of 2007 and eventually the CFA ended in January 2008.

10.3 Factors associated with political and ethnic violence

1. Political victimization with the change of governments.
2. High rate of unemployment and the perceived need of political influence for appointment and promotions.
3. Rampant incidents of bribery and corruption leading to a disposition that any act of crime can be hushed up with gratifications.
4. High rate of poverty and many people could be motivated to engage in violent activities by offering a small amount of money.
5. Breakdown of the system of law and order in some areas.
6. Inadequacy of stringent and deterrent penalties for the offenders of collective violence due to a variety of reasons.
7. Inequity in the distribution of resources by Provinces and sometimes by different ethnic and religious groups.
8. Perceived in-equal political patronage for activities of different religions and of different ethnic groups.
9. Inadequate resources for the organizations maintaining the law and order.
10. Presence of underworld operations and gangsterism, especially in major cities.
11. Easy access to high-tech sophisticated firearms and weaponry.
12. The drug menace plaguing the society which is responsible for many crimes in the society including political and ethnic related violence.

10.4 Consequences of collective violence

Impact on health

Collective violence both political and ethnic has had a negative impact on the health care of the country. The difficulty on the part of the displaced and the refugees in camps to gain access to medical care is one dimension; trials and tribulations encountered by the medical personnel in the conflict–stricken areas to discharge their duties efficiently is another facet. Staffing and maintaining the medical institutions and the support services in areas inaccessible to state officials are other issues. The victims who have been exposed to the war

and undergone traumatic experiences leading to physical and mental stress become the responsibility of the health sector.

In conflict situations, as it is globally accepted children and women are the most vulnerable groups who are forced to bear the brunt of consequences of armed clashes, sometimes with adverse impacts lasting a lifetime.

The early consequences of physical torture include injury to the chest, head and other organs or visceral problems of the abdomen like renal impairments. The late consequences are infections, temporary and permanent disabilities, and post traumatic stress disorder. Common symptoms in what has been called 'war neurosis' are dejection, weariness, tension, irritability, hypersensitivity, startled reaction, sleep disturbance and tremors; or more specially anxiety phobias and depression (7). In clinics held in refugee camps, the majority of cases, apart from skin conditions (e.g. scabies), gastrointestinal disturbances (e.g. diarrhoea and peptic ulcer) and upper respiratory tract infections, were suffering from transient stress relations, reactive depression and anxiety. They manifested somatic symptoms of which the following were common: headache, dizziness, dyspepsia, backache, palpitation, chest pain, paresthesiae and other multiple complaints for which no obvious organic cause could be found.

Impact on economy

Violence in any form on a widespread scale in a country would invariably have a drastic impact on the local economy. Sri Lanka, a developing country, has been forced to inject massive doses of funds to maintain the law and order in the country, vis-à-vis a catastrophic armed struggle that has plagued all the sectors of the economy for over two decades. The maintenance of a large contingent of troops across the North and the East and the importation of high-tech, state of-the–art weaponry and other equipment have necessarily made a sizeable dent in the economy at the expense of the finances much needed for the development of the other sectors-health, education and welfare.

Impact on community and culture

Violence in whatever form it exists underscores an erosion of benign socio-cultural values. Age old deep rooted values associated with the local way of living-compassion, tolerance, amiability and non-violence are just brushed aside. Path to violence is being cemented.

10.5 Interventions and policy response

Different forms of interventions have been used by the state to curb violence. India's intervention constituted the deployment of the IPKF (Indian Peace Keeping Force) on the invitation of the Sri Lankan Government. A large contingent of Indian soldiers landed in Sri Lanka and they were deployed in the Northern and Eastern Provinces, vested with the authority of maintaining peace in the area. At least for a short while, there was a lull in the storm but in the face of heavy opposition against the IPKF by the nationalist forces the then President had to ask India to withdraw the troops.

The intensity of the demand for a separate state for the north and the east escalated with increasing violence and as a policy response the state mulled the devolution of the centralized power to the periphery. With an amendment to the constitution the Provincial Council system was set-up. The desired goals could not be achieved.

Norway's intervention on the invitation of the Sri Lankan state was in the form of a team of facilitators who engaged in a diplomatic mission between the state and the LTTE to bring them on to the negotiating table. Their attempts culminated in the ceasefire agreement (CFA) which came to an end in early 2008.

