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SURVEY ARTICLE

Knowledge and Attitude Towards Intimate Partner Violence Among Ever-Married Women: A Cross-Sectional Study from Sri Lanka

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ABSTRACT

Effective approaches are needed to address high prevalence of intimate partner violence (IPV) against women in developing countries. Among them, addressing the attitudes of women justifying IPV is crucial. Yet, Sri Lankan studies so far have not adequately examined the community members' knowledge and attitude toward IPV. Hence, this study aimed at i) describing knowledge and attitude towards IPV among women, ii) explore the association of socio-demographic variables with knowledge and attitude towards IPV, and iii) examine the association of knowledge and attitude with the abuse experiences. A cross-sectional survey was conducted with women (n = 600) aged 15-49 years from a selected health administrative area in Sri Lanka. Multistage cluster sampling was used to select participants and data collection was performed using an interviewer-administered questionnaire. Descriptive summaries, cross-tabulations and logistic regression analysis were performed to describe and explore the associations. Most respondents had poor knowledge (64.3%, n=386) on IPV with approximately half of them having attitudes generally justifying IPV (48.7%, n=292). Women with low levels of education and low household income were more likely to justify IPV. Further, employed women had good knowledge on IPV. Poor knowledge on IPV increased the risk of being abuse by 1.5 times and women who had justifying attitudes toward IPV had two times risk of being abuse. The necessity of interventions to be targeted on knowledge and attitudes and the contributory socio-demographic factors such as education, employment and income are emphasized.

Keywords: Abuse, women, socio-demographic factors, knowledge, attitude

1 Introduction

Intimate partner violence (IPV) is widely recognized as a serious public health problem and as an important human right concern. It is a serious cause of poor physical and mental health to both partners, their families and creates significant impact on society and economy (Campbell et al., 2002; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Semahegn et al., 2019; World Health Organization, 2012). Although both men and women experience IPV, the vast burden is on women (Black et al., 2011; Heise, Ellsberg, & Gottemoeller, 1999; Tjaden & Thoennes, 2000). Globally 30% of ever-married women have experienced IPV during their lifetime. IPV prevalence varies between countries in terms of physical abuse (13%-61%), emotional abuse (20%-75%), sexual abuse (6%-59%), and controlling behaviours (21%-90%)(WHO, 2005). Among the global burden of disease (GBD) regions, highest IPV prevalence reported from Central sub-Saharan Africa (65.6%), whereas the South-East Asian region has reported a prevalence of 28.0% (WHO, 2013). As a country in the South-East Asian region, IPV prevalence of Sri Lanka varies between 18.3% and 60% with a recent study indicating 38.6% being abused during their lifetime and 15.9% being abused during the past 12 months (Muzrif, Perera, Wijewardena, Schei, & Swahnberg, 2018; Perera, Gunawardane, & Jayasuriya, 2011). The reported high prevalence of IPV and the wide range of health, social and economic

consequences reveals overwhelming burden of IPV and its effect on women. (Black et al., 2011; Heise et al., 1999; Tjaden & Thoennes, 2000; WHO, 2012).

The risk of IPV can be influenced by factors arising from the individual, relationship, community and societal levels (Ellsberg & Heise, 2005). Attitudes justifying IPV increase the risk of IPV perpetration and victimization of individuals (Abramsky et al., 2011; Semahegn et al., 2019; Wang, 2016). In the relationship level, women are more abused when IPV is treated as a matter of privacy (Ellsberg & Heise, 2005). Community-level factors such as male peer groups approving men's violence, justifying the use of violence to settle disputes, providing nonspecific excuses and weak community sanctions normalize and create acceptance of IPV within communities (Benebo, Schumann, & Vaezghasemi, 2018; Beyer, Wallis, & Hamberger, 2015; Ellsberg & Heise, 2005; Jewkes, 2002; McQuestion, 2003; Raghavan, Rajah, Gentile, Collado, & Kavanagh, 2009; World Health Organization and London School of Hygiene and Tropical Medicine, 2010). Societal factors including culture, social norms, power imbalance and acceptance of gender roles emphasizing male dominance are also prompting IPV (Benebo et al., 2018; Ellsberg & Heise, 2005; Semahegn et al., 2019). Research have revealed that IPV justification prevail in all societies where the percentages considerably differ across and within countries (Krug et al., 2002; Waltermaurer, 2012).

Responses addressing IPV requires positive changes in attitude towards IPV at all levels where some have focused on increasing knowledge on IPV and changing attitudes (Krug et al., 2002; Michau, Horn, Bank, Dutt, & Zimmerman, 2015). Though the link of attitude and behavior may be weak at times and changes only in attitudes may not adequately predict the behavioural change, scholars have strongly argued that attitude changes toward IPV as an essential component for sustaining IPV interventions (Gracia & Herrero, 2006; Whitaker et al., 2006; Whitaker, Murphy, Eckhardt, Hodges, & Cowart, 2013; WHO and LSHTM, 2010). Improved knowledge can increase management of IPV while improved attitudes can reduce acceptance and justification of IPV (Krug et al., 2002; Michau et al., 2015).

