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Addressing domestic violence through antenatal care in Sri Lanka's plantation estates: Contributions of public health midwives

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ABSTRACT

Domestic violence in pregnancy is a significant health concern for women around the world. Globally, much has been written about how the health sector can respond effectively and comprehensively to domestic violence during pregnancy via antenatal services. The evidence from low-income settings is, however, limited. Sri Lanka is internationally acknowledged as a model amongst low-income countries for its maternal and child health statistics. Yet, very little research has considered the perspectives and experiences of the key front line health providers for pregnant women in Sri Lanka, public health midwives (PHMs). We address this gap by consulting PHMs about their experiences identifying and responding to pregnant women affected by domestic violence in an underserved area: the tea estate sector of Badulla district. Over two months in late 2014, our interdisciplinary team of social scientists and medical doctors met with 31 estate PHMs for group interviews and a participatory workshop at health clinics across Badulla district. In the paper, we propose a modified livelihoods model to conceptualise the physical, social and symbolic assets, strategies and constraints that simultaneously enable and limit the effectiveness of community-based health care responses to domestic violence. Our findings also highlight conceptual and practical strategies identified by PHMs to ensure improvements in this complex landscape of care. Such strategies include estate-based counselling services; basic training in family counselling and mediation for PHMs; greater surveillance of abusive men's behaviours by male community leaders; and performance evaluation and incentives for work undertaken to respond to domestic violence. The study contributes to international discussions on the meanings, frameworks, and identities constructed at the local levels of health care delivery in the global challenge to end domestic violence. In turn, such knowledge adds to international debates on the roles and responsibilities of health care professionals in responding to and preventing domestic violence.

1. Introduction

Sri Lanka's achievements in maternal and child health (MCH) are widely acclaimed in the South Asia region, and often put forward as an example for other low-income countries. The maternal mortality ratio (MMR) has declined steadily since the 1930s to 29 per 100,000 live births in 2013, a figure significantly lower than other South Asian countries, such as India and Nepal, which both had MMRs of 190 in the same year (World Bank, 2015). Nearly all (99%) pregnant women today have at least one antenatal care visit, and 98% of births occur in a hospital in the presence of a skilled attendant (Senanayake et al., 2011; United Nations Children's Fund, 2009). To a large extent, this situation is attributed to the expansion and decentralisation of infrastructure for pregnancy care and delivery, as well as investment in the increased presence of trained,

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community-based public health midwives (PHMs). Sri Lanka's PHMs are considered the 'backbone' of the public health care system (Senanayake et al., 2011). They provide the majority of MCH and family planning services at the community level, as well as public health and preventative health duties such as immunisations and nutritional assessments.

Amidst this success story however, maternal health in Sri Lanka is significantly compromised by pervasive violence in all spheres of women's lives (de Mel et al., 2013; Jayasuriya et al., 2011; Jegathesan, 2013; Moonesinghe et al., 2004). Sri Lanka's MCH achievements are also tempered by inequalities in indicators of maternal health across segments of society, with Tamil women in the tea estate sectors amongst the populations who fare the worst (Hollup, 1994; Hyndman, 2014).

The setting for this study is the tea estate sector of Badulla district. Poverty and gender-based violence (GBV) are widespread in Sri Lanka's estates, and the estate populations lag behind national figures on the majority of key health indicators (Centre for Poverty Analysis, 2005; Wijayathlake, 2003). GBV covers a range of events directed at women and girls because of their sex; for example, human trafficking, female infanticide, and intimate partner violence. Our focus is domestic violence, one of the most pervasive forms of GBV. Domestic violence is a significant health concern during pregnancy as the consequences can be severe, including depression and suicide, preterm births, low birth rates and fetal death, amongst many others (Shah and Shah, 2010). In Sri Lanka, prevalence surveys over the past three decades have produced estimates of domestic violence ranging from 18% to 72% (Jayasuriya et al., 2011; Moonesinghe, 2002; Samarasinghe, 1991; Subramaniam and Sivayogan, 2001), including 42% during pregnancy (Deraniyagala, 1992).

