# FACTORS CONTRIBUTING TO INTIMATE PARTNER VIOLENCE AND ITS CONSEQUENCES IN NEPAL

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52nd Master of Public Health/International Course in Health Development (MPH/ICHD)

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

by
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Nepal

Declaration:
Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.
The thesis "Factors contributing to intimate partner violence and its consequences in Nepal" is my own work.

Signature: 

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Table of Contents

## List of tables

## List of figures

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## List of abbreviations

| | |
|---|---|
| AMDA | Association of Medical Doctors of ASIA |
| AMDA PHCP for BR | AMDA Primary Health Care Project for Bhutanese Refugee |
| BBC | British Broadcasting Corporation |
| BCC | Behaviour change communications |
| CBOs | Community Bases Organisations |
| CIA | Central Intelligence Agency World Factbook |
| DHS | Demographic Health Service |
| DoHS | Department of Health services |
| DV | Domestic Violence |
| FCHV | Female Community Health Volunteers |
| GBV | Gender Based Violence |
| GDP | Gross Domestic Product |
| GoN | Government of Nepal |
| GTAs | Gender Transformative Approaches |
| HCS | Health Care Services |
| HIC | High Income Countries |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System of Nepal |
| HSPs | Health Service providers |
| IEC | Information, Education and Communication |
| INGOs | International Government Organisations |
| INSEC | Informal Sector Service Centre |

| | |
|---|---|
| IPV | Intimate Partner Violence |
| LBW | Low birth weight |
| LIC | Low Income Country |
| MOH | Ministry of Health |
| MoHP | Ministry of Health and Population |
| NBA | Nepal Bar Association |
| NDHS | Nepal Demographic Health Survey |
| NGOs | Non-Governmental Organisations |
| NISVS | National Intimate Partner and Sexual Violence Survey |
| PID | Pelvic Inflammation Disease |
| PTSD | Post - Traumatic Stress Disorder |
| RHDs | Regional Health Directorates |
| SBA | Safe Birth Attendance |
| SEA | South East Asia |
| SGBV | Sexual and Gender Based Violence |
| SHPs | Sub Health posts |
| SHR | Sexual Reproductive health |
| SRH | Sexual and Reproductive Health |
| STIs | Sexually Transmitted Infections |
| UNHCR | United Nations High Commissioner for Refugees |
| USA | United States of America |
| USAID | United States Agency for International Development |
| VAW | Violence Against Women |

| | |
|---|---|
| VDC | Village Development Committee |
| WHO | World Health Organisation |

## Glossary

### Violence:

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. (WHO 2014)

### Gender Based Violence:

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females.

The term "gender-based violence" is often used interchangeably with the term "violence against women" and "sexual and gender-based violence". The term, "gender-based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, including sexual violence (SV), particularly when they are subjected to torture and/or detainment. (IASC, 2005)

### Violence against women:

The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." (WHO 2016)

### Domestic Violence:

The term 'domestic violence' is used in many countries to refer to partner violence but the term can also encompass child or elder abuse, or abuse by any member of a household. (WHO 2012)

### Intimate partner violence

Intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including

physical aggression, sexual coercion, psychological abuse and controlling behaviours. (WHO 2016)

**Sexual violence**

Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object." (WHO 2016)

**One Stop Centres**

An increasingly popular strategy for addressing SGBV is through the establishment of one-stop centres (OSCs), which provide integrated, multi-disciplinary services in a single physical location. The basic services of the OSC model in low resource settings in East and Southern Africa comprise health care (including psychosocial support), police and justice sector responses, and on-going social support. These are often provided within the context of a health facility due to the highly medicalized nature of the initial response services.

## Abstract

**Background:** IPV is one of the public health and human rights problems that are rampant in Nepalese society. Despite the Gender – Based Violence laws, the general population is still unaware of the laws and policies that are against IPV in Nepal.

**Objective of the study:** To explore the main factor and consequences that is associated with IPV in Nepal and to provide policy recommendation to the government.

**Methodology:** The study is supported by literature review using articles, published and unpublished literature. The study used the adopted "Heise" framework to analyse the factors contributing to IPV.

**Findings:** Women of indigenous group living in Terai region, low family socioeconomic status and low level of education are mostly affected. The cultural norm with gender roles and inequality plays a significant role in IPV. There is a limitation to these findings because most of the studies used for this thesis are carried out in the Terai region only and far fewer studies are found on the same subject on the other ecological regions of Nepal.

**Conclusion:** IPV is common in Nepalese society and have severe health consequences. IPV is not about men and women; it is about the complex interplay of various components such as religion, age, education, the socioeconomic status that affects the social and cultural norms, the power relation, attitude, and the perception that causes it.

**Recommendations:** Gender transformative approaches would be one of the best methods to change cultural norms, gender roles and inequality in order to prevent IPV in Nepal.

**Keywords:** Intimate Partner Violence, causes, consequences of IPV, intervention and Nepal.

**Word Count: 12,627**

## Introduction and organisation of thesis

"There is one universal truth, applicable to all countries, cultures and communities: violence against women is never acceptable, never excusable, and never tolerable."

-United Nations Secretary-General, Ban Ki-Moon (2008)

I was serving for Refugees in seven camps of the eastern region of Nepal as Health coordinator in Association of Medical Doctors of ASIA - Primary Health Care Project for Bhutanese Refugee (AMDA Nepal PHCP for BR).The problems of Gender Based Violence (GBV) in refugee camp lead me to choose my topic in this area. However, I have chosen a topic "Intimate Partner Violence (IPV)" which is indeed a component of GBV. IPV is a worldwide public health issue which influences the health of women. In Nepal, IPV is seen as a private matter which influences directly on women's health. Thus, in order to know more about the factors associated with the private issue and its consequences this topic was chosen.

In 2011, National Demographic Health Survey (NDHS) reports the prevalence of women suffering from IPV as 33.3% and 17% during their lifetime and in the last year prior to the survey respectively in Nepal. Out of these, 23.2% suffered from physical, 14.3% of sexual and 16.4% of emotional violence during their lifetime and 10.4% suffered from physical, 9.6% from emotional and 7.7% sexual violence in last 12 months from their current or former partner. NDHS reports the data once in a five - year, hence, the data on IPV started to report only once from the year 2011. Therefore, the magnitude of the IPV in the general population is not known clearly. The factors affecting IPV and its consequences are multifaceted and hard to recognise. As a result, this thesis will explore the main factors and consequences that are associated with IPV in Nepal.[1]

Worldwide around 30% of women suffers from violence inflicted by their current partner representing it as widespread among all the countries. In a population based survey worldwide, 10% - 69% of women reported of physical IPV by their husband. IPV has a huge impact on health from minor injuries to fatal outcomes such as a murdered by the husband.[2] The evidence shows that there are multiple factors interlinked with each level i.e. individual, relationship, community and society level that perpetrates IPV.

# 1. Background information of Nepal

## 1.1. General description

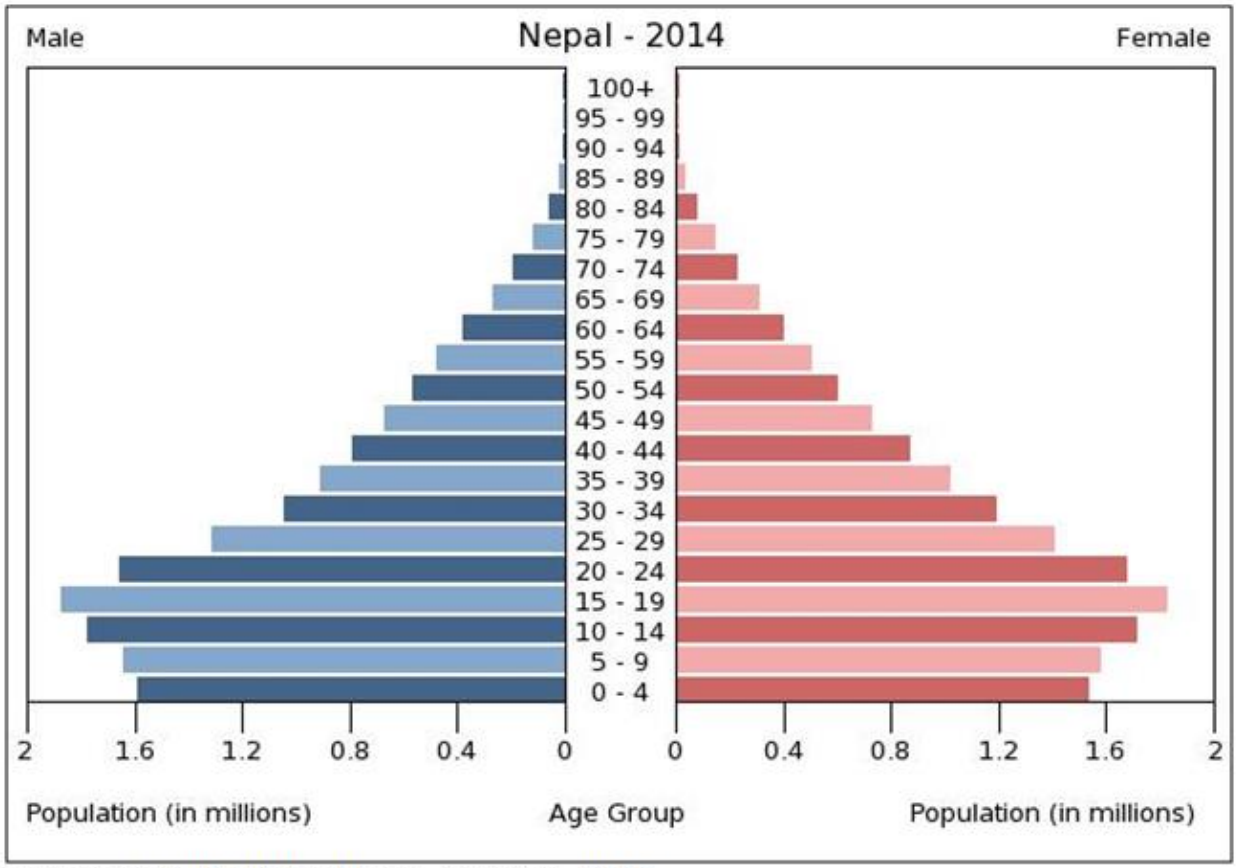
Nepal is a mountainous country and is known for its natural beauty and Himalayan Mountains. It is a landlocked country surrounded by China in the north and India to the east, west, and south. Nepal has a total land area of 147,181 square kilometres. Although Nepal is a relatively small country compared to its neighbours, it has a great variety of landscapes due to the vast differences in altitude from the Terai in the south through the middle Hills to the Himalayan mountains in the North. Administratively, Nepal is divided into 5 developmental regions, 14 zones, 75 districts and 3663 Village Development Committee (VDC).[1,3] Map of Nepal with its administrative division and boundary is shown in Figure 1.

Figure 1: Map of Nepal with its administrative division and boundaries bounded by its neighbouring countries.


Source: http://ncthakur.itgo.com

Nepal has a total population of 28,513,700 where females are 51.5% and males are 48.5% as per the World Bank report (2015). Urban area accommodates 18.6% of the total population (5,303,548) whereas 81.4% (23,210,152) lives in rural areas of Nepal.[4] Kathmandu is the capital city of Nepal with 2.5 million inhabitants.[1,3,5] The population density is 180 person per square kilometres. The annual average growth rate of Nepal is 1.35%.[1] The Population pyramid of Nepal by age and sex is shown in Figure 2 which shows the bulk of population lies in the age group of 10 – 24 years.

Figure 2: Population pyramid of Nepal by age and sex, 2014.