Past studies assessing knowledge and attitude towards IPV were largely focused on similar occupational and educational groups, yet general population-based studies are limited (Guruge, Jayasuriya-Illesinghe, Gunawardena, & Perera, 2015; Roelens, Verstraelen, Egmond, & Temmerman, 2006; Sharma, Vatsa, Kalaivani, & Bhardwaj, 2018; Wang, 2016). Studies have inadequately examined the implication of both knowledge and attitudes of general public to identify, manage and address IPV in their communities. Thus, it is important to recognize the prevailing knowledge and attitudes of a community on IPV to design appropriate interventions (Abeid et al., 2015; WHO and LSHTM, 2010).

Few studies conducted on IPV attitudes in Sri Lanka have revealed patriarchal attitudes and cultural norms of community members towards IPV (A. C. Jayatilleke, Poudel, Yasuoka, Jayatilleke, & Jimba, 2010; A. Jayatilleke et al., 2011; Perera et al., 2011). Some attitudes propagate traditional gender roles in family settings where wife is expected to be obedient and respect the husband (A. Jayatilleke et al., 2011). Studies have revealed stronger attitudes on considering marital affairs as personal matters where outsiders should not intervene (A. Jayatilleke et al., 2011). However, studies have not adequately examined both the knowledge and attitude towards IPV among Sri Lankan women and how it can influence by socio-demographic factors. Therefore, the present study aims to i) describe knowledge and attitude towards IPV among ever-married women, ii) explore their association with the socio-demographic variables and, iii) examine the association between knowledge and attitude towards IPV and their experience of abuse. This is one of the first studies which examine both knowledge and attitude towards IPV among Sri Lankan women.

2 Research Methodology

This cross-sectional study was conducted in a Medical Officer of Health (MOH) area in the Kandy district of Sri Lanka. The study population included ever-married women aged 15 to 49 years excluding women with diagnosed mental illnesses and cognitive impairments. Based on a recent IPV study conducted in Sri Lanka (Guruge et al., 2015), the prevalence rate of 30% was used to calculate the sample size (Naing, Winn, & Rusli, 2006). Calculated design effect was 1.95 with a consideration of cluster size of 20 and the intra-

cluster correlation coefficient of 0.05 (Abramsky et al., 2011). The final sample size was increased to 700 by adding 10% for non-response or non-participation errors and to include 35 clusters with 20 participants each. The multistage cluster sampling technique comprised of random and systematic sampling methods was used to select the participants. Primary sampling units were the randomly selected ten public health midwife (PHM) areas. The second stage was the selection of 35 villages within chosen PHM areas as clusters, where a number of clusters within a PHM area was decided based on probability proportional to size. Finally, 20 participants satisfying the eligibility criteria were randomly selected within each cluster.

Initially, the study instrument was developed by the Principal Investigator using the existing literature. The questions on IPV attitudes were developed considering the studies reported in the Sri Lankan context (Jayasuriya, Wijewardena, & Axemo, 2011; A. Jayatilleke et al., 2011). The prevalence questions were adapted from the questionnaire on multi-country study on women's health and domestic violence against women conducted by the WHO (Ellsberg & Heise, 2005). The clarity of questions and adapting to the specific context was improved with the inputs of health, medical and IPV experts, comments of field health staff and community members. The study instruments were translated to local languages i.e. Sinhala and Tamil and pretested in a different MOH area in the same district which represented a similar ethnic and socio-economic characteristic to the study area. Four research assistants were recruited and trained for data collection. The training aimed at six aspects: improving understanding of IPV; validity of data collection; safeguarding the confidentiality and privacy, respecting the autonomy of every individual; safety measures for both interviewee and interviewer; ethics and practice on field data collection and field sessions on conducting study protocols (Campbell et al., 2002; Ellsberg & Heise, 2005). During data collection research assistants were randomly checked at least once during two weeks to maintain uniformity of questioning and to avoid information bias.

The developed interviewer-administered questionnaire titled 'knowledge, attitudes, practices, determinants and prevalence of IPV' consisted of the following components: Component I - socio-demographic characteristics; Component II - knowledge, attitudes, practices and determinants of IPV; Component III – the prevalence of IPV. Knowledge on IPV was assessed using the following four items: any kind of awareness/education on IPV, knowledge on different types, consequences and available prevention methods/support services to reduce or prevent IPV. In absence of a prevention method/support service availability, the participants' knowledge was assessed whether they are able to suggest any prevention method/support service. Attitudes on IPV was assessed using 12 items categorized into three subcomponents; categorization of IPV act/impact/type (three statements), specific approvals for tolerating IPV (six statements) and confronting IPV (three statements). Questions on attitude were presented with the preamble "Following are some attitudes on violence that occur between intimate partners. For each of the statement, indicate your level of agreement/disagreement based on the given scale of strongly agree, agree, disagree and strongly disagree." Participants with IPV, who experienced any abuse (physical, psychological, sexual abuse and controlling behaviours) at least once during their lifetime was considered as 'ever abuse' and any abuse (physical, psychological and sexual abuse) during the last 12 months was considered as 'current abuse'.