The importance of health sector responses to domestic violence is now well established given that the vast majority of women worldwide access health services at some point in their lives (Chibber and Krishnan, 2011). Antenatal care (ANC) services have been recognised as a particularly unique 'window of opportunity' to intervene to potentially safeguard the health of abused women and their unborn children (Yimer et al., 2014). Over the past decade, Sri Lanka's Ministry of Health has made some effort to improve the capacity of public health professionals to assist pregnant women experiencing domestic violence, notably through the development of a training module on all types of GBV for health care providers. However, there is still an acute lack of health care interventions that effectively increase the safety of pregnant women living with domestic violence in low-income settings in general (Jahanfar et al., 2013). In Sri Lanka, the key role of the front line health service providers for pregnant women, PHMs, is also strikingly absent in the public health and GBV research evidence. Without such knowledge, we are left with an inadequate understanding of the nature and underlying causes of domestic violence in Sri Lanka and how to improve health sector prevention and response work in the future.

We begin to address these gaps with this study by exploring PHM's experiences identifying and responding to pregnant women affected by domestic violence in the estates of Badulla district. Our argument is developed in several stages. In the first section of the paper, we present the historical roots of and present day vulnerabilities to ill-health and domestic violence in our study setting. Next, we introduce our conceptual framework, a modified livelihoods model; then we describe our study methodology. Over the remainder of the paper, we develop our conceptual framework in relation to our major findings from fieldwork in Badulla's estates. We highlight the complex interplay of physical, social and symbolic assets, strategies and constraints of PHMs in these settings that estate PHMs navigate in their work. We conclude the paper by offering locally-relevant suggestions for future antenatal care policies and interventions.

1.1. Vulnerabilities

1.1.1. Historical roots of modern ills

The plantation estates of Badulla district are located in a mountainous region of central Sri Lanka. The majority of the district's population is engaged in agricultural work, many employed by the 161 tea plantation estates in the region (Badulla District Secretariat, 2012). Sri Lanka is one of the world's largest exporters of tea. The origins of the tea plantations date back to the mid-1800s when the country was under British rule. During this era, British planters brought low-caste, primarily Tamil-speaking labourers from villages in South India to work in Sri Lanka's plantations (Ilyas, 2014). For most of their history in Sri Lanka, the migrant plantation labourers lived and worked in deplorable conditions, responsible for much of the economic production of the nation yet largely excluded from the financial benefits of such productivity (Ilyas, 2014; Jegathesan, 2013). Plantation Tamils have also historically occupied a precarious social position in Sri Lanka, being denied citizen rights until 2003 (with the exception of a few years). As non-citizens, they had few basic entitlements: they could not vote; own land or property, access health services or education, or secure government employment outside the estates; procure identity cards or open bank accounts (Philips, 2003a).

The management of health services for estate Tamils has been similarly unstable, shifting between a private health system managed by the plantation companies and the public sector a few times since the 1800s. Most recently, in 2006, estate hospitals and other health services were taken over by the Ministry of Health. These shifts have resulted in suboptimal health facilities and staffing compared with national norms, which has in turn directly and negatively affected the health and wellbeing of estate residents (Jegathesan, 2013). Today, labour, land, and housing for plantation workers are controlled by the plantation estate owners and management, but health services are being continuously re-integrated into the national health framework. Plantation workers are therefore entitled to access free government health care, as well as private clinics off the estates. Such services, however, are not easily accessible for many estate residents given their long work hours in the plantations and lack of transportation or resources to travel from typically remote areas; hence, health inequalities persist.

1.1.2. Framing domestic violence in the estates

There are no published studies on the prevalence of domestic violence in Badulla's estate sector. We are currently conducting a questionnaire-based prevalence survey to fill this gap (results forthcoming). The limited information available from other estate populations tends to focus on the broader category of GBV rather than domestic violence specifically. Such studies suggest that GBV is a significant cause of vulnerability and ill-health for estate women in Sri Lanka. Wijayathlake's (2003) cross-sectional study in Nuwara Eliya, for example, identified 83% of female estate workers as victims of GBV occurring in their homes, workplaces and public places such as buses. Jegathesan's (2013) study, based on extended anthropological fieldwork in estates neighbouring to Badulla, powerfully accounts for the frequency and far-reaching impact of domestic violence in plantation womens' lives.

Domestic violence is understood and experienced differently according to cultural beliefs and socially sanctioned norms. We will account more for the nuances of domestic violence in the estates in a subsequent phase of this research. For now, briefly, cultural narratives of patriarchal privilege, the sanctity of family, and the inferior position of women in families influence the ways that