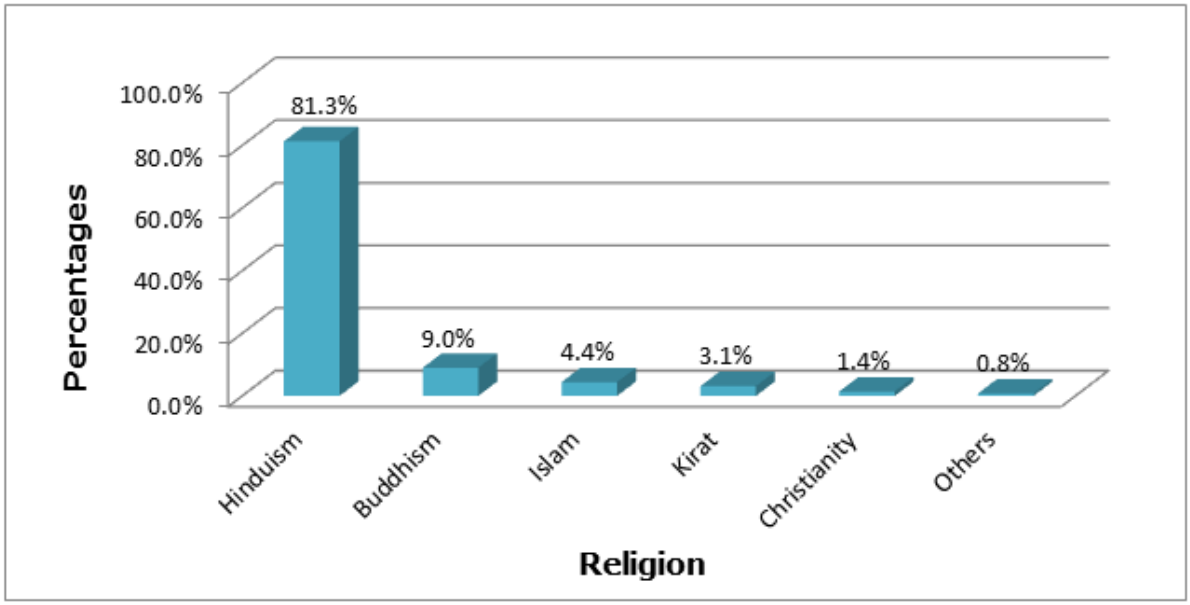

*Source: CIA, World Fact book, June 30, 2015*

## 1.2. Socio Cultural settings

Nepal is a country rich in culture and religion with diverse in ethnicity and caste. There are 10 different religions and 123 ethnicities and castes in Nepal as of 2011.[3] Hinduism (81.3%) is followed by most of the Nepalese people. Most of the Nepalese are Chhetri (16.6%) followed by Brahman

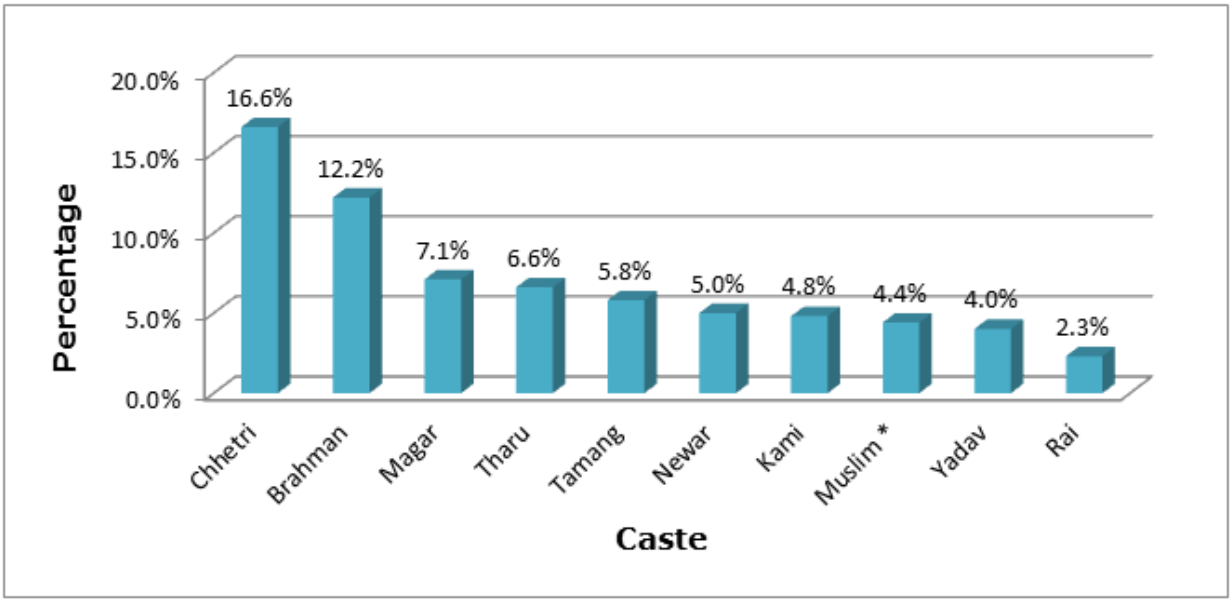
(12.2%). The rest of religion and caste is shown in Figure 3 and 4 respectively.[1]

Figure 3: Percentages of total population with different religion in Nepal, 2011.




*Source: NDHS, 2011, Nepal*

Figure 4: Percentages of total population with different caste in Nepal, 2011.




*Source: NDHS, 2011, Nepal*

**Muslim is recognized as one of the caste in Nepal by Nepal demographic health survey report in the year 2011.*

### 1.3. Economy

Nepal has GDP per capita of $ 732.3, GDP (PPP) of $ 20.88 billion, and GDP growth rate of 3.4 per annum.[4] The inflation (2015) is at 7.9% and the unemployment rate (2014) is 2.7%.[4,6] Agricultural is the main occupation of the country with 76% of household involving in agricultural activities.[1,3]

### 1.4. Education and Gender

The average literacy rate of Nepal is 77% where 87% men and 67% women are literate. The urban literacy rate (89%) is higher than the rural literacy rate (74%).[1]

### 1.5. Socio-political System

After a decade long civil war between protestors and government, Nepal observed the end of the cabinet, parliament and the power of the king. Following a nationwide election, Nepal has declared a federal democratic republic in April 2008. The constituent elected the first president of Nepal in July 2008. In August 2011, the leaders of all political party in the chairmanship of Maoist prime minister agreed to complete the draft of the

constitution by May 2012.[7] Currently, Nepal has elected its first women president by parliament in October 2015.[8]

### 1.6. Health Situation

The life expectancy at birth in Nepal is 69.6 years with 68.2 years for males and 71.1 years for females.[4] Nepal Demographic Health Survey (NDHS) (2011), shows the total fertility rate of 2.6 births/women with 1.6 in an urban area and 2.8 in rural areas.[1] Maternal Mortality ratio is 190/100,000 live births in the year 2013.[9] Nepal has made an achievement in most of the MDG targets like Maternal Mortality Rate (MMR) which decline from 281 to 170/100,000 live births in 2010. Infant Mortality Rate (IMR) and under 5 Mortality Rate (U5MR) declined from 108 to 46 and 162 to 54/1000 live births from the year 2006 to 2011 respectively.[10]

### 1.7. Health system

The overall Healthcare system in Nepal is led by Ministry of Health and Population (MoHP). The primary responsibility of MoHP, is to provide preventive, promotional, diagnostic, curative and palliative Health Care Services (HCS) along with policy making, planning, development and mobilisation of human resources, financial management, monitoring, and evaluation. Department of Health Services (DoHS), under the MoHP, is responsible for the formulation of programs and implementations as per policies and plans, alongside with monitoring and evaluation of HCS throughout Nepal. Five Regional Health Directorates (RHDs), directly under the MoHP, is responsible for providing technical support and monitoring to the district hospitals. The organisational structure of DOHs is attached in annexe 1.[11]

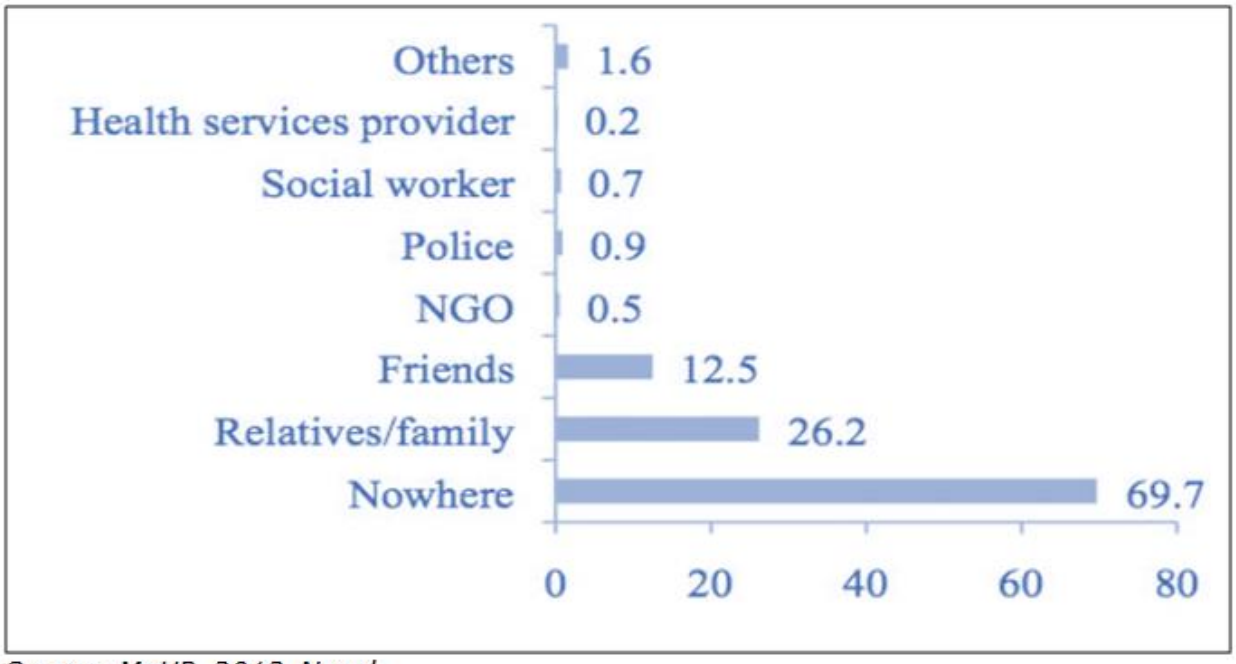
Sub Health Posts (SHPs) are the first entry point for basic health services in VDCs. Female Community Health Volunteers (FCHV) referred the cases to SHPs. The network of referral goes from SHPs to the health post, to primary health care centre, then to the district, zonal, sub-regional, regional and finally to tertiary level hospitals. The main aim of referral network is that the majority of the population can get the health services at accessible places and cheaper rate.[11] The private health care providers, civil society, and Non-Governmental Organisations (NGOs) all work in harmony with MoHP and Government of Nepal (GoN).

## 1.8. IPV in Nepal:

In Nepal, Intimate Partner Violence (IPV) is a major public health and social problem. According to NDHS (2011), 33% of married women reported undergoing IPV once in their lifetime and 17% of them reported IPV within 12 months of the survey.[1] MoHP in coordination with NGOs and International NGOs (INGOs) working in Gender Based Violence (GBV) related fields are working together to address the problems related to violence and protection of the victims in different parts of Nepal. Their activities include awareness raising, capacity buildings, providing support and shelter to victims and advocacy. Despite all these activities, IPV is still common in Nepal.[12]

There is a system in place by which victims can use mediators who support them to go to the health centre and/or access to legal support.[1] The study done by Tuladhar et al[13] showed that half of those women who suffered IPV went to the health centre, sought help for reproductive health and used the reproductive health as a cover for the IPV they experience. The women did not explicitly seek help for the violence they experienced.[13] The study done by MoHP (2012) showed that 61.3% of (432) women have not shared the experience of violence to anyone in their lifetime. Only 3 out of 10 women sought help from police personnel, lawyers and Health Service Providers (HSPs) as shown in Figure 5. Hence, we can conclude that only a small percentage of survivors of IPV seeks HCS and only a few percentages of HSPs are aware of the IPV.[14]

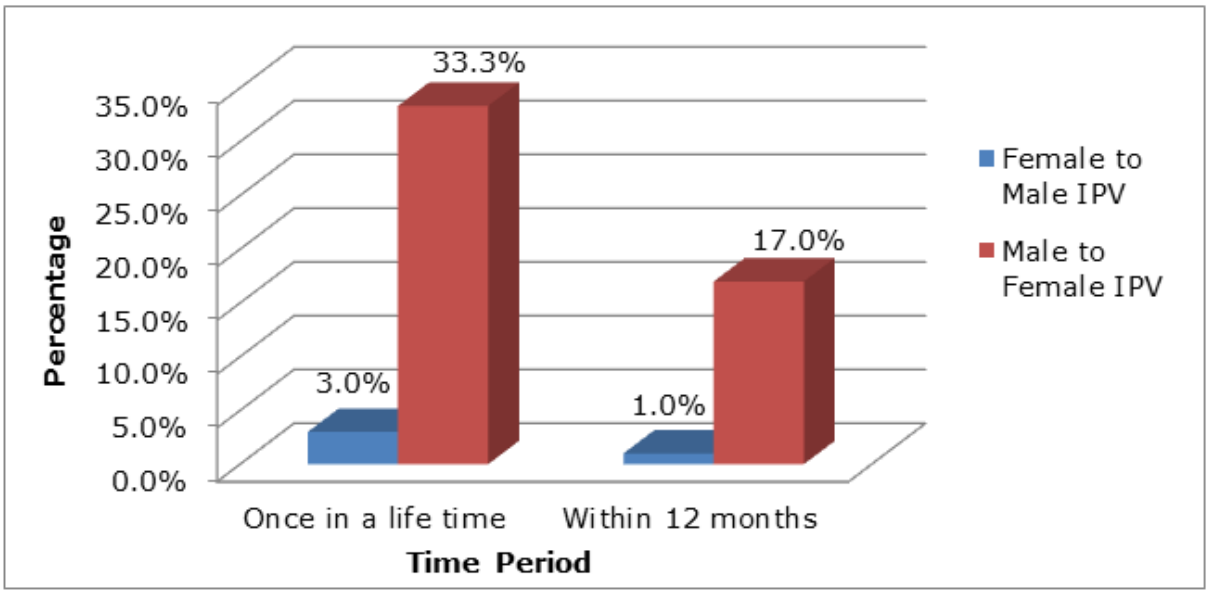
Figure 5: Persons or organization where women of 15- 49 years sought help when they were violated in 6 rural districts of Nepal in the year 2012.




*Source: MoHP, 2012, Nepal*

It is evident that IPV against men by their female partners and same sex is also present. As per the NDHS (2011), the IPV against men is minimal as shown in Figure 6.[1] This can be due to stigmatisation by society and perceived stigma causing men not to report the cases of violence. Overall, the prevalence of violence against men seems to be small and the violence against women (VAW) by intimate partners huge with severe consequences. Therefore, the thesis will focus on IPV towards women only and not towards men.