Descriptive summaries, cross-tabulations and logistic regression were performed to describe and explore the associations. On a logical basis, some independent variables were combined to reduce the number of categories. Primarily data were presented as the proportion of responses to each question/statement. Assessment of knowledge was measured by giving scores to the correct responses and the total score for the knowledge component was 28. It was dichotomized by splitting 50% or less (score of 14 or less) as 'poor' knowledge and more than 50% (score of more than 14) as 'good' knowledge on IPV. Assessment of attitude was measured on the Likert scale for the given 12 attitudes. Scales were transformed to numerical scores [strongly agree (-2), agree (-1), disagree (+1), strongly disagree (+2) and don't know (0)]. The total score given for attitude ranged from – 24 to + 24. It was dichotomized by splitting 50% or less (score of ≤ 0) as 'agreed' with attitudes justifying IPV and more than 50% (more than 0) as 'disagreed' with attitudes justifying on IPV. Finally. The outcome variables were considered as knowledge on IPV (poor/good) and

attitudes toward justifying IPV (agreed/disagreed). Cross tabulations and logistic regression were performed to determine associations of participants' socio-demographic characteristics with knowledge and attitude outcomes. Logistic regression was performed to determine associations of 'ever abuse' and 'current abuse' with participant knowledge and attitude scores. Data analyses was performed using the software Statistical Package for the Social Sciences (SPSS) version 20. Significance level was set at < 0.05.

To conduct this study, ethical clearance was obtained from the Ethics Review Committee of the Faculty of Applied Sciences, Rajarata University of Sri Lanka (Reference number – ERC/007/16). Permission to conduct this study in the area was sought from the Regional Director of Health Services, Kandy. Informed written consent was obtained from the respondents before administering the questionnaire by providing an information sheet and clearly explaining the details of the study. Participants were informed about the objectives of the study, potential risks, voluntary participation and the right to withdraw from the study at any stage. Measures were taken to ensure privacy and confidentiality. Data collected anonymously and safely located with limited access only to the research team.

3 Results

3.1 Knowledge on IPV

Table 1 presents the descriptive statistics of knowledge on IPV. Among the participants, 85.3% (n=512) had received some kind of awareness on IPV. The most common source of awareness was media (n=252, 49.2%) followed by friends (n=147, 28.7%). Only 11.9% (n=61) were aware of IPV from a formal course, training or a workshop. Participants were mainly aware of IPV effects on children (n=276, 46.4%), family (n=268, 45.0%) and health (n=211, 35.5%). Impact on mental wellbeing and education were mentioned in relation to the effects on children. Separation from the partner, family disruption and effect on other family members were the commonly recognized effects on the family. Identified health effects included homicide, suicide, mental health problems, injuries and physical health effects such as wounds and illnesses. The proportion of respondents who identified economical (n=24, 4.0%) and societal effects (n=33, 5.5%) were low. Only 32.3% (n=194) were aware of available methods and support services to prevent or reduce IPV. Respondents who were unaware of available prevention methods or support services, mainly suggested involvement of friends and family to solve IPV (n=124, 20.7%). However, 18.5% (n=111) of the participants did not suggest any prevention method or support service to reduce or prevent IPV.

Table 1: *Descriptive statistics of knowledge on IPV*

Component of knowledge	**No. of responses* (N=600)**	**Percentage (%)**
Methods of IPV awareness		
Respondents aware of IPV	**512**	**85.3**
Formal course/training/workshop	61	11.9
Media	252	49.2
Social media	8	1.6
Friends	147	28.7
Other means	154	30.1
Awareness on IPV effects		
Affects health	211	35.5
Affects economy	24	4.0
Affects family	268	45.0
Affects children	276	46.4
Affects society	33	5.5

Component of knowledge	**No. of responses* (N=600)**	**Percentage (%)**
Other effects	41	6.9
Awareness on available prevention methods and support services**		
Aware on prevention methods and support services	**194**	**32.3**
Social services	31	16.0
Health services	17	8.8
Services for women	27	13.9
Legal services	53	27.3
Religious interventions	9	4.6
Family and friends involvement to reduce solve IPV	33	17.0
Villagers involvement to solve IPV	31	16.0
Other	21	10.8
Knowledge on suggesting prevention methods and support services		
Awareness through training/lectures/workshops/	43	7.2
Establishment of counselling services	74	12.3
Law enforcement to address IPV	29	4.8
Religious interventions to reduce IPV	14	2.3
Friends and family involvement to solve IPV	124	20.7
Alcohol prevention activities	9	1.5
Improve communication between intimate partners	53	8.8
Other prevention methods	228	38.0
Don't know	111	18.5

*Multiple responses were considered

**Proportions are presented from respondents who were aware on prevention methods

Figure 1 presents respondents awareness on different types of abuse. Among them, 49.5% (n=297) stated that physical abuse such as 'slapping' or 'pushing' should be always considered as violence. Some respondents did not consider 'scolding in a threatening manner' (n=127, 21.2%) and 'forcing sex' (n=77, 12.8%) as a type of abuse.