10.6 Conclusions and recommendations

All peace loving citizens of the country should support the control of collective violence which takes place in a sporadic manner.

- It is obligatory on the part of the state to use all the available mechanisms and strategies to curb violence, which threatens to explode the social order. Perpetrators of violence need to be brought to book irrespective of their social standing.
- It is the Police that have the direct and the closest link with the masses in keeping the law and order, intact. It was observed in the last Presidential Election, 2005, that the Police Commission was very effective in controlling pre and post election violence.
- The ethnic violence is the scourge of the country, a cancerous growth eating into all the sectors of the country. Attempts over two decades have not brought any fruitful results and the ceasefire too ended without results. However for the country to proceed with its development goals peace should be negotiated and a solution worked out to satisfy all parties and the interests of all the communities. A policy of live and let live should prevail.
- The gun culture has to be eliminated. Those who are caught with illegal firearms in their possession should be made to face long terms of imprisonment and even the confiscation of their property can be considered.
- Organizations and authorities vested with the onerous responsibility of child protection need more teeth to prevent children from being dragged into violence. The state should go all out to create a world opinion so that all militant organizations could be pressurized to stop the child conscriptions.
- The health sector should be in preparedness to meet the health consequences particularly to manage the injured following collective violence.
- There is a need for a comprehensive counseling mechanism, in the wake of thousands of women and children who have been exposed to traumatic experiences of the conflict and are suffering from symptoms of war neurosis. They have to be got into the mainstream of the civil society. These impacts cannot be allowed to plague them throughout their life.
- Rehabilitate the youth and alternative employment should be provided for those who have taken arms under the military system of the LTTE, when lasting peace is achieved.

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11. Conclusions and recommendations

This report makes a major contribution towards understanding violence and its impact on our society. It illustrates the different aspects of violence within the local context. It was observed that all forms of violence exist in Sri Lanka. The information on certain categories of violence is very limited. However, the data related to suicides and homicides gives an idea regarding the real situation of violence in Sri Lanka. The different aspects of violence within the local context were highlighted in this report. This reminds us to take appropriate action towards its control and prevention.

Recommendations

The multifaceted nature of violence requires the engagement of both government and private organizations for the prevention of violence. The following recommendations reflect this need for multisectoral and collaborative approaches.

1. Enhance the capacity for collecting data on violence

It is important that data is collected at all levels and the standard methods of data collection should be adopted in the country. This will enable the comparison of data between different strata, sectors and also with other countries. It is strongly recommended that a surveillance format be introduced together with unintentional injuries for the hospitals which provide accident and emergency care services in Sri Lanka.

2. Establish a mechanism for inter-ministerial collaboration

Violence has been regarded mainly as a police, legal or social problem. The health sector has historically played the role of care provider for affected persons. In order to address this national problem in an effective manner, there should be collaboration between sectors that are involved with prevention of violence such as Health, Education, Labour, Justice, Social Welfare and the NGO sector. Therefore establishing a national committee on prevention of violence involving all relevant stakeholder departments is highly recommended. The Health Ministry can take the lead role in convening this national level initiative. This would ensure implementation of a national prevention programme through a multi-sectoral approach.

3. Strengthen collaboration and exchange of information on violence prevention at local level

It is important to maintain a proper working relationship between all relevant parties engaged in violence prevention. Sharing of knowledge and experience becomes vital for coordinated action. Therefore a mechanism for exchange of information on violence prevention should be established.

4. Prioritize primary prevention strategies

Primary prevention strategies have to be emphasized and prioritized in order to ensure a sustainable violence prevention programme. Preventive efforts that have to be given due consideration are:

- Social development programmes for children and adolescents and incorporating life skills development into the school curriculum.
- Encouraging good parenting practices and improved family functions.
- Launching a media campaign to change attitudes, behavior and social norms.
- Engaging primary health care workers actively to deliver positive messages to improve family harmony in the community.

5. Improve care for victims

The health system should aim to provide comprehensive care to victims of all types of violence. Improving emergency response and rehabilitation services will ensure proper care to victims.

The Health Ministry together with the Police, Judicial and Social Services should comprehensively address the problem of repeated victimization of individuals.

6. Integrate violence prevention into national policies

Violence mostly has links with gender and social inequalities. The government should promote gender equality in developing national policies in all the programmes. It is also necessary to ensure equal opportunities for all ethnic and religious groups in the country.