Figure 6: Life time and recent prevalence of IPV among 15- 49 years men and women in Nepal, 2011.




*Source: NDHS 2011, Nepal*

### 1.9. Nepal's Legal system related to DV and GBV

Domestic Violence (DV) includes all the violence that is perpetrated by husband, in-laws and can also include violence to children and elderly.[15] GBV also includes all the violence that is against women. So, IPV is also one of the forms of DV and GBV perpetrated by the husband. So, all the VAW is looked into DV and GBV.[16] Nepal does not have separate laws specifically for IPV.[17] The terms GBV and VAW are used interchangeably in various research documents, policies, and interventions that address the GBV.[18]

Nepal Treaty Act, 1990 amends the national laws with the international laws. The DV laws in Nepal are consistent with international human right treaties. The legal provision, acts, and rules on DV and "Muluki Ain" can be considered while addressing IPV cases.[19] Nepal's Supreme Court has a power of jurisdiction and acts as a court of appeal and review. It supervises 16 appellate and 75 district courts.[20] For the first time in Nepal's history respecting the right of every person to live safely, for prevention and control of the violence occurring at homes and outside, "DV and Punishment act" 2008 criminalises and punishes the perpetrator. It also provides legal support to file a case against the perpetrator, provides protection, compensations as well as counselling and rehabilitation to the survivors. The

three - year plan (2010 – 2013) included eliminating various forms of GBV and discrimination against women, and promoting women's empowerment and gender equality.[1,14]

The issue of GBV was raised during the developmental process of the treaties but only after the fast track trial prevention activities, the cases were formally reported in 2010. The year 2010 was declared as "the year to end GBV'' and introduced hospital-based "one stop crisis management centres" in 15 districts together with services for survivors by the GoN.[14] For the first time, NDHS (2011) reported the violence experienced by women at national level.

Nepal has legally accepted the laws and policies on DV and GBV but the interventions and programs are limited that can really act at the grass root level. The interventions such as awareness, building safe houses and training to health care workers are mostly on knowledge based and not on gender transformative.[18] Thus, the newer programs and interventions are limited in Nepal.

## 2. Problem Statement, Justification, Objectives and Methodology

### 2.1. Problem statement

IPV is one of the major public health issues in Nepal leading to physical, social, psychological and economic consequences for the abused women and their family. IPV occurs in all countries and societies and is also associated with women of all age group irrespective of culture, religion, races and socioeconomic status. It is one of the major human right problems that have negative effects on the physical and mental health of the women.[21,22]

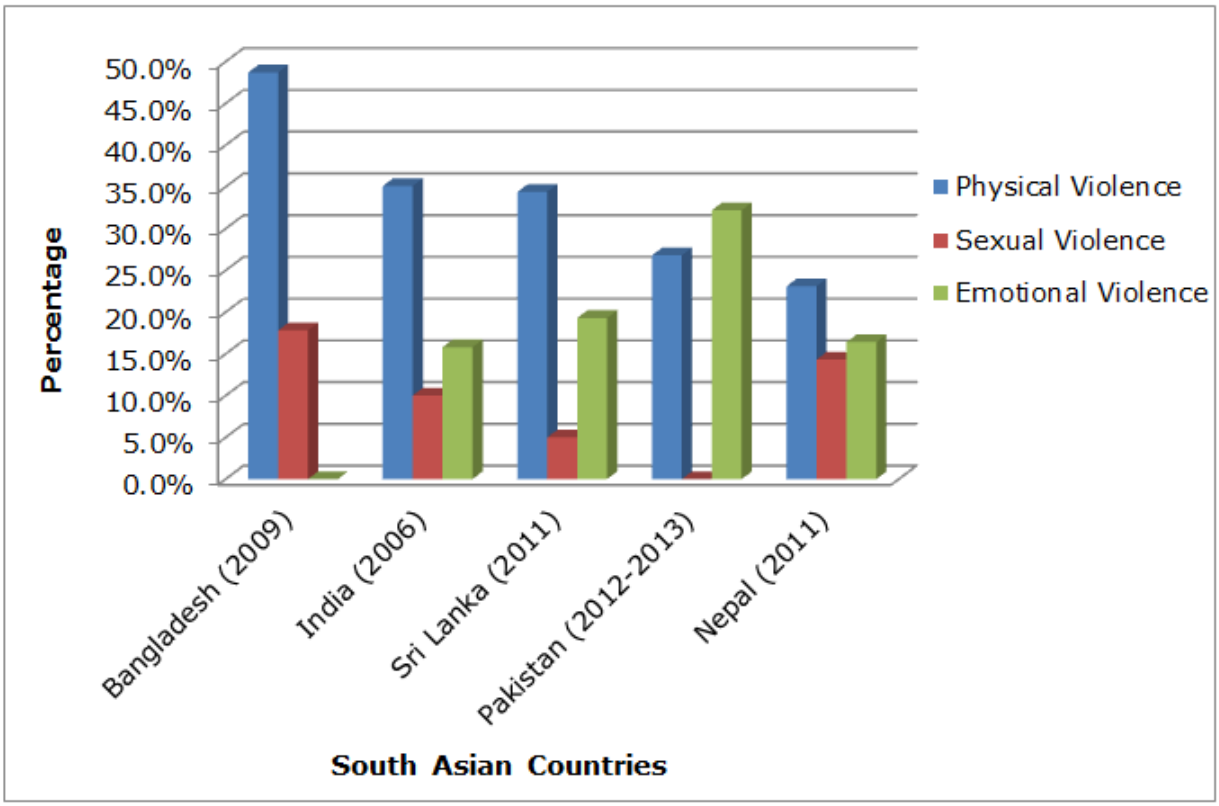
As mention in chapter one, Nepal has recently started reporting the data of IPV, so the trend of IPV is not known clearly. The different surveys in Nepal have reported the data on IPV differently and are likely under-reported. So, in order to better understand the magnitude of IPV in Nepal, data from different South Asian Countries Demographic Health Survey (DHS) reports were collected and presented in Table 1 and Figure 7.[1,23–26]

Table 1: Trends of IPV from different South Asian countries from the year 2006 – 2013.

| Countries | Physical Violence | Sexual Violence | Emotional Violence | Date of Survey |
|---|---|---|---|---|
| Bangladesh | 48.7% | 17.8% | 0.0% | 2009 |
| India | 35.1% | 10.0% | 15.8% | 2006 |
| Sri Lanka | 34.4% | 5.0% | 19.3% | 2011 |
| Pakistan | 26.8% | 0.0% | 32.2% | 2012 -2013 |
| Nepal | 23.1% | 14.3% | 16.4% | 2011 |

*Source: DHS 2009, Bangladesh, DHS 2006, India, Jayasuriya et al. 2011, Sri Lanka, DHS 2012-2013, Pakistan, DHS 2011, Nepal.*

Figure 7: Prevalence of different forms of intimate partner violence among the population in different South Asian Countries from the year 2006 - 2013.




*Source: DHS 2009, Bangladesh, DHS 2006, India, Jayasuriya et al.2011, Sri Lanka, DHS 2012-2013, Pakistan, DHS 2011, Nepal.*

The above table and graph show, the prevalence of IPV is lowest in Nepal as compared to other neighbouring countries. This can be due to under-reporting of the IPV cases as it was the first time that the data was collected. The other factor contributing to possible under-reporting can be the cultural norms that prevail talking of IPV outside of the house.[27] This indicates a need to better study the magnitude and different forms of IPV in Nepal.

The consequences of IPV in women can be fatal as well as non-fatal and are also largely unknown in Nepal. The non-fatal health outcomes would be physical and mental health effects. Physical health effects such as unwanted pregnancy, injuries, gynaecological problems, miscarriage, sexually transmitted infections (STIs) including HIV, and mental health effects such as depression, fear, low self-esteem, anxiety, and Post Traumatic Stress Disorders (PTSD). The fatal health outcomes could be suicide, homicide and maternal mortality etc.[28]

The factors influencing IPV are complex and hard to understand. A deeply rooted cultural norm such as a patriarchal family structure, social and religious norms may contribute to the cause of IPV. Other factors associated with IPV are early marriage, lack of autonomy of women, lack of education, lack of openness to talk about sex and sexuality, the conviction of many women and believing that it is their fate to experience IPV. Some of the studies have shown that alcohol is the precipitating causes for IPV in Nepal.[22,29]

## 2.2. Justification

IPV is a burning issue worldwide including both men and women, but mostly women, have a higher chances of experiencing IPV during their lifetime. The causes of IPV are complex and largely unknown. The social and health consequences for people, who experience IPV, are far reaching and require a health and legal response. Due to such major consequences of IPV in women, studies need to be identified in order to explain the main causes associated with IPV and its consequences in Nepal. A good response to IPV is currently lacking in Nepal and therefore information on evidence based interventions is necessary to provide recommendations to the government for better planning and implementation of policies in near future.

## 2.3. Objectives

### Overall objective

To explore the main factors and consequences that are associated with IPV in Nepal and to provide policy recommendations to the government for its response.

### Specific objectives

1. To map the different forms and its consequences of IPV in Nepal.
2. To identify the main factors associated with IPV in Nepal.
3. To make an overview of evidence based interventions from other countries that are implemented in respond to IPV.
4. To identify gaps in Nepal's response to IPV and to formulate policy recommendation to government.

## 2.4. Methodology

### Literature Review

A literature review was done to address the study questions and provide policy recommendations. The literature review comprised of both published and unpublished (Grey) literature.

The literature for the thesis was searched through Google scholar, PubMed, Google and VU library for published articles. These articles were screened by reading the abstracts and leaving out the one that does not suit the thesis. Bibliographies of the relevant articles were also used. The grey literature was collected through the Google to find out the various websites of WHO, UNHCR, MOH, Health Management Information System of Nepal (HMIS), CIA Factbook, BBC, World Bank. Information from books, factsheets, policy documents, standard guidelines and protocols were retrieved from the institutional website. The keywords were mostly used in combination or separately to find the information needed.

Search words used to find the literature for each objective are illustrated in Table 2

Table 2: Search Table

| Source | Search words used by objectives | | |
|---|---|---|---|
| | **Objective 1** | **Objective 2** | **Objective 3** |
| PubMed<br>Google Scholar<br>VU e- library | "IPV in Nepal" "trends of IPV in Nepal", "consequences of IPV in Nepal", "physical violence in Nepal", emotional violence in Nepal, "sexual violence in Nepal" "IPV and pregnancy in Nepal" | "child abuse and IPV in Nepal", "alcohol and IPV in Nepal", "attitude and IPV in Nepal", "age and IPV in Nepal", "caste and IPV in Nepal", "religion and IPV in Nepal" "ethnicity and IPV in Nepal", "region and IPV in Nepal", "socioeconomic and IPV in Nepal", "poverty and IPV in Nepal", "dowry and IPV in Nepal", "polygamy and IPV in Nepal", "culture norms and IPV", "gender and IPV in Nepal" "acceptance of violence and IPV in Nepal" | "IPV and intervention", "GBV and intervention", "health care provider and IPV", "multi-sectorial approach and IPV" "gender transformative and IPV" |
| Website of Ministry of Health, Nepal | "domestic violence", "gender based violence" | "GBV laws in Nepal", "domestic violence law in Nepal" Laws and Nepal" | "IPV programs", "IPV intervention" |
| Website of WHO, World Bank, UNHCR, | "Intimate Partner Violence", "consequences of IPV", "violence against women" | | "IPV interventions" "Prevention and response to IPV", "GBV intervention", "GBV guidelines" |

## Inclusion and exclusion criteria:

The literature were included if - i) Reporting on main factors and consequences of IPV or interventions. ii) If it suited for the situation of IPV including the data's was used.

The literature were excluded if - i) No access to full text, ii) Not in the English language, iii) Focused on GBV and or iv) DV committed by the neighbours.

## Conceptual framework

Factors influencing IPV have been explored in studies using different conceptual frameworks in understanding its contributing factors differently. The studies that explicitly focused on IPV and conceptual framework was found in a limited number of studies.