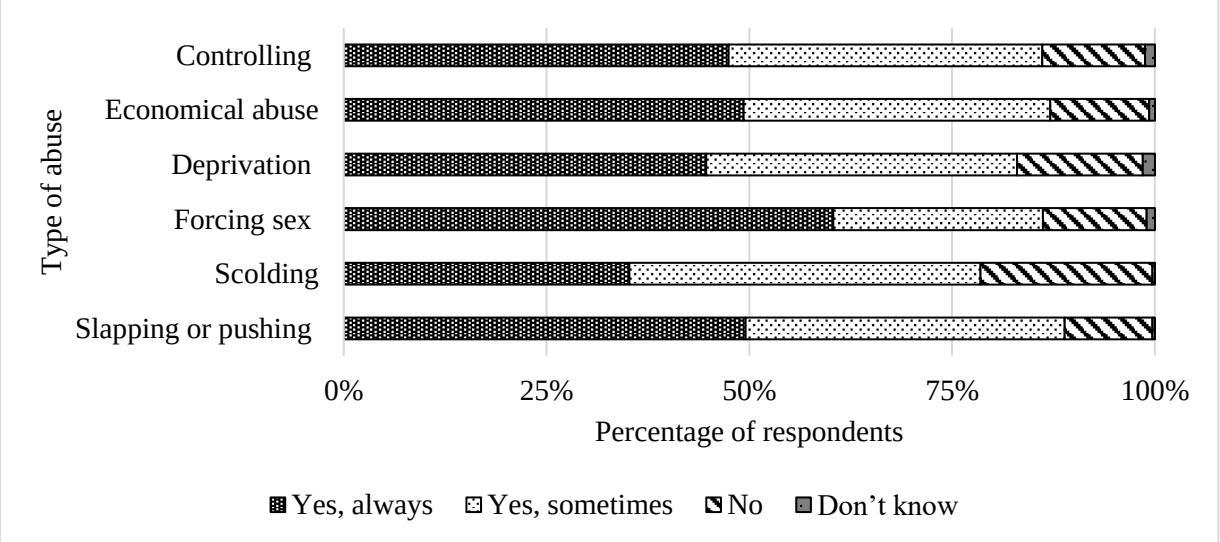

Figure 1: *Awareness on types of abuse*

3.2 Attitudes toward IPV

Table 2 presents descriptive statistics of attitude towards IPV. The most common attitude justified by women is 'IPV is a personal matter and outsiders should not intervene' (n=463, 77.6%). The second most common was 'IPV will resolve with time' (n=442, 75.3%) followed by 'IPV should be tolerated for the family' (n=405, 68.1%). Approving IPV due to alcohol use (n=552, 92.3%) and uncontrolled anger (n=483, 81.9%) were disagreed by the respondents.

Table 2: *Descriptive statistics of attitude towards IPV*

Attitude statement	**Agreed n (%)**	**Disagreed n (%)**
Attitudes on categorizing IPV act/impact/types		
- If the wound is small, there is nothing much to worry about that	239 (40.2)	355 (59.8)
- It is acceptable to blame the wife, rather than beating	235 (39.7)	357 (60.3)
- The attention given by the community members towards the violent incident depends on the harm it has caused	331 (56.6)	254 (43.4)
Specific approvals for tolerating violence		
- Violence should be tolerated in an intimate relationship	359 (60.1)	238 (39.9)
- As a woman, the wife should tolerate violence	281 (47.0)	317 (53.0)
- For the sake of family wellbeing, the wife should tolerate violence	405 (68.1)	190 (31.9)
- It is acceptable to beat when the wife has an irresponsible behavior	325 (54.9)	267 (45.1)
- It is acceptable to beat when the husband has consumed alcohol	46 (7.7)	552 (92.3)
- It is acceptable to beat when the husband has uncontrolled anger	107 (18.1)	483 (81.9)
Attitudes on confronting or preventing violence		
- IPV is a personal matter and outsiders should not intervene	463 (77.6)	134 (22.4)
- IPV will resolve with time	442 (75.3)	145 (24.7)
- IPV cannot be prevented	187 (31.7)	402 (68.3)

Note: Response of "do not know/refused to answer" excluded from the analysis

3.3 Association between socio-demographic characteristics and knowledge and attitude towards IPV

Table 3 present the association between socio-demographic characteristics and knowledge and attitude towards IPV**.** Current marital status of majority of the respondents were married (n=580, 96.7%). With regard to the sector of residence, 40% (n=240) were urban, 30% (n=180) were rural, and 30% (n=180) were estate. Approximately half of the respondents belonged to the categories of no education (n=21, 3.5%) and primary or junior secondary level (47.5%, n=285). Among 25.2% (n=151) women who were employed, majority belonged to the estate sector occupations. Most women (n=289, 48.2%) belonged to the lowest income category with less than LKR 34,999/= monthly household income.