7. Encourage and support research on violence

Although the country has conducted various quantitative research projects by different stakeholders, the qualitative aspect of violence has not been addressed. Therefore, there is a need to conduct in-depth research on the causes, consequences, cost and prevention of violence. Research on risk and protective factors related to different types of violence is another important area for research.

Annex

RESOURCE LISTINGS OF SELECTED ORGANIZATIONS CONCERNED WITH PREVENTION OF VIOLENCE

GENDER-BASED VIOLENCE

Action Network for Migrant Workers (ACTFORM)

Affected Women's Forum
Office located: R.K.M Road, Akkaraipattu

All Ceylon Women's Buddhist Congress

Centre for Women and Development (CWD)
Office located: Jaffna

Centre for Women's Research (CENWOR)
Address: 225/4, Kirula Road, Colombo 05
Telephone: 2502153

Empowered Women's Forum
Office located: Moneragala

Hanguranketha Women and Children's Forum
Office located: Hanguranketha

Hill Country Women's Forum
Office located: Polgollawatte

Kantha Shakthi
Office located: Colombo and Balangoda

Muslim Women's Research and Action Forum
Office located: Colombo

National Committee on Women, Ministry of Women Empowerment and Social Welfare
Address: 177, Nawala Road, Narahenpita, Colombo 05
Telephone: 2368841

Raja Rata Kantha Padanama
Office located: Kekirawa

Rural Women’s Front
Office located: Kirindiwela

Rural Women’s Organization
Office located: Hambantota

Rural Women’s Organization Network
Office located: Galle

Sarvodaya Women’s Movement
Office located: Moratuwa

Sinhala Tamil Rural Women’s Network
Office located: Nuwara Eliya

Sri Lanka Campaign to End Violence against Women
Office located: P. O. Box 2006, Colombo

Sri Lanka Federation of University Women
Office located: Colombo

Sri Lanka Muslim Women’s Conference
Office located: Colombo

Sri Lanka Women's Conference
Office located: Colombo

Sri Lanka Women Lawyers' Association
Office located: Colombo

Sri Lanka Women’s NGO Forum (SLWNGOF)
Address: 20/1, 8th Lane, Nawala
Telephone: 2805127
E-mail: womedia@sltnet.lk

Suriya Women’s Development Centre (SWDC)
Address: 20, Dias Lane, Batticaloa
Telephone: 065 2223297
E-mail: suriyaw@sltnet.lk

The Women and Media Collective (WMC)

Uva Wellassa Women Farmers' Organization
Office located: Buttala

Voice of Women
Office located: Colombo

Women and Development Centre
Office located: Kandy

Women's Bureau of Sri Lanka, Ministry of Women's Affairs
Address: 177, Nawala Road, Narahenpita, Colombo 05
Telephone: 2368297
E-mail: MWA@sltnet.lk

Women's Counseling Centre
Office located: Ratnapura

Women's Development Centre
Office located: Kandy

Women's Development Federation
Office located: Hambantota

Women's Development Forum
Office located: Batticaloa

Women's Development Foundation
Office located: Akkaraipattu

Women's Development Foundation
Office located: Kurunegala

Women's Education & Research Centre
Address: 58, Dharmarama Road, Colombo 06
Telephone: 2590985, 2596313

Women in Need (WIN)
Address: 122, Cotta Road, Colombo 08
Telephone: 4718585, 2671411
E-mail: win@eureka.lk

CHILD ABUSE AND NEGLECT

National Child Protection Authority
Address: 330, Thalawathugoda Road, Madiwella, Sri Jayawardnepura Kotte
Telephone: 2778911 – 3
Fax: 2778915
E-mail: ncpa@childprotection.gov.lk

Department of Probation and Child Care Services
Address: 150A, LHP Building, Nawala Road, Nugegoda
Telephone: 2853596, 2853549

Children's Secretariat, Ministry of Social Welfare
Address: 5th Floor, "Sethsiripaya", Battaramulla
Telephone: 2888424
Fax: 2877376

Save the Children
Address: 58 A, Horton Place, Colombo 07
Telephone: 2672668, 2672670
Fax: 2672671
E-mail: office@scfsl.chilalliance.org