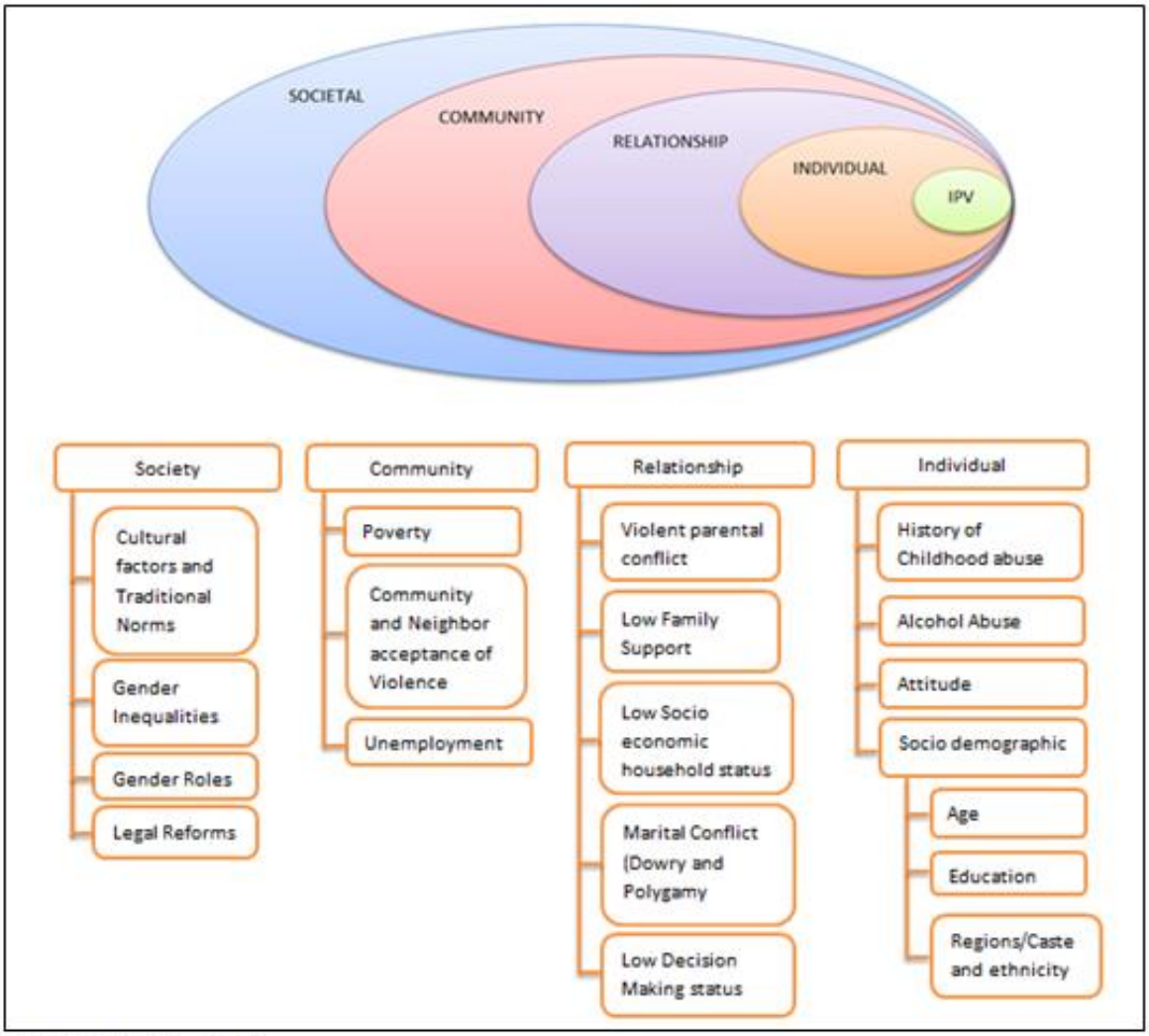
The "Social Relation framework" concentrates on the unequal power relation between men and women thus creating an imbalance in the distribution of resources, responsibilities, and power. All these factors leads to GBV under certain favourable condition.[30]

The "Heise framework" deals with the complex interplay between different factors such as individual, relationship, community and society at large that cause IPV.[31] These interrelationships between different levels are found to be playing a key role in understanding the causes of IPV. Therefore, the Heise framework was identified as best suited framework and adapted to further explore these factors influencing the IPV in detail including the ways to overcome in breaking the vicious cycle of violence.

## Adapted Heise Framework

The "Heise framework" for understanding IPV was developed in 1998 that describes the risk factors at four different levels i.e., individual level, relationship level, community level and society level.[31] The adapted Heise framework was used to identify the contributing factors of IPV at the different levels of framework which is modified from the WHO ecological framework and revised conceptual framework for partner violence (Annex 2 and 3). These adapted frameworks illustrated in Figure 8 will help us analyse the factors at each level with equal importance.

Figure 8: Framework for factors contributing to intimate partner violence at different levels: adapted from WHO ecological framework and revised conceptual framework for partner violence.




*Source: Heise, 1998*

**Individual level:** It recognizes personal history and biological factors that influence the individual behaviour leading to increasing the risk of becoming a victim as well as being the perpetrator. For example, history of child abuse, alcohol or substance abuse, the attitude of an individual and young age.

**Relationship level:** It studies the close interaction with family, friends, peers and intimate partner influencing the risk of becoming the victim. For example witness of marital violence, low socioeconomic household status, and low decision making power.

**Community level:** It explores the settings such as schools, neighbours and work places where the social relationship exists and looks for identifying factors that determine the likelihood of violence.

**Society level:** It works at the broad societal factor that creates an area in which violence is inhibited or stimulated. Society level includes health, education, economic, social, cultural norms that accept violence as a method to resolve conflicts and policies that maintain socioeconomic inequalities between people and society.

## Limitation of the study and analysis

Overall, the literature review only searched the online articles in English while, articles that did not allow full access and articles in other language are not used. The study mainly focused on IPV, while others form of violence like DV and GBV was not the focus of the study. Studies that focus only on IPV in Nepal are limited and national data of IPV on general population was collected only once in 2011.

The research focused on the interventions to IPV is linked to DV and GBV in Nepal. Interventions for IPV alone are not found. The study limits itself to VAW perpetrated by intimate partners while there is much VAW which is perpetrated by family members, neighbours, and strangers. There are also reports of violence against men by their wives but all these are not included in the study.

## 3. Mapping the different types of IPV and its consequences.

This chapter reports on the trends and consequences of IPV globally and in Nepal which related to the objective one of the thesis**.**

### 3.1. Global trend of IPV

Globally, around 30% of women have ever experienced physical or sexual violence by their intimate partners. As shown in Table 3, the regional prevalence of IPV was found to be highest ever in the lifetime in South East Asia (SEA) (37.7%) followed by East Mediterranean (37%) and Africa (36.6%). High Income Country (HIC) has the lowest prevalence of IPV in the world (23.2%).[2]

Table 3: WHO regional prevalence of physical or sexual intimate partner violence ever experience by women in the year 2010.

| WHO region | Prevalence, % | 95% CI, % |
|---|---|---|
| Low- and middle-income regions: | | |
| Africa | 36.6 | 32.7 to 40.5 |
| Americas | 29.8 | 25.8 to 33.9 |
| Eastern Mediterranean | 37.0 | 30.9 to 43.1 |
| Europe | 25.4 | 20.9 to 30.0 |
| South-East Asia | 37.7 | 32.8 to 42.6 |
| Western Pacific | 24.6 | 20.1 to 29.0 |
| High income | 23.2 | 20.2 to 26.2 |

*Source: WHO 2010*

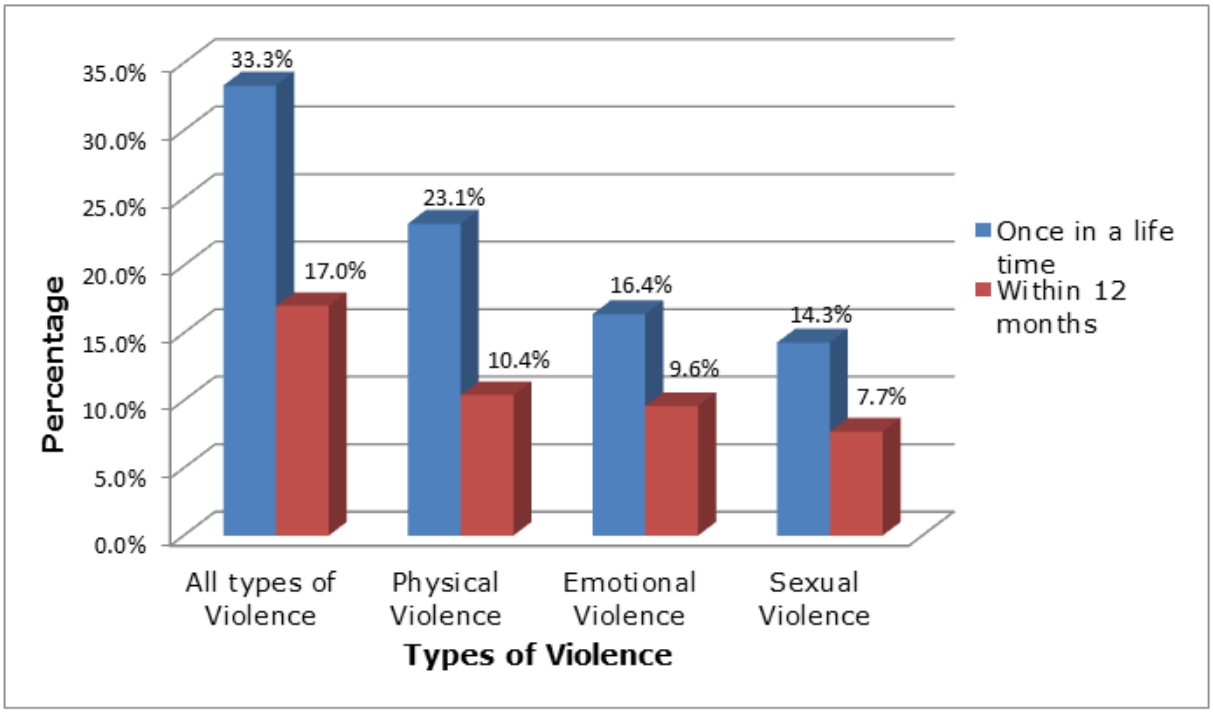
The WHO multi-country study on women's health and DV against women has measured the prevalence of IPV against women in 10 different countries which states that IPV is widely spread across the globe. The survey states that provincial of Peru (61%) has the highest prevalence of physical IPV committed by husband than that of Japan (13%). Japan also has the lowest

prevalence of sexual IPV (6%). More than half of the Ethiopian women suffered from sexual violence within their marriage. The same study also shows that the rural provinces have high IPV than the urban provinces in some of the countries.[32] Similarly, National Intimate Partner and Sexual Violence Survey (NISVS), 2010 done in the United States of America (USA) also states that lifetime and 12 months prevalence of violence were 35.6% and 5.9% respectively in the women of 18 years and above. Out of 9,086 women, 32.9% was physical violence and 9.4% was sexual violence by the current or former partner. However, in the latter case of 12 months, the prevalence was 4% physical violence and 0.6% sexual violence caused by their current or former partners.[33]

### 3.2. Trends of IPV in Nepal

The different forms of IPV that exist in Nepal are physical violence, sexual violence, and emotional violence. According to NDHS report (2011), 33.3% of 3225 women suffered from IPV at least once in their lifetime and 17% in the last year prior to the survey. Of the first group, 23.2% suffered from physical, 14.3% of sexual and 16.4% of emotional violence during their lifetime from their husband. Of the second group, 10.4%, suffered from physical, 9.6% from emotional and 7.7% sexual violence from their husband in the last 12 months as shown in Figure 9.[1]

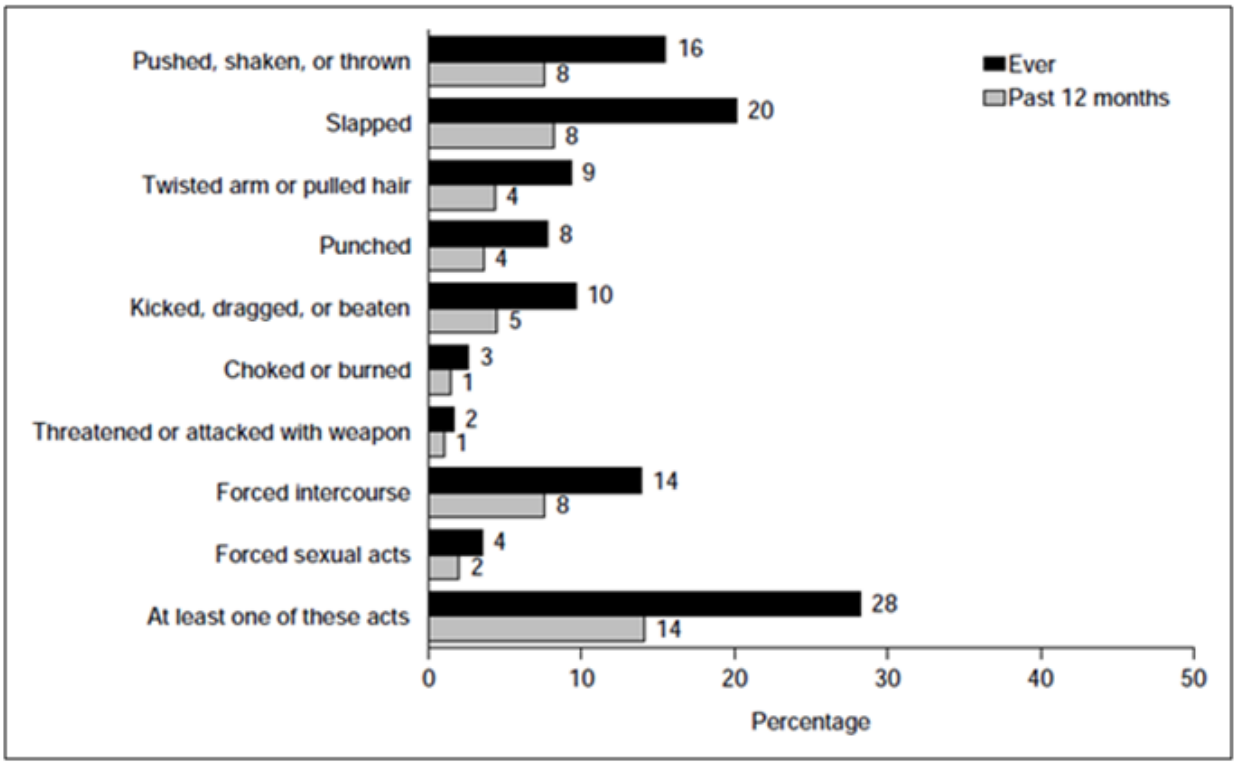
Figure 9: Life time and recent prevalence of intimate partner violence among 15-49 years female in Nepal during the year 2011.