Among the respondents 64.3% (n=386) had poor knowledge on IPV and 48.7% (n=292) had justifying attitudes toward IPV. Significantly, higher proportions of women who justified IPV were found among women with no education (n=16, 76.2%), being employed (n=85, 56.3%), residing in the estate sector (n=112, 62.2%) and with low level of household income (n=163, 56.4%) ($p< 0.05$). More women who did not respond to household income also had justifying attitudes towards IPV (n=35, 76.1%).

Table 3: *The association between socio-demographic characteristics and knowledge and attitude towards IPV*

Characteristics	Total n (%)	Knowledge on IPV			Acceptance of IPV		
		Poor n = 386 (64.3%)	Good n = 214 (35.7%)	Chi² p value	Agree n = 292 (48.7%)	Disagree n = 308 (51.3%)	Chi² p value
Age categories							
15 - 29	220 (36.7)	148 (67.3)	72 (32.7)	0.03	108 (49.1)	112 (50.9)	0.88
30 - 39	279 (46.5)	165 (59.1)	114 (40.9)		133 (47.7)	146 (52.3)	
40 - 49	101 (16.8)	73 (72.3)	28 (27.7)		51 (50.5)	50 (49.5)	
Marital status							
Married	580 (96.7)	375 (64.7)	205 (35.3)	0.53*	281 (48.4)	299 (51.6)	0.90*
Divorced/Separated	13 (2.2)	7 (53.8)	6 (46.2)		7 (53.8)	6 (46.2)	
Cohabit	1 (0.2)	0 (0.0)	1 (100.0)		1 (100)	0 (0.0)	
Widowed	6 (1.0)	4 (66.7)	2 (33.3)		3 (50.0)	3 (50.0)	
Sector of residence							
Estate	180 (30)	158 (65.8)	82 (34.2)	0.17	112 (62.2)	68 (37.8)	< 0.01
Urban	240 (40)	106 (58.9)	74 (41.1)		101 (42.1)	139 (57.9)	
Rural	180 (30)	122 (67.8)	58 (32.2)		79 (43.9)	101 (56.1)	
Educational level							
No education	21 (3.5)	13 (61.9)	8 (38.1)	< 0.01	16 (76.2)	5 (23.8)	< 0.01
Primary and junior secondary	285 (47.5)	205 (71.9)	80 (28.1)		163 (57.2)	122 (42.8)	
Senior secondary education	125 (20.8)	77 (61.6)	48 (38.4)		58 (46.4)	67 (53.6)	
Post-secondary, tertiary and above	169 (28.2)	91 (53.8)	78 (46.2)		55 (32.5)	114 (67.5)	
Employment							
Housewives	449 (74.8)	303 (67.5)	146 (32.5)	< 0.01	207 (46.1)	242 (53.9)	0.03
Employed/Self employed	151 (25.2)	83 (55.0)	68 (45.0)		85 (56.3)	66 (43.7)	
Income level							
< LKR 34,999	289 (48.2)	190 (65.7)	99 (34.3)	0.10	163 (56.4)	126 (43.6)	< 0.01
LKR 35,000 – 74,999	226 (37.7)	138 (61.1)	88 (38.9)		84 (37.2)	142 (62.8)	
LKR 75,000 ≤	39 (6.5)	22 (56.4)	17 (43.6)		10 (25.6)	29 (74.4)	
Don't know, Refused/ No answer	46 (7.7)	36 (78.3)	10 (21.7)		35 (76.1)	11 (23.9)	

[#]Only variables significantly associated with attitudes towards IPV in the bivariate analyses were included in the multivariate analysis

Table 4 presents bivariate and multivariate logistic regression analysis of knowledge and attitude towards IPV. Among the variables that revealed statistically significant association with knowledge, only employment status was the strongest predictor where employed/self-employed women had good knowledge on IPV (AOR = 1.7, 95% CI: 1.2 – 2.6) compared to housewives. Women with an educational qualification of post-secondary, tertiary and above were knowledgeable on IPV compared to women with no education (AOR = 1.6, 95% CI: 0.6 – 4.3) but there was no statistically significant difference (p=0.35). Women those who were unaware of the household income or who refused to respond, had less knowledge on IPV compared to women belonging to the lowest income category (AOR = 0.5, 95% CI: 0.2 – 1.0). Disagreeing attitude towards IPV were more likely to be found among women with higher education and higher household income. The higher the level of education, the more likely the person was to have attitudes disagreeing IPV (senior secondary education: AOR = 2.7, 95% CI: 0.9 – 8.2 and post-secondary, tertiary and above: AOR=3.9, 95% CI: 1.3 – 11.9). Compared to women of less than LKR 34,999 household income, women with higher income were two times likely to have disagreeing attitude towards IPV (AOR=2.3, 95% CI: 1.0 – 5.3). Women who were unable to disclose the household income had more justifying attitudes towards IPV, compared to women with less income (AOR=0.4, 95% CI: 0.2 – 0.7).