Child Protection Society of Ceylon
Address: 185, Union Place, Colombo 03
Telephone: 2446080

YOUTH VIOLENCE

National Youth Services Council
Address: 65, High Level Road, Maharagama
Telephone: 2850759, 2850990
E-mail: youngnet@slt.lk

ELDER ABUSE AND NEGLECT

National Secretariat for Elders
Address: 150A, LHP Building, Nawala Road, Nugegoda

Help Age Sri Lanka
Address: P.O Box 09, 102, Pemananda Mawatha, Raththanapitiya, Boralesgamuwa
Telephone: 2803752 – 4
E-mail: helpage@sltnet.lk

NGO Forum on Ageing
Telephone: 2365593, 2581315, 2698619, 2573157

SELF-INFLICTED VIOLENCE

Sumithrayo
Address: 60 A, Horton Place, Colombo 07
Telephone: 2692909, 2683555

Sahanaya
Address: 96/20, Kitulwatta Road, Colombo 8
Telephone: 685960
E-mail: sahanaya@panlanka.net

COLLECTIVE VIOLENCE

Presidential Committee on Ethnic Violence, Ministry of Relief, Reconstruction & Rehabilitation
Address: 177, Galle Road, Colombo 03

OTHERS

Family Health Bureau, Ministry of Health
Address: 231, De Saram Place, Colombo 10

Human Rights Commission of Sri Lanka
Address: 36, Kynsey Road, Colombo 08
Telephone: 2694925, 2673806

Police Headquarters
Address: Sir Baron Jayathilake Mawatha, Colombo 1

Lawyers for Human Rights and Development (LHRD)

Human Rights Documentation Centre

International Centre on Ethnic Studies
Address: 2, Kynsey Terrace, Colombo 08

Sarvodaya
Address: No.98, Rawatawatta Road, Moratuwa
Telephone: 2647159, 2655255
E-mail: edo@sarvodaya.lk

Department of Social Services
Address: 150A, LHP Building, Nawala Road, Nugegoda
Telephone: 2825235

Department of Labour
Address: Labour Secretariat, Kirula Road, Narahenpita, Colombo 5
Telephone: 2368164
E-mail: slmol@slt.lk

INTERNATIONAL AGENCIES

International Labour Organization
Address: Country Office, UN Compound, 202-204 Bauddhaloka Mawatha, Colombo 07
Telephone: 2592525

United Nations Children Fund (UNICEF)
Address: Country Office, 3, Gitanjani Place, Colombo 03
Telephone: 2555270
E-mail: colombo@unicef.org

World Health Organization (WHO)
Address: Country Office, 226, Bauddhaloka Mawatha, Colombo 07
Telephone: 2502319, 2502842
E-mail: borra@whosrilanka.org

United Nations High Commission for Refugees (UNHCR)
Address: 97, Rosmead Place, Colombo 7
Telephone: 2683968
E-mail: lkacoweb@unhcr.org

United Nations Development Programme (UNDP)
Address: 202-204, Bauddhaloka Mawatha, Colombo 7
Telephone: 2580691

United Nations Population Fund (UNFPA)
Address: 202-204, Bauddhaloka Mawatha, Colombo 7
Telephone: 2580840

International Organization on Migration (IOM)
Address: 31, Police Park Avenue, Colombo 3
Telephone: 5351941
E-mail: ginaw@iomsrilanka.org

Canadian International Development Agency (CIDA)

Address: Canadian High Commission, 6, Gregory's Road, Colombo 7
Telephone: 5226232

CARE International
Address: 7A, Gregory's Road, Colombo 7
Telephone: 2662905

Oxfam – Great Britain
Address: 8, Kinross Avenue, Colombo 04
Telephone: 2506944, 2585965
E-mail: Colombo@oxfam.lk

World Bank (WB)
Address: 73/5 Galle Road, Colombo 3
Telephone: 5561323, 2448070

International Monetary Fund (IMF)
Address: Level 14, Central Bank Building, Colombo 1
Telephone: 2477155

Asian Development Bank (ADB)
Address: 49/14, Galle Road, Colombo 3
Telephone: 2387055
E-mail: apio@adb.org

Food and Agriculture Organization (FAO)
Address: 202-204, Bauddhaloka Mawatha, Colombo 7
Telephone: 2580798
E-mail: fao-lk@fao.org