*Source: NDHS 2011, Nepal*

Out of these, the most common forms of physical violence ever perpetrated towards wives are slapped (20%), pushed, shaken or something thrown at them (16%) and kicked, dragged or beaten is (10%). Similarly, the most common forms of sexual violence are forced intercourse (14%) and forced sexual act (14%) as shown in Figure 10.[1]

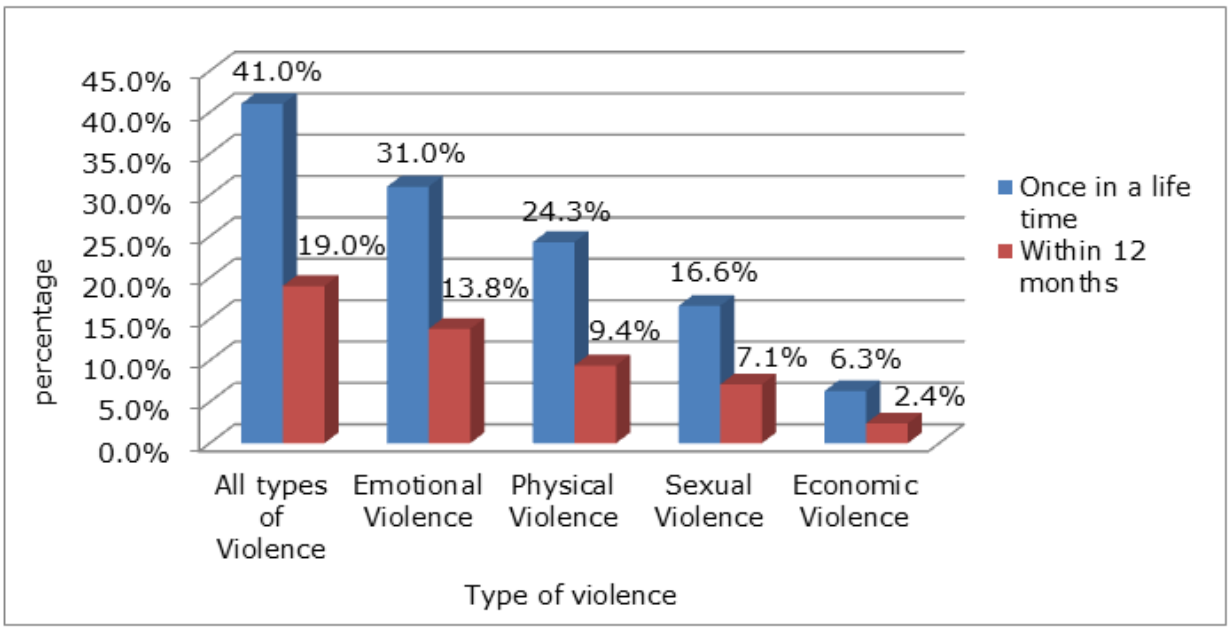
Figure 10: Specific forms of physical and sexual violence committed by husbands in Nepal during the year 2011.




*Source: NDHS 2011, Nepal*

The quantitative study conducted by MoHP (2012) in 6 rural districts of Nepal, showed slightly higher figures; two in five (41%) of married women experienced violence from their intimate partners during their lifetime and one in five (19%) within a year before the survey. Out of those women, emotional violence was reported by 31%, followed by physical violence (24.3%), sexual (16.6%) and economic violence (6.3%) once in their lifetime. The prevalence of IPV prior to the survey was emotional (13.8%), physical (9.4%), sexual (7.1%) and emotional (2.4%) as shown in Figure 11.[14]

Figure 11: Lifetime and recent prevalence of IPV among 15 – 59 years married women in six rural districts of Nepal in the year 2012.




*Source: NDHS 2011, Nepal*

According to NDHS (2011), there is not much difference in prevalence of IPV between urban (30.5%) and rural (31.5) population in Nepal.[1] However, the cross-sectional study done by Oshiro et al found that the prevalence of physical violence was high in the urban population with low-income level (33%) than in the general population(19.9%) in Kathmandu valley.[34] IPV was also found higher among women of Terai region (38%) as compared to other ecological zones (26–30%).[1] This could be due to the traditional and cultural norms that prohibit women for a change.

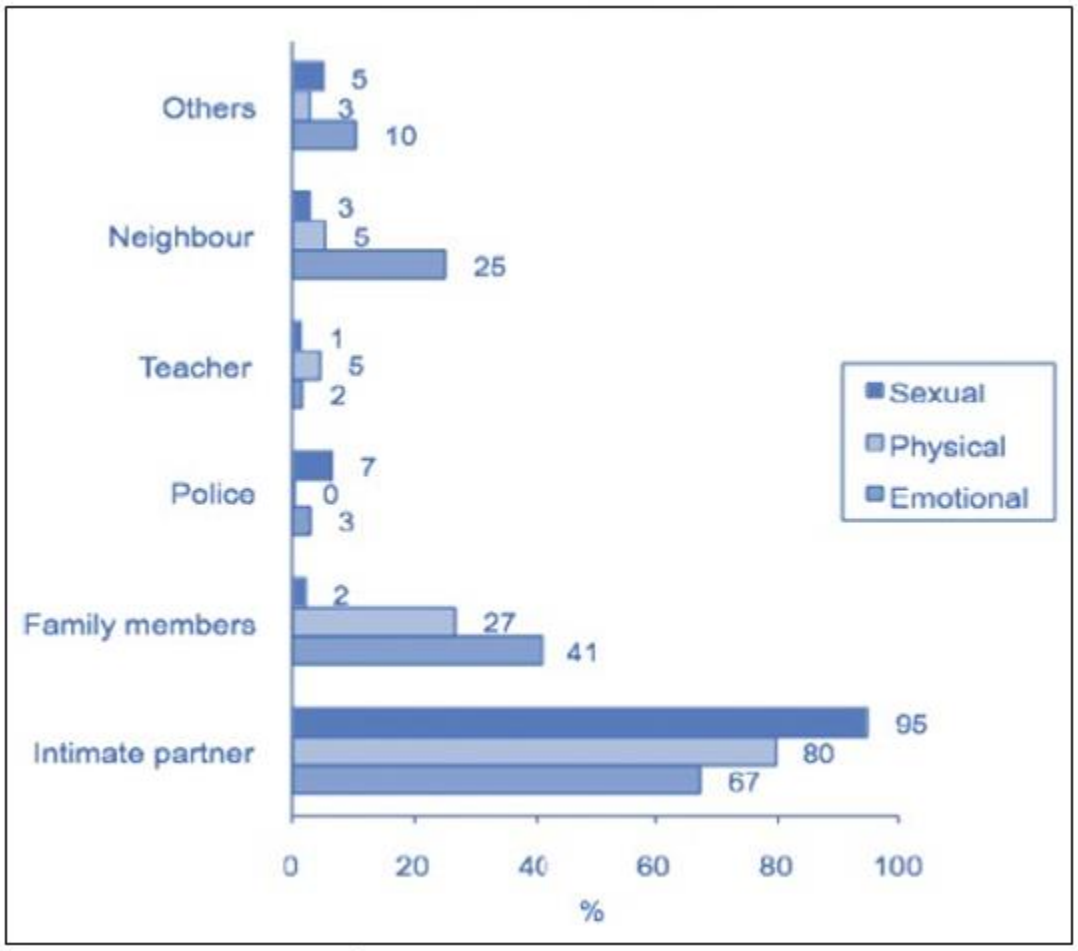
**IPV in Pregnancy**

IPV is also found in women with pregnancy and disability.[35,36] The NDHS report 2011, shows that around 6% of women had ever experienced physical violence during pregnancy.[1] The young age (15-19 years) pregnant women are more likely to have violence than older pregnant women. The prevalence of IPV among pregnant women living in the rural area is 7% and just 4% in urban area. Similarly, the women of Terai region (9%) have the higher prevalence than that of other ecological area (4-5%).[35] IPV during pregnancy was also found in the cross-sectional study among the pregnant women in Mumbai slums area (2013) where 12% of pregnant women ever

experienced violence and 2% have reported sexual violence. Further, the study also reported higher IPV among pregnant women in rural areas than in urban slums in India.[37]

In regard to the IPV, Nepalese women are also at high risk of violence from family members (58%), neighbours (52.6%) and friends (8%) and less likely from strangers (12.8%). Intimate partners (39.1%) are the main perpetuator of the violence.[1,16] This is supported by a quantitative study, 2012 which showed that more than three-quarter of the perpetrators were intimate partners, 35.2% were family members and 23% were neighbours as shown in Figure 12.[14] NISVS, 2010 also states that 86.1% of the IPV was caused by current partner.[33] It also shows that sexual violence is mostly perpetrated by their husbands while physical and emotional violence is committed by family members and neighbours.[36]

Figure 12: Perpetrators by the types of violence among 15-59 years women in six districts of Nepal in the year 2012.




*Source: MoHP 2012, Nepal*

## 3.3. Consequences of IPV

### Global consequences of IPV

IPV is a global health issue that poses a greater risk for physical and mental health problems to the women who have been violated by their partners. The most common consequences pertaining to IPV among the women as shown in WHO report (2013) are physical injuries, Low Birth Weight (LBW), induced abortion, depression, alcohol and substance abuse. They are also at higher risk of being infected with STIs/HIV.[2,28]

Other consequences are unintended pregnancy, abdominal pain, Pelvic inflammatory disease (PID), chronic pelvic pain, STIs, still births, intrauterine haemorrhage, disability, anxiety, PTSD as well as non-

communicable diseases. The victim of IPV has higher chances of attracting to risky behaviours like substance abuse, smoking, unsafe sex and unsafe abortion as shown in Table 4.[2,28,15]

Table 4: Health consequences of intimate partner violence by WHO, 2012.

| Physical | Sexual and reproductive |
|---|---|
| • acute or immediate physical injuries, such as bruises, abrasions, lacerations, punctures, burns and bites, as well as fractures and broken bones or teeth<br>• more serious injuries, which can lead to disabilities, including injuries to the head, eyes, ears, chest and abdomen<br>• gastrointestinal conditions, long-term health problems and poor health status, including chronic pain syndromes<br>• death, including femicide and AIDS-related death | • unintended/unwanted pregnancy<br>• abortion/unsafe abortion<br>• sexually transmitted infections, including HIV<br>• pregnancy complications/miscarriage<br>• vaginal bleeding or infections<br>• chronic pelvic infection<br>• urinary tract infections<br>• fistula (a tear between the vagina and bladder, rectum, or both)<br>• painful sexual intercourse<br>• sexual dysfunction |
| **Mental** | **Behavioural** |
| • depression<br>• sleeping and eating disorders<br>• stress and anxiety disorders (e.g. post-traumatic stress disorder)<br>• self-harm and suicide attempts<br>• poor self-esteem | • harmful alcohol and substance use<br>• multiple sexual partners<br>• choosing abusive partners later in life<br>• lower rates of contraceptive and condom use |

*Source: WHO, 2012*

## Consequences of IPV in Nepal

The health effects seen in Nepal due to IPV are injury, death, disability, abdominal pains, miscarriages, LBW, STIs and HIV transmission, Pelvic inflammation and depression.[38,39] The qualitative study conducted by Puri et al in the year 2006 - 2007 at 2 districts of Nepal (Dang and Tanahu) with 12-24 age group women consisting of Tharu and Brahmin or Chhetri ethnicity shows that 10 out of 15 women reported backache, headache, body pain and lower abdominal pain. Another 5 out of 15 women reported of white discharge, vaginal itching and dark blood flow. About 80% of women reported of physiological trauma like being depressed and stress.[40]

The NDHS (2011) stated that 69% of women experiencing IPV reported to have psychological problems like fear, depression and tension while 6% have attempted suicide in Nepal. Around 37% of women who was abused by intimate partner have cuts, bruises, eye injuries, dislocations, burns, broken bones and other serious injuries.[1]

## 3.4. Conclusion

The overall prevalence of IPV in general population was found to be 33.3% ever in life time whereas 17% in past 12 years. The study done by MoHP (2012) found that the prevalence of IPV was 41% ever in life time and 19% during past 12 months. The physical violence reported was 23.2% in general public whereas 24.3% in 6 rural districts. Likewise, emotional violence was 16.4% and 31%, sexual violence was 14.3% and 16.6% and economic violence was 0% and 6.3% in general population and rural population of 6 districts of Nepal respectively. Higher prevalence was found in rural areas of Nepal. IPV was also prevalent among pregnant women. Women also face violence from family members, neighbours and friends other than intimate partner. The consequences reported in Nepal among women are multiple, severe reproductive and psychological problems and even death. Globally, similar results on consequences (very poor health) are reported.

## 4. Factors associated with IPV in Nepal.

This section describes the contributing factors related to IPV in Nepal using adapted Heise Model and relates to objective two of the thesis. All the information in this section refers to research and data found in literature review from Nepal unless specified otherwise.