Table 4: *Bivariate and multivariate logistic regression analysis of knowledge and attitude on IPV*

Characteristics	**Good knowledge on IPV**					**Disagreeing attitudes toward IPV**				
	n (%)	**Crude OR* 95% CI**	**p value**	**Adjusted OR** 95% CI**	**p value**	**n (%)**	**Crude OR* 95% CI**	**p value**	**Adjusted OR** 95% CI**	**p value**
Age category										
15 - 29	72 (32.7)	Reference		Reference		112 (50.9)	Reference		Reference	
30 - 39	114 (40.9)	1.4 (1.0 – 2.0)	0.06	1.4 (0.9 – 1.9)	0.12	146 (52.3)	1.1 (0.7 – 1.5)	0.75	0.9 (0.6 – 1.4)	0.74
40 - 49	28 (27.7)	0.8 (0.5 – 1.3)	0.37	0.8 (0.5 – 1.4)	0.40	50 (49.5)	0.9 (0.6 – 1.5)	0.81	0.9 (0.6 – 1.6)	0.96
Sector of residence										
Estate	82 (34.2)	Reference		Reference		68 (37.8)	Reference		Reference	
Urban	74 (41.1)	1.1 (0.7 – 1.6)	0.68	1.0 (0.6 – 1.5)	0.87	139 (57.9)	2.3 (1.5 – 3.4)	0.00	1.5 (0.9 – 2.3)	0.90
Rural	58 (32.2)	1.5 (0.9 – 2.3)	0.08	1.3 (0.8 – 2.0)	0.35	101 (56.1)	2.1 (1.4 – 3.2)	< 0.01	1.4 (0.9 – 2.3)	0.12
Educational level										
No education	8 (38.1)	Reference		Reference		5 (23.8)	Reference		Reference	
Primary and junior secondary	80 (28.1)	0.6 (0.2 – 1.5)	0.33	0.7 (0.3 – 1.8)	0.51	122 (42.8)	2.4 (0.8 – 6.7)	0.10	2.0 (0.7 – 5.7)	0.20
Senior secondary education	48 (38.4)	1.0 (0.4 – 2.6)	0.98	1.1 (0.4 – 3.1)	0.78	67 (53.6)	3.7 (1.3–10.5)	0.02	2.7 (0.9 – 8.2)	0.07
Post-secondary, tertiary and above	78 (46.2)	1.4 (0.5 – 3.5)	0.49	1.6 (0.6 – 4.3)	0.35	114 (67.5)	6.6 (2.3–19.0)	< 0.01	3.9 (1.3– 11.9)	0.01
Employment										
Housewives	146 (32.5)	Reference		Reference		242 (53.9)	Reference		Reference	
Employed/self-employed	68 (45.0)	1.7 (1.2 – 2.5)	0.06	1.7 (1.2 – 2.6)	< 0.01	66 (43.7)	0.7 (0.5 – 1.0)	0.03	0.7 (0.5 – 1.1)	0.11
Income level										

Characteristics	Good knowledge on IPV					Disagreeing attitudes toward IPV				
	n (%)	Crude OR* 95% CI	p value	Adjusted OR** 95% CI	p value	n (%)	Crude OR* 95% CI	p value	Adjusted OR** 95% CI	p value
< LKR 34,999	99 (34.3)	Reference		Reference		126 (43.6)	Reference		Reference	
LKR 35,000 – 74,999	88 (38.9)	1.2 (0.8 – 1.8)	0.27	1.0 (0.6 – 1.4)	0.92	142 (62.8)	2.1 (1.5 – 3.1)	< 0.01	1.7 (1.2 – 2.5)	< 0.01
LKR 75,000 ≤	17 (43.6)	1.5 (0.7 – 2.9)	0.25	0.9 (0.4 – 1.8)	0.72	29 (74.4)	3.7 (1.8 – 8.0)	< 0.01	2.3 (1.0 -5.3)	0.04
Don't know, Refused / No answer	10 (21.7)	0.5 (0.2 – 1.1)	0.09	0.5 (0.2 – 1.0)	0.06	11 (23.9)	0.4 (0.2 – 0.8)	0.01	0.4 (0.2 – 0.7)	< 0.01

OR – Odds ratio; *Bivariate logistic regression.