### 4.1. Individual level

#### *4.1.1. History of Child abuse:*

History of violence in the childhood is significant risk factors for men and women for being victimized and perpetrator of IPV. Total of 12.8% and 5.4% of men and women has experienced violence in childhood respectively. Men who has been beaten regularly during the childhood is more likely to perpetuate IPV to his wife.[41] About 75% of men who has experiences gender inequalities and violence during the childhood tend to have higher chances of perpetuation of IPV against his wife.[42]

#### *4.1.2. Alcohol Abuse:*

Although illegal, home production and selling of alcohol is widely acceptable. Alcohol is culturally accepted and used in most of the occasions by the religions and ethnic groups in Nepal.[35] Sharma et al found that 41.6% of victims of IPV expressed that after consuming alcohol their husband scolds and beats them.[39] The study done by Atteraya et al found that the husband who drank alcohol has 2.32 times higher chances of abusing their wives than non-alcoholic husband. Whereas, 37.1% of women whose partner consume alcohol faced IPV.[22] The study done in two districts (Dang and Tanahu) found that 62% of the respondent had experienced sexual violence from their husband after consumption of alcohol.[40] The result of meta-analysis conducted by Heather M. Foran states a clear linkage between the alcohol and IPV among both husband and wife.[43,44] As a result, alcohol is the root cause that influences the violence within the married couples.

#### *4.1.3. Attitude:*

In general, Nepalese women are shy, introvert and do not easily talk about sexual violence and abuse which they experience from their husbands, who then might feel that abusing their partner is not problematic.[29] It is also stated that those husbands who are habituated to violence were less likely

to report and talk about the issues; rather they remain strong perpetrator of IPV against their wives.[41] The male supremacy and suspicious attitude towards their wives are also other prevailing factors for IPV.[45]. The study done by Nanda et al showed that 67% of Nepalese men feel strongly about their own masculinity and feel superior to female, thus leading to IPV against their wives.[42]

### *4.1.4. Socio Demographic:*

**Age:**

NDHS (2011) and MOHP (2012) found that the prevalence of IPV was higher in women aged above 25 years than those below 25 years.[1,22] Whereas the other three studies done by Puri et al, on women aged 15 – 49 years on rural part of Nepal on similar topics found that younger aged women are more likely of being expose to sexual violence than older aged women. However, in the case of husband it was just the opposite.[29,36,40] This is also evident from the study done by Hindin, in 10 DHS countries which shows that younger age of the women is more at risk of becoming victim of IPV than older age.[46] This shows that woman in the age group 15- 49 years are more vulnerable for IPV. The evidence shows that the reason for older men being the perpetuator against his wife is mainly because of his status in the family and community at large.[29] This is also evident from the study done in Vietnam.[47]

**Education:**

Education is directly related to the attitude of an individual towards violence. The NDHS report (2006) shows that the non-educated person thinks that violence against the wife is acceptable.[48] Therefore, the perception of IPV is less known to the general population because most of the population of Nepal lives in rural areas where they do not have proper education and the society is more conservative regarding violence than the people living in urban cities.[49]

The study conducted by Atteraya et al found that about 37% of women who had never attended the school and about 41.6% of women whose husband were illiterate experiences IPV.[22] This is supported by the MoHP (2012) study which shows that 52.6% and 26.3% of women who are illiterate experience violence during their life time and in past year respectively.[14] More than half of the women (52%) expressed an opinion that their own

lower level of education was one of the main causes for IPV in one of the surveys conducted in Nepal.[50] Similarly, men who have not attended the school and men who have completed primary level education were 1.62 and 1.30 times more engaged in IPV respectively.[22] Husband with high level of education was found to be protective factor for IPV.[29]

**Regions, Religion and Ethnicity:**

Women living in Terai region, mostly inhabited by Tharus people, are found to be experiencing more IPV than those living in hills and mountain regions. Similarly, the cross sectional study done on 3,373 women shows that women from indigenous groups (29%), untouchables (Kami and Damai) (40%) and Muslim (44%) of Terai regions were more likely to experience violence from their husband than the women from Hilly regions and of Hindu caste.[22] The qualitative study conducted in two districts showed that more than half percentage (55%) of Tharu women and 42% of Brahmin and Chhetri women reported having sexual violence within their marriages.[40]

Another study conducted by Attereya states that approximately 29% of 3176 surveyed women in Nepal experienced IPV in the last year. The prevalence of IPV was highest among Terai indigenous group (49.2%) than Hill indigenous group (25.7%). The remaining caste and ethnic groups consist of Muslim (46.1%), Madeshi (43.8%), and Untouchables (39.5%). Among all the woman of Hindu ethnic groups has the lowest prevalence of IPV (19.4%).[51]

## 4.2. Relationship level

### *4.2.1. Violent Parental Conflict:*

It is stated that approximately 44% of women who has witnessed violent parental conflict in the childhood experiences IPV in their lifetime.[22] Men who experienced violence of his mother during childhood have an increased risk of becoming a perpetrator of violence when they are adults and are more likely to be violent towards their wives. The cross sectional study done by Yoshikawa et al report that nearly 20% of men (10.6%) and women (9.2%) were exposed to the violence of their father beating their mothers during their childhood has higher significant in perpetuation of violence towards their wives.[41]

### *4.2.2. Family Support*

Nowadays most of the Nepalese boys and girls get married against their family's will and caste by eloping, while some marry in agreement with the family. However, some of these girls are unfortunate not to get the support from their in-laws and family. Due to this, most of the women suffer violence from their in-laws and husband. If the husbands listen to his family members, then the women have lesser chances of social support and higher chances of being the victim of IPV. Most of the female respondent of the qualitative survey done in Bardiya district stated that they have to perform all the duties of household by themselves. None of the in-laws and husband help her because they think it is the work of female and often felt that she does not need any support.[45]

However, the study done by Puri et al showed that the women who have the support from their natal family/homes, or involved in community groups and organizations are less likely to experience violence.[29]. The women who took part in the qualitative study revealed that they are the only one who will face such kind of gender based problem. In addition, they also fell that if any such issues are being brought up to their husband then they will be isolated and victimized. The evidence shows that half of the women have reported the violence to their family, mothers in laws, friends and neighbour but this did not result in positive action.[40]

### *4.2.3. Socio economic household status*

The lower the socioeconomic household status; more likely to experience IPV. Approximately 34% of women were victimized for IPV due to lower socioeconomic status.[22] Women and her husband who are from the lower level employee (agricultural, poultry, daily wages labour etc.) or who didn't have cash income were most likely to experience and perpetuate sexual violence than those in in-services or small business. However, the higher level of husband's occupation is found to be the protective factors in IPV.[29] The lower level of family income was also one of the causes related to IPV according to the study done by Sharma et al in Nepal.[39] In a cross sectional survey, 43.4% women informed that due to lack of their own source of income, they experience violence.[36]

### *4.2.4. Marital conflict (Power Imbalance)*

Women are less educated and have less decision-making power than men which shows the difference or power imbalance between men and women in Nepal.[1] The study done by Atteraya found that the families with the larger number of children were more likely to experience IPV.[22] However, the cross sectional survey done in four districts (Dolkha, Sindhupalchowk, Dang, and Kapilvastu) showed that the prevalence of IPV decreased among couples who have at least one living son.[29] In Nepal, sons are preferred more than daughters due to the fact that sons will continue their generations in the family, perform funeral rituals and will take care of the family when they are old.[42,52] Superiority feeling of being male is one of the causes of marital conflict leading to violence towards wives.[45]

Dowry is one of the causes of marital conflict and violence in Terai region of Nepal.[19] Findings from the study done by Sharma et al found that perceived small amount of dowry from wife's house was one of the causes for violence.[39] Dowry related violence was found to be high (41.3%) in the general population as compared to urban slum population of Kathmandu valley.[34] One of the studies done by Informal Sector Service Centre (INSEC) (2013) reported that the 20 years female from Terai region was brutally killed by her husband for not bringing sufficient dowry to his home.[19] This is also evident from the study done in Bangladesh that 56.5% of women were tortured by their husband due to dowry - related issues.[53] Thus, insufficient dowry contributes to marital conflict leading to IPV.

Polygamy is also considered as one of the factors for marital conflict leading to IPV.[19] Polygamy was found to be higher in urban slum population (20.9%) than that of the general population (7.5%) of Kathmandu valley.[34] The qualitative study from Bardiya district reveals that 64% of the respondent have reported practicing polygamy.[45] The study done by INSEC (2013) reported that a total of 283 women were victimized by polygamy. Despite the laws criminalizing polygamy, the men still practice polygamy in Nepal leading to IPV to his first wife.[19] This was also common in India which shares similar cultural settings.[54]

### *4.2.5. Decision making status*

About 35% of women who lacked decision - making autonomy in the family or household were victims of IPV.[22] One of the studies done by Puri et al

showed that the 42% of the women with low autonomy had faced sexual violence as compared to those women with higher autonomy (23%). As expected, half of those women who are self-empowered were found to be significantly protected from the violence.[29] The respondents of the study done in Bardiya district of Nepal stated that mostly the decision of household was taken by the Father-in-law and husband while only a few decisions were taken by Mother-in-law. They believed male members of the family are the main decision makers for household chores.[45]

## 4.3. Community level

### *4.3.1. Poverty*

Poverty is also one of the factors for IPV victimization in Nepal. About 40% of the women who are victimized are from the poor family.[22] The family of the women who pay less dowries due to poverty was more likely to be perpetrated by the husband, family members, and the community.[34] The difference in economic status affects IPV in women. The study was done by Atteraya clearly states that women with low poverty status were 22 times more at risk than those of higher status. The poverty linked with lower caste and ethnic group has higher chances of experiencing IPV. For example, Madhesi ethnic group women with low poverty status have 2.56 times higher chances of IPV than the other ethnic groups.[51]

### *4.3.2. Community and neighbour acceptance of violence as a way to resolve gender violence*

Nepal has a strong patriarchal society, and IPV within the family is not talked about. People see this as their own private affairs.[14] Violence against daughters is experienced as shame and guilty by family members. Therefore, no matter the intensity of the problem, the family members remain silent. The study done by Khatri,[45] shows that the participants were not satisfied by the response from the police. As a result, many don't intend to report to the police. The other reason cited by the participants' especially the women were due to the fear of being further abused.[4] So, they hide their problem from the rest of the community.[14]

Yoshikawa et al found that more than 80% of couples does not accept wife beating but 56.6% of the husband accepts the wife beating when she is disloyal. Furthermore, the finding shows that 23% women and 21% men

accept the wife beating under certain circumstances confined to their roles and responsibilities. For example, burning of food and being unfaithful to the husband including the refusal of sex.[41] This shows that community norms are highly influential factors for perpetuation of violence against wives.

### *4.3.3. Unemployment:*

According to the NDHS (2011), the married women who are working on daily wages are at higher risk of IPV than those who were unemployed and do not work for cash. These women under daily wages experience more physical violence (27.1%) than emotional (21.7%) and sexual violence (19.5%) from their husband. In contrast, the women who are housewives, experiences less IPV as compared to those who work outside as daily low-income wage.[1] Another study done by Sharma et al with the similar findings shows that physical violence was higher in women working as a daily wager than other forms of IPV.[39] Similarly, the study done by Nanda et al in Vietnam and Nepal (2012), reported that 78.7% of women working as a manual labour experiences IPV which is higher than the unemployed women (72.2%) and women who works on a farm (65.3%) ever in their lifetime.[42] However, Lamichhane et al suggest that IPV is higher in women who earn money from occupation such as manual worker, agriculture and poultry farming.[55] This clearly shows that women who are engaged in low-income work are more susceptible to IPV from their husband who either depends on them financially or are alcoholic.

## 4.4. Society level

### *4.4.1. Cultural factor and norms*

Patriarchal family structure, cultural, and religious patterns are the most common in Nepalese society which shows that women have a lower status in the family and society. These act as a means of violence against wives in the society.[17] Culturally, there is a norm that if you are born as a female child then it is due to the bad deeds that was done in the previous life. So, as a societal culture, it is accepted as women's fate. In most of the societies and communities, beating the wife by the husband is largely accepted as man's right. In our context, it is believed that it is women's responsibility "dharma" and is expected to look after their homes, children, to be obedient and respectful to in-laws and satisfy the husband.[29] If she failed to do so, then the husband has right to beat her. The society has created an environment

where they accept the violence done by the abuser but they don't support the victim who revolts against the IPV.[45] In Nepal, it is a taboo to talk about the sexual violence done by their husband which prevents wives from sharing such incidents to maternity home, friends, community or society.[17]

### *4.4.2. Gender inequalities*

The study conducted by Nanda et al shows that nearly half (48%) of the men agrees that women have to take care of the household while 84% and 22% believed that women should obey their husband and reproduce a son for her family respectively in Nepal. Remarkably, less than half (43%) of the men said that they have a right to make a final decision in the family. This study also states that more than half (52%) of the men agreed that women cannot refuse to have sex with their husband when they desire and 58% of men believed that it is not a rape. The result was similar and more obvious in Vietnamese men.[42]

In the same study, 77% of Nepalese men felt that it is the right of a husband to beat a woman when she does something wrong while 44% felt that women should be beaten at times. Half (50.8%) of the Nepalese men believe that women should tolerate beating by her husband to unite the family. This study done by Nanda et al also believed that lower the education level higher was the men's attitude towards gender inequality.[42] Although it is believed that men can have the extramarital relationship, polygamy, and gambling but women are not allowed to do such things in Nepalese society. [45] Thus this gender inequality also contributes to IPV.

### *4.4.3. Gender Roles:*

Females in the household are taught to be in low profile, speak softly and are kept under strict supervision and rules since childhood as they are to live with husband after marriages. While males are taught to be bold, strong and was given special preferences. Total 70% of men agree on the view that men have to be strong and tough.[42] As the prescribed role of male partners, dominant and decision makers in the family, sons are preferred to daughters as their first child. All the respondents of the Khatri's study stated that the community and family consider men as breadwinners, future pillars, and outdoors workers whereas female was considered as indoor workers and subordinates to their husbands.[45] Thus, the male dominant society gives

birth to victimization of women for IPV where women have no rights and has to take permission from their partner for everything.

### *4.4.4. Legal reforms*

In 2009, the GON had passed a law against GBV. The law specifies that a husband, who forces his wife to have sexual relation without consent, can be brought to court and are liable to imprisonment up to six months. However, this law is rarely implemented in practice. Moreover, the organisations dealing with GBV, police personnel, local authorities, lawyers and the majority of Nepalese population are still unaware of the laws and policies.[29] One of the studies done by Sharma on knowledge, attitude and practices among law enforcers states that 11% police, 11% government lawyers and 10% Nepal Bar Association (NBA) lawyers were in the opinion that wife beating was acceptable if she refuses sex.[17] However, this states that police and lawyers are unaware of the rights of the women. This shows the level of knowledge and awareness on legal reforms of police and lawyers are at low level.

## 4.5. Conclusion

Alcohol abuse by the husband, a history of child abuse, husband's supremacy and suspicious attitude towards their wives, young age of women, low level of education of both (husband and wife), women from indigenous group and lower caste, women living in Terai region of Nepal, Muslim women and women living in rural areas of Nepal are mostly likely to be violated by their intimate partners at the individual level.

A history of witnessing parental violence during childhood, lower support from husband and his family, low household socioeconomic status, the larger number of children, not providing the larger amount of dowry, polygamy, and low decision-making status of women are factors associated with IPV. Whereas, women receiving support for the natal family or involved in community groups, self-employed or having a son in the family decrease the likelihood of experiencing IPV.

Poverty linked with the lower caste, lower ethnic group, and women who worked as manual labours are at higher risk for IPV at the community level. Whereas cultural norms including patriarchal family structure, gender norms,

gender inequalities and legal reforms are the factors associated with IPV at the societal level.

## 5. Evidence based interventions and best practices from other countries to respond to IPV.

According to the finding, there are many factors that contribute to IPV in Nepal. The GON has made acceptable changes in legislation but it was not implemented thus the general populations were not aware of the legal options that are in place to protect them from the violence. Therefore, it affects the IPV victims from seeking the right treatment from HSPs which directly affects the health of the survivor.[14]

This section describes the evidence based interventions from other countries which respond to IPV in the communities. The examples from different countries help to explain the intervention at all levels of the conceptual framework. The example from Mozambique and Zambia clarifies the multi-sectorial level intervention to prevent IPV and help to treat the adverse health consequences of the survivors. This multi-sectorial approach helps to mitigate IPV at all levels of the adapted conceptual framework by involving individual, both the partners with their family, community, and society at large. The examples from India, and Sierra Leone on gender transformative and Sri Lanka on training to HSPs on IPV, explain the intervention at community and society level engaging both community and young men and boys.

### 5.1. Multi-sectorial approach to prevent IPV against women - an example form Mozambique:

IPV is a multi-dimensional and complex structure including strong sociocultural factors that supports violence which needs a comprehensive approach to prevent IPV. Multi-sectorial approaches are to coordinate and cooperate with different stakeholders including Community Based Organizations (CBOs), community leaders, religious leaders, youths, HSPs, legal service providers, and police personnel, etc. It includes primary and secondary level prevention approaches as listed in Table 5.

Table 5: Definitions of Primary and Secondary prevention in the context of prevention and response to GBV, Mozambique, 2015.

**PREVENTION:** Efforts to enhance the protective factors that prevent GBV (e.g., deconstructing harmful gender norms, education, gender equality, and non-violent conflict resolution)

**SECONDARY PREVENTION:** Interventions that aim to moderate the immediate effects of GBV (i.e., a package of clinical services including provision of PEP for HIV and STI prevention and provision of emergency contraception, treatment of injuries, temporary shelter, forensic evidence collection where feasible, and psychosocial, police and legal support)

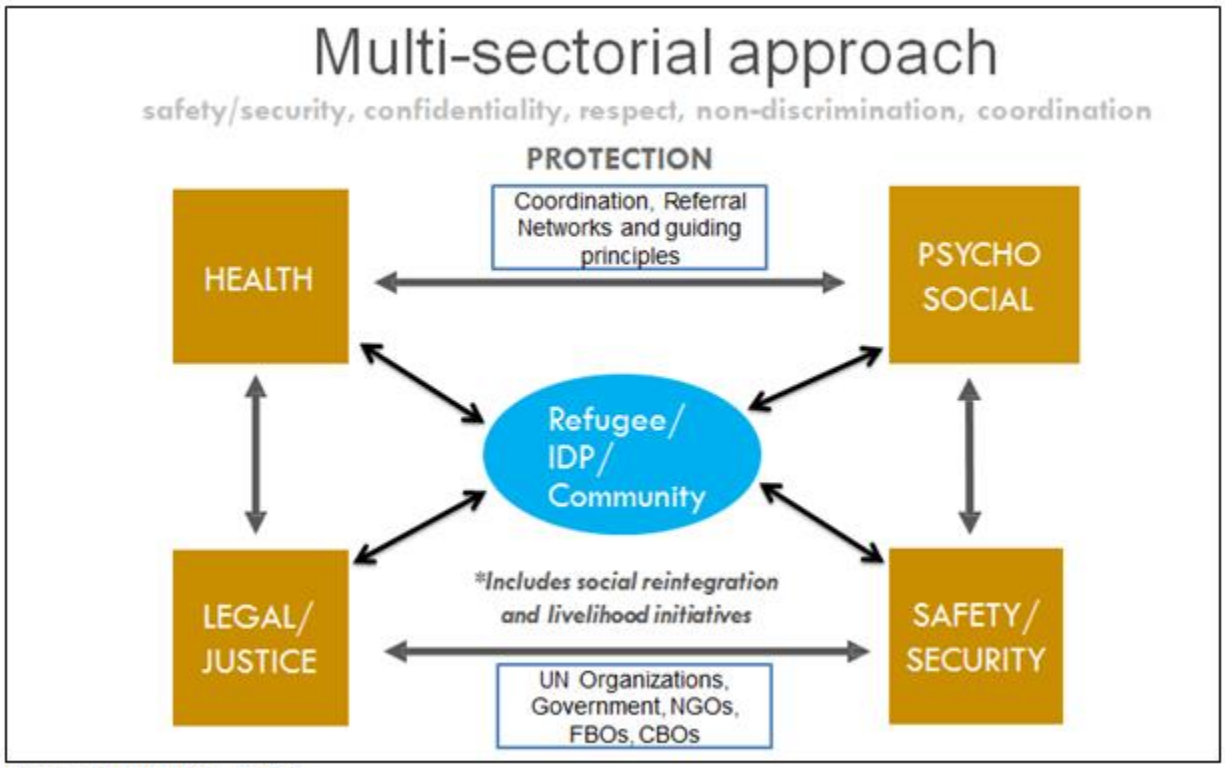
*Source: Multi-Sectorial Response in GBV, Mozambique, 2015 /Pathfinder, Mozambique, 2015*

Primary prevention includes training and engaging different stakeholders like CBOs, community leaders, religious and influential persons in the community, judges, and youths. These youths, in turn, educate the community, school teachers, and students on shifting their attitude on gender roles and norms, Sexual Reproductive Health (SRH), GBV, service available and laws regarding violence. These youths can also educate a large number of communities and individual through dramas, theatres, debates and quiz competitions. The CBOs, community, religious and influential leaders including the judges have also taken part in creating the awareness on IPV. Secondary prevention includes training of legal, psychosocial, police and health personnel and providing health and legal services to the survivors through "one-stop centres". The clinical services needed by survivors of the violence need to be incorporated into the existing health system and also to provide the referral services whenever required. This holistic approach of integrated services will help to increase the accessibility and availability of the services and reduces the victimization rate of the survivors.[56,57]

According to the UNHCR guidelines (2003)[58] on "Sexual and Gender Based Violence (SGBV) against refugees, returnees and Internally displaced population (IDP)", a multi-sectorial approached is used to prevent and respond the cases of GBV in emergency settings. Once the survivor is brought to health centre by their relatives or the focal person, they are

clinically examined and treated for wounds after the proper consent. Then, she/he is asked to visit for the psychosocial counsellor and is also referred to police personnel on security and legal aspect for a further legal procedure as per willingness of the survivor for legal assistance. Different organizations cooperate and coordinate to provide a multi-sectorial response to the survivors of the violence as shown in Figure 13.[58]

Figure 13: Interagency and Multi-sectorial framework for prevention and respond to sexual and gender based violence, 2003.




*Source: UNHCR, 2003*

Multi-sectorial approaches work in each level of the adapted conceptual framework. Involving the affected women, her family, neighbours, community and organization working for them with other stakeholders working in the field of GBV to prevent IPV would help the programs run successfully. For example, Mozambique and Zambia have a higher prevalence of IPV than Nepal, the success of the pilot project done in those countries have led to spread the project in other African countries. Also, there are similarities in culture and societal norms between this country and Nepal. Although the model is developed for emergency settings, the approach is being implemented successfully in refugee camps in eastern Nepal. These refugees camp exist already for many years in Nepal and are in

a stable situation. Thus, it could be a successful intervention in Nepal to reduce IPV in general.

But it has certain advantages and disadvantages in Nepal. The advantages are that the multi-sectorial approach would save time and cost of the victims whereas the disadvantages are that the victim would be further stigmatised and they are also vulnerable to victimisation by the community for breaking the silence.[56,57] Human resources to implement this project will be one of the challenges that are foreseen.

### 5.2. Engaging men and young boys in prevention and response to violence – Gender Transformative Approaches (GTAs) from India and Sierra Leone.

Engaging man in GBV response program does not mean that they are involved as a part of guardians to protect women but as a part of mediator involving themselves and community to be responsible for rejecting IPV. Involving men and boys in order to end violence focus on understanding the cost of harm done by the men to their wives. A collaborative approach involving different communities with different culture and ethnicity, policies, religious and traditional healers will help in change the attitude where gender inequalities and norms occur. This shows that engaging men along with the communities help to shift the gender norms and inequalities by preventing and responding to the violence against intimate partners. [54,59]

The studies done in India and Sierra Leone states that VAW is the issue of society at large and not a private. They also said that men are the culprit of causing violence. Therefore, it is man's role to eradicate the violence that is still prevailing in the society. As a result, they have engaged men and young boys in order to seek justice for gender equality in the society. These examples from India and Sierra Leone in engaging men and young boys along with the community help reduce the VAW in their respective areas.[60]

The Heise model also helps to identify that IPV is not just individual and relationship problem but also a societal and community problem. So in order to address violence in society and community, it is necessary to engage men and young boys at all level of intervention.[61,62] This approach of engaging men in gender norms transformation will help in changing the attitude of men against women.[60,63] Therefore, the gender transformative programs will

be more effective than just a sensitization method to change the existing cultural norms in relation to gender inequality.

For example, there are many gender awareness programs including GTAs that are implemented in SEA countries. Most of the result shows that India has successfully implemented the GTAs in SEA. Nepal has also implemented GTAs in HIV and AIDS sectors but not in GBV. The GTAs programs in HIV had proved to be the success.[62] Therefore, such programs if implemented in GBV sector can also be an effective way to address the IPV.

### 5.3. IPV training to health care providers: A study result from Sri Lanka

The evidence shows that only a few victims seek help from HSPs, thus resulting in under diagnosis of the IPV cases.[14] Therefore, it is important to provide necessary knowledge and skills on IPV besides to help make proper diagnosis and treatment related to health problems caused by IPV. For example, Ministry of Health, Sri Lanka has introduced the community level violence prevention initiatives by training the frontline HSPs to reduce VAW in the country. These frontline health workers were taught to identify and refer the under reported IPV problems for psychological care and counselling to the medical doctors. Under certain condition, the medical doctors will then refer the case to legal and social services. [64]

Therefore, it is shown that providing such training to the frontline health care providers help timely referral and diagnosis of cases and ultimately reduces the IPV in the community. As a result, taking into consideration the similar cultural setting and norms of Sri Lanka to that of Nepal, the above interventions can be adapted and implemented.

### 5.4. Conclusion

The three approaches were discussed in order to provide an intervention to respond and prevent IPV in Nepal. The multi-sectorial intervention with primary and secondary prevention methods used in Mozambique is a good preventive approach to prevent and respond to IPV in Nepal. This approach involves the community along with the individual, family of the victim and multiple stakeholders to identify IPV and channel them to different levels of interventions such as treatment, psychosocial and legal aspect. The on-going

programs in the refugee camp in eastern Nepal show that there is potential in Nepal to utilize this model to other parts of the population.

The examples of India and Sierra Leone of engaging men and young boys in prevention and response to violence to solve the problems of IPV are also a great method to prevent VAW. GTAs are being implemented in SEA countries including Nepal with the project on HIV and AIDS programs which has proven to be successful.

The training to HSPs in the frontlines to prevent IPV in the community are one of the best practices in Sri Lanka which involve the HSPs at all level of conceptual framework by involving in individual, family, community and society level respecting the cultural values and norms. These best practices of Sri Lanka can be applied in low-income country like Nepal to prevent and respond to IPV.