**Multiple logistic regression: age, sector, education, employment and income were included.

3.4 Association between knowledge and attitude towards IPV and ever/current abuse

Among the participants 59.5% (n=357) experienced any abuse (physical, psychological, sexual abuse and controlling behaviours) at least once during their lifetime, while 41.3% (n=248) experienced abuse (physical, psychological and sexual abuse) during the last 12 months (Table 5). Women with poor knowledge on IPV had an increased risk of ever abuse compared to women with good knowledge on IPV (OR = 1.5, 95% CI: 1.1 – 2.1). Having agreeing attitudes towards IPV increased the risk of both ever abuse (OR = 1.9, 95% CI: 1.1 – 3.3) and current abuse (OR = 2.1, 95% CI: 1.2 – 3.6) by twice.

Table 5: *Association between knowledge and attitude towards IPV and ever/current abuse*

Component		Total (%)	Ever abuse n = 357 (59.5%)			Current abuse n = 248 (41.3%)		
			n (%)	p value	OR (95% CI)	n (%)	p value	OR (95% CI)
Knowledge on IPV	Poor	386 (64.3)	216 (60.5)	0.02	1.5 (1.1–2.1)	156 (62.9)	0.54	1.1 (0.8 – 1.6)
	Good	214 (35.7)	141 (39.5)	Reference		92 (37.1)	Reference	
Attitudes towards IPV†	Agree	292 (48.7)	196 (54.9)	0.02	1.9 (1.1–3.3)	146 (58.9)	<0.01	2.1 (1.2 – 3.6)
	Disagree	308 (51.3)	161 (45.1)	Reference		102 (41.1)	Reference	

Note: †Response of "do not know/refused to answer" excluded from the analysis

4 Discussion

This study aimed to describe knowledge and attitude towards IPV among ever-married women. More respondents had poor knowledge on IPV with approximately half of them having attitudes generally justifying IPV. Knowledge on IPV was associated with employment status and attitude towards IPV was associated with level of the education and income. The study also found poor knowledge on IPV and attitudes justifying IPV increased the risk of being abuse.

Knowledge on IPV was comparatively low in terms of recognizing different natures of IPV, consequences and available support services or prevention methods. However, comparing this finding with other studies was difficult due to inadequate research assessing knowledge on IPV among Sri Lankan women. Among the various socio-demographic factors, knowledge on IPV was only associated with the employment status. This finding is not directly supported by the literature, but it may be due to employed women being more

associating with the external community. Although studies on other types of violence have identified good knowledge of violence based on the level of education (Abeid et al., 2015) the present study did not reveal a statistically significant association of knowledge on IPV with education. This may be due to approximately 51% (n=306) of women of the present study having a low level of education or no formal education. Further, comprising urban, rural and estate women with a significant disparity in educational attainment also would have contributed for poor knowledge on IPV.

The most common source of awareness method on IPV was media. Due to the power of media in formulating opinions, measures can be initiated strategically to deliver correct awareness on IPV through media (Krug et al., 2002; WHO and LSHTM, 2010). Less than 10% (n=61) have been aware of IPV through a formal method. It has been revealed that training can improve knowledge in the short term, yet problematic in sustaining changes (Krug et al., 2002; WHO and LSHTM, 2010). Approximately 10% of respondents considering well defined types of physical and sexual abuse as 'non-violence' indicates the limited perception on types of IPV. The present study identified only 32.3% (n=194) were aware of available methods and support services to prevent or reduce IPV. Yet, IPV prevention methods and support services are available in Sri Lanka (Guruge et al., 2015; Perera et al., 2011). Both limited perception and unawareness of the services may be reasons for having a very low level of help-seeking by IPV victims as reported by other Sri Lankan studies (Jayasuriya et al., 2011; Perera et al., 2011).

IPV has been justified with several attitudes where cultural norms playing a crucial role (Abramsky et al., 2011; Ellsberg & Heise, 2005; Kishor & Johnson, 2004; Krug et al., 2002; WHO, 2012; WHO and LSHTM, 2010). In accordance with this research, 48.7% (n=292) respondents generally had justifying attitude towards IPV. Several studies have produced comparable figures and have identified strong attitudes towards approving violence and patriarchy within the partner relationship (Antai & Antai, 2008; Jayasuriya et al., 2011; Krug et al., 2002). The present study revealed strong acceptance of tolerating IPV considering 'the intimate relationship' and 'the family.' Similarly, other studies have also reflected women having more concern towards family and being passionate towards intimate relationship (Ellsberg & Heise, 2005; Krug et al., 2002). The most common attitude agreed in the present study was 'IPV is a personal matter and outsiders should not intervene to solve.' This attitude has been consistently reported in other Sri Lankan studies where marital conflicts are considered personal matters in which outsiders should not intervene (A. C. Jayatilleke et al., 2010; A. Jayatilleke et al., 2011). The most common attitude disagreed in the present study was 'beating after alcohol consumption.' Habitual alcohol use is recognized as the most common and the strongest factor associated with IPV (Abramsky et al., 2011; Coker, Smith, McKeown, & King, 2000; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Jewkes, 2002; WHO, 2012; WHO and LSHTM, 2010). Yet, the finding reflects women are no more justifying physical abuse due to alcohol use.

Among the various socio-demographic factors, attitude towards IPV was associated with education and income status. The present study revealed the higher the level of education, the more likely the participants were to have disagreeing attitudes on IPV. Previous studies have reported tolerant attitudes to IPV of women with primary or no education, and lower household income (Antai & Antai, 2008). It suggests that simple reforms in education curricula can inculcate attitudes against IPV. Yet, the mechanism of how low income has been influential for women to develop tolerant attitudes towards IPV is not clear. However, low economic empowerment and dependency on men for income may have strapped them into a situation of tolerating IPV.

Sri Lankan estate communities have been recorded with a high prevalence of IPV and gender based violence (Muzrif et al., 2018; Perera et al., 2011; Senanayake, Navaratnasingam, & Moonesinghe, 2008). In the present study, women residing in the estate sector have reported more justifying attitudes towards IPV compared to both rural and urban women. This may be due to the norms operating in the estate community to be more likely to justify IPV. Prevention efforts should focus on such specific social settings and address attitudes that promote IPV (Benebo et al., 2018; Semahegn et al., 2019). Among the three sectors, rural women showed an increased knowledge on IPV compared to both urban and estate women. Yet, there was no significant difference between urban and estate women.

The present study reported comparatively higher prevalence of ever abuse and current abuse. In accordance with past studies (Kishor & Johnson, 2004), the present study revealed that abused women had more agreement with attitudes towards IPV. Although many studies have suggested traditional norms increase women's vulnerability to IPV, contradictorily some studies reveal that the wives who respect cultural norms are less vulnerable to IPV (Krug et al., 2002). A Sri Lankan study has found, wives were less likely to experience IPV when they believed 'a good wife always obeys her husband' and 'outsiders should not intervene to prevent IPV' (A. Jayatilleke et al., 2011). Some attitudes propagate traditional gender roles in family settings where wife is expected to be obedient and respect the husband (A. Jayatilleke et al., 2011). Although the present article did not separately analyze different types of IPV, conventional gender role attitudes have a stronger protective effect against psychological abuse. This may be due to women who respect cultural norms would be less unlikely to challenge the male-dominant family norms and would try to avoid conflicts with their husbands (A. Jayatilleke et al., 2011; Jewkes, 2002). Hence, further studies should examine the mechanisms of how women's attitudes influence vulnerability to IPV.

There were certain limitations in the present study. First, the study examined only the influence of socio-demographic factors influencing knowledge and attitude towards IPV, but it did not capture other possible contextual factors such as neighbouring community, exposure to media etc.,. Hence, further studies are needed to analyze the factors affecting knowledge and attitude towards IPV. Second, the possibility of recall bias which might have over-estimated or under-estimated their experiences of abuse. Third, the survey study design which provides superficial details and fails to develop a better understanding of different perspectives. However, these findings can produce conclusions generalizable for larger populations because the study was conducted in a setting representing urban, rural and estate sectors with different ethnic communities of Sri Lanka. Furthermore, a community-based survey tends to capture the knowledge and attitude of both abused and non-abused women. The fourth limitation is interviewer-administered questionnaires may affect with social desirability bias. However, compared to self-administered questionnaires use of interviewer-administered questionnaires would have improved consistency.

5 Conclusions

IPV is a serious public health concern where women suffer long lasting health problems caused by their intimate partners. Direct and indirect pathways of IPV can lead to serious physical, psychological and reproductive health problems. The present study reveals attitudes justifying IPV as an important underlying cause of IPV. One out of two women generally justified IPV and had two times risk of being abuse. Hence, the attitudes commonly justifying IPV should be targeted among women to reduce tolerance of IPV in their relationships and to reduce acceptance of IPV in their communities. Higher the level of education and higher the household income, women were more likely to disagree with attitudes justifying IPV. Hence, educational reforms could be used to develop disagreeing attitudes justifying IPV. Majority of participants reported poor knowledge on IPV and they had an increased risk of being abuse. Interventions should focus to increase knowledge on IPV in terms of types of IPV, effects and prevention methods to safeguard themselves from IPV and to sensitize women to prevent IPV in their communities. Moreover, the media should be used as an effective mode of awareness on IPV and promoting available prevention methods and support services. Further studies should explore other associations of factors influencing knowledge and attitude towards IPV.

6 Declarations

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6.3 Competing Interests

The authors declared that no conflict of interest exist.

6.4 Ethical Approval

Ethical approval was obtained from the Ethics Review Committee of the Faculty of Applied Sciences, Rajarata University of Sri Lanka (Reference number – ERC/007/16).

6.5 Informed Consent

Informed written consent was obtained from the respondents before administering the questionnaire by explaining the objectives and the relevance of the study, ensuring privacy and confidentiality. Data collected anonymously and located safely with access limited only to the research team. Confidentiality of all records were safeguarded.

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