# 6. Discussion

The literature reviews explore the main factors that contribute to IPV and its consequences in Nepal. The literature review also gathered best practices and evidence based interventions from other countries that can be used to prevent IPV in Nepal.

**Relevance of the conceptual framework**:

The conceptual framework adapted from Heise was useful to fulfil the purpose of the study i.e. explore in details about the factors influencing IPV in each level and its consequences in Nepal. The framework has also helped to find out the answers for the research objectives of the thesis. It also helped to find out the way to break through the vicious cycle of violence.

## 6.1. Mapping different forms of IPV and its consequences in Nepal

In Nepal, some of the literature shows the high prevalence of physical violence whereas other literature showed the high prevalence of emotional violence. The difference in reporting is due to the fact that Nepal has done the survey on IPV in the general population only once in the year 2011 whereas multiple studies on IPV is done in different population and different parts of Nepal.[29,38,40] However, the reports from India, Bangladesh, and USA also have shown the high prevalence of physical violence.[23,24,33] Therefore, in general, it seems that physical violence is more prevalent as compared to other forms of violence.

High prevalence of IPV was also found in rural areas of Nepal. This may be because of the various factors such as low education, gender inequality, and low socioeconomic status. This is clear from the study done by WHO (2005) in 10 different DHS countries which found that the rural provinces have higher IPV than the urban provinces.[32] The cross-sectional study by Das et al showed the lower prevalence of IPV among the urban pregnant women in the slums of Mumbai. This result resembles the case in Nepal, where the prevalence of IPV is lower in urban pregnant women as compared to rural. [37] Besides husband, women also face violence from family members, neighbours, and friends. This is evident from the NISVS (2010), which shows the high prevalence of IPV by their current partners (81.6%) than their former partner (21.9%).[33]

The consequences of IPV reported among women in Nepal are multiple and severe. The most common are physical, reproductive and psychological problems often leading to death. Globally, the similar result on consequences was also reported from the women who had ever experience IPV. Although a majority of women who had ever abused reported the injury as minor while women from Namibia, Peru, Samoa, Urban Thailand and Tanzania reported the major injury.[32] In Nepal, many IPV victims do not seek help from HCS due to stigmatization. This is evident from the reports from MoPH (2012) which showed only 3% of the victims seeking health services.

## 6.2. Contributing Factors related to IPV in Nepal.

The Heise model represents the complex interaction of individual, relationship, community and society level. These factors are interlinked and add to the complexity of IPV and how to address its causes.

Alcohol was shown to be one of the main contributing factors for the IPV in Nepal. Alcohol affects the cognitive and physical function of an individual reducing self-control and negotiation skills resulting in violence. This is also supported by the similar findings of WHO (2012).[(44)] Thus, resulting in violence between husband and wife.

The national evidence shows that history of childhood abuse is one of the factors that influence an individual to engage in IPV. For example, if the child has grown in an environment where he/she has been abused then the likelihood of those children becoming perpetrator is high. Younger the age of the women; higher the IPV because of younger age, she is not able to cope up with her husband and her family. The DHS study from India (2005) and Bangladesh (2009) also revealed the history of childhood abuse and younger age of the women as one of the factors causing the IPV.[23,24]

The attitude of the husband where he thinks himself as superior to women and can do everything that they wish to do. So, this superiority feeling creates violence in the household relation. Another factor that provokes violence is the suspicion attitude of the husband towards their wife. The uneducated partner has the high role in partner violence than that of primary and secondary level educated partners. This is also evident from the DHS reports of India and Bangladesh.[23,24]

Women who are married at younger age suffer more IPV from their husband than their counterparts who are married at the later age. This is also evident from the study done in 10 DHS countries by Hindin showing younger age as a reason for becoming the victim of IPV. [46]

The indigenous group and underprivileged castes like Tharu, Kami, and Damai (untouchables) in Nepal have the higher prevalence of IPV. Similarly, the women of Terai are highly perpetrated by their husband than the Hilly and Mountainous region in Nepal. The Muslims women have experienced more IPV than that of Hindu women. However, there is the limitation to these findings because most of the studies that are used for this thesis are carried out in the Terai region only and far less study is found on the same subject that is carried out in the other ecological regions of Nepal. This might have to do with the limited access to these regions.

The finding shows that the different factors are associated at the relationship level. The adults who have witnessed the violence during their childhood in their family are more susceptible to IPV during their lifetime. Lower socio-economic household status of both the women and men are one of the factors for IPV. If the family of the women has weak financial status, then she is most likely to be violated by her husband and his family. In addition, the women are also having less decision making power in their family thus increasing their vulnerabilities to IPV. Less decision making authority linked with the lower level of education is also the reason for the power difference between men and women. All this is evident from the study done by USAID in 10 different DHS countries.[46]

The strong belief of generation continuation by the son which increases the son preference and polygamy when the wife does not give birth to son is other factors for marital conflict leading to IPV. Thus, son preference leads to the larger number of children in Nepal whereas if there is a son in the family it acts as a protective factor. The study done in Vietnam and Nepal shows that the son preference is one of the factors associated with IPV.[42]

Lower support from husband and family members increases the risk of IPV whereas the support from natal family, women working in community groups and those who are employed are protected. Dowry is one of the old cultural practices in Terai region of Nepal. For example, the girls from the poor family in Terai region are not being able to get married with the wealthy family due to the dowry. If the husband of the girl doesn't get enough

dowries then the disputes arise in the family leading to IPV. The similar results were also shown in the study carried out in Bangladesh, where poverty and dowry as one of the main reasons for IPV.[53]

Poverty linked to low wage employment is one of the main factors that cause IPV at the community level in Nepal. Poverty itself leads to many problems that are very difficult to resolve. Poverty linked to lower caste and lower ethnicity aggravates IPV in Nepalese community. As a result, most of the IPV are resolved among them and it continues as vicious cycle resulting in harm to the women.

Women who worked as a daily wage employee and manual labour are more prone to IPV than those who are housewives. Although women whose husband has a better job is less violated than those whose husband works on a daily basis as evident from different studies from Bangladesh and India.[23,24]

The most important factors that are associated with IPV are cultural norms, gender roles, inequalities and the legal reforms at the societal level in Nepal. Socio-cultural norms are the most common factor that perpetuates the VAW in Nepal. Nepal has a strong patriarchal society where it is difficult for the wives to talk about the violence done by her husband in the society. And also it is thought that after the marriage of the women it is their responsibility to uphold cultural norms of respecting the husbands. In many cases, wives have less power as compared to husband thus they land up in working under the direction of their husband with limited rights.

It is culturally believed that god has created men and women differently so they have different gender roles. For example, men are supposed to work outside the house for the family livelihood while women are to take care of the house. This difference in gender roles often creates problems between husbands and wives and can contribute to IPV. The family expectation of having a son from their wives often leads to IPV if they are not being able to give birth to the son. This clearly shows that in Nepal, gender roles and gender inequality greatly influences the IPV.[42]

As discussed in Chapter four, the legal reforms are in place in Nepal but it has not been implemented which is also one of the causes of IPV.

## 6.3. Evidence based interventions and best practices from other countries to respond to IPV.

Three approaches, the multi-sectorial approach in Mozambique, engaging young men and boys (GTAs) in India and Sierra Leone and IPV trainings to HSPs in Sri Lanka are discussed in chapter five in order to provide an intervention to respond and prevent IPV in Nepal. Based on the factors associated with IPV in Nepal, engaging men and young boys (GTAs) seems most appropriate for Nepal.

The interventions such as awareness to community and individuals about the IPV and its consequences, Behaviour Change Communications (BCC) programs, Information, education and communication (IEC) program, mass radio programs, support to survivors, training to HSPs, etc. are implemented and on-going in Nepal. However, this has not been as effective as the GoN or organizations have expected due to the cultural norms and stigma. As discussed in chapter one, only a few of the victims seeks hospital services for their health related problems but they don't inform that IPV is the cause for their problems. This shows that HSPs are not aware of the IPV and its related problems owing to the inadequate skills and knowledge on IPV.

However, at present in Nepal there are some of the activities on IPV which are linked with the components of the three models discussed in chapter five are being implemented. Awareness and sensitizations programs, BCC, IEC, mass media programs, radio programs are the most common activities geared towards primary prevention level. However, engaging men and young boys are not adequately addressed which needs greater attention.

This is evident from Bihar, India, where GTAs have changed the knowledge and behaviour on issues related to SRH, gender and education of the young women. For example, the project successfully retained the young school dropout girls, improved the age of marriage (after 18 years) and pregnancy (after 21 years). The attitude of parents and community were also changed as they started supporting the education for girls.[54] Therefore, this approach in India successfully and effectively helped in transforming the attitudes of men and boys towards violence against women and girls leading to gender equality and equity.

# 7. Conclusion and Recommendation

## 7.1. Conclusion

IPV is one of the public health issues that abuse the rights of women. It occurs every day and in most of the corners of the countries, regardless of culture, race, religion, caste, ethnicity, society, and community. It has individual, family, social and economic effects leading to severe health consequences.

Although the prevalence of IPV is lower in Nepal than other countries, IPV is rampant and socially acceptable in many parts of the country. The prevalence of physical IPV is higher than sexual and emotional IPV. IPV is most commonly found in women of rural areas and is also seen in pregnant women living in those areas of Nepal. Women also face violence from different perpetuator like family members, friends, and neighbour beside husband. The consequences of IPV are severe and multiple leading to even death of the women.

The socio-demographic factors such as women's young age, lower education, and lower caste have influenced their husband to act violently against them. Those women living in Terai region are mostly affected in Nepal. In terms caste and religion, the women belonging to lower caste and those from Muslim groups are mostly affected as compared to other caste and religion. However, there is no such information to gauge the intensity of IPV in Hilly and mountainous regions.

Dowry is one of the main factors associated with IPV in Terai region. It is a cultural practice that is deeply rooted in the society. Contributing factors to IPV on the individual, relationship, community, and society levels are closely interlinked; dowry coupled with low socioeconomic household condition of the family, and women's low decision-making power. This aggravates IPV on the family level.

Poverty coupled with unemployment is the main key factor for IPV in Nepal. The lower the employment level of women; the higher the violence between husband and wife. Cultural norms along with gender inequality are the main culprit of IPV in Nepalese society. Gender is not about women and men; it is about the complex intersection of various components such as religion, age,

education, the socioeconomic status that affects the social norms, the power relation, attitude, and perception that causes IPV.

Based on the factors associated with IPV in Nepal, GTAs engaging men and young boys is chosen as the most appropriate intervention for Nepal than the other two multi-sectorial approaches and IPV training for HSPs model. Adapted Heise framework was recognized to identify the factors associated with IPV, thus, systematic and sustainable efforts are also needed in every level of framework i.e. individual, relationship, community and society to prevent IPV. Engaging men and young boys as a mediator in the community and working with them has the significant effect in changing the attitude and behaviour of men and boys towards violence. Thus, gender transformative works towards changing the attitudes against cultural norms, gender inequalities, and gender roles in order to prevent and respond to IPV.

There are updated GBV and DV guidelines and policies that exist in Nepal and programs are also in line to implement and some are on-going but there are no documentations or literature found on the programs on GBV in the general population. Since Nepal is also facing political instability, the general population has lost faith and trust in government and policies that protect them. This political instability also hindered the successful implementation of GBV programs.

## 7.2. Recommendation

The causes of IPV are complex; factors on individual, relationship, community, and societal level are closely interlinked. In order to address and eliminate IPV, the implementation should focus on through these individual, relationship, community and society levels. Therefore, in order to end violence against women, the GTAs would be the best recommendations for the GoN to implement plans and strategies in future.

**Policy level**

1. As, Nepal is a Low Income Country (LIC), the funds from MoHP is not sufficient to run all the programs. So, MoHP should prioritize the funding through government budget and donors support for the intervention programs that are to be implemented to prevent IPV in Nepal. MoHP in collaboration with other donors support should also make a continuous supply of logistic materials support the victims of IPV.

2. MoHP should improve the recording and reporting of IPV indicators to capture the information in HMIS for evidence - based planning.

**Program Level:**

3. MoHP in collaboration with other stakeholders and service provider need to focus more on GTAs by engaging men and young boys in training to the community. In addition, comprehensive sensitization programs are to be carried out among the community leaders, religious leaders, judges, advocates, school teachers, and women and girls on gender roles, gender inequality, cultural and traditional norms, and the attitude that causes GBV against women.

4. MoHP with other civil society organizations, NGOs, CBOs and women groups working in the field of GBV should arrange a public awareness campaign engaging men and young boys together with women and girls to aware on gender - related issues and rights.

5. MoHP should review and revise school and training curriculum, guidelines and protocols to integrate gender equality and to address VAW and disseminate to different organizations working in GBV field, different stakeholders, governmental organizations, legal and security organizations, private hospital and health care services.

6. MoHP along with legal and security personnel should sensitize the general population on existing laws and policies on GBV to create larger public awareness.

**Research level**

7. The prevalence of IPV and its factors needs to be assessed in Hill and mountainous region of Nepal in order to prevent IPV and provide necessary services to the victims. Therefore, MoHP along with research council should conduct a study to quantify and explore the current situation. The mixed method would be appropriate where quantitative survey needs to be supplemented by the qualitative study. The various factors associated with

the IPV among this community can be explored through in-depth open-ended interviews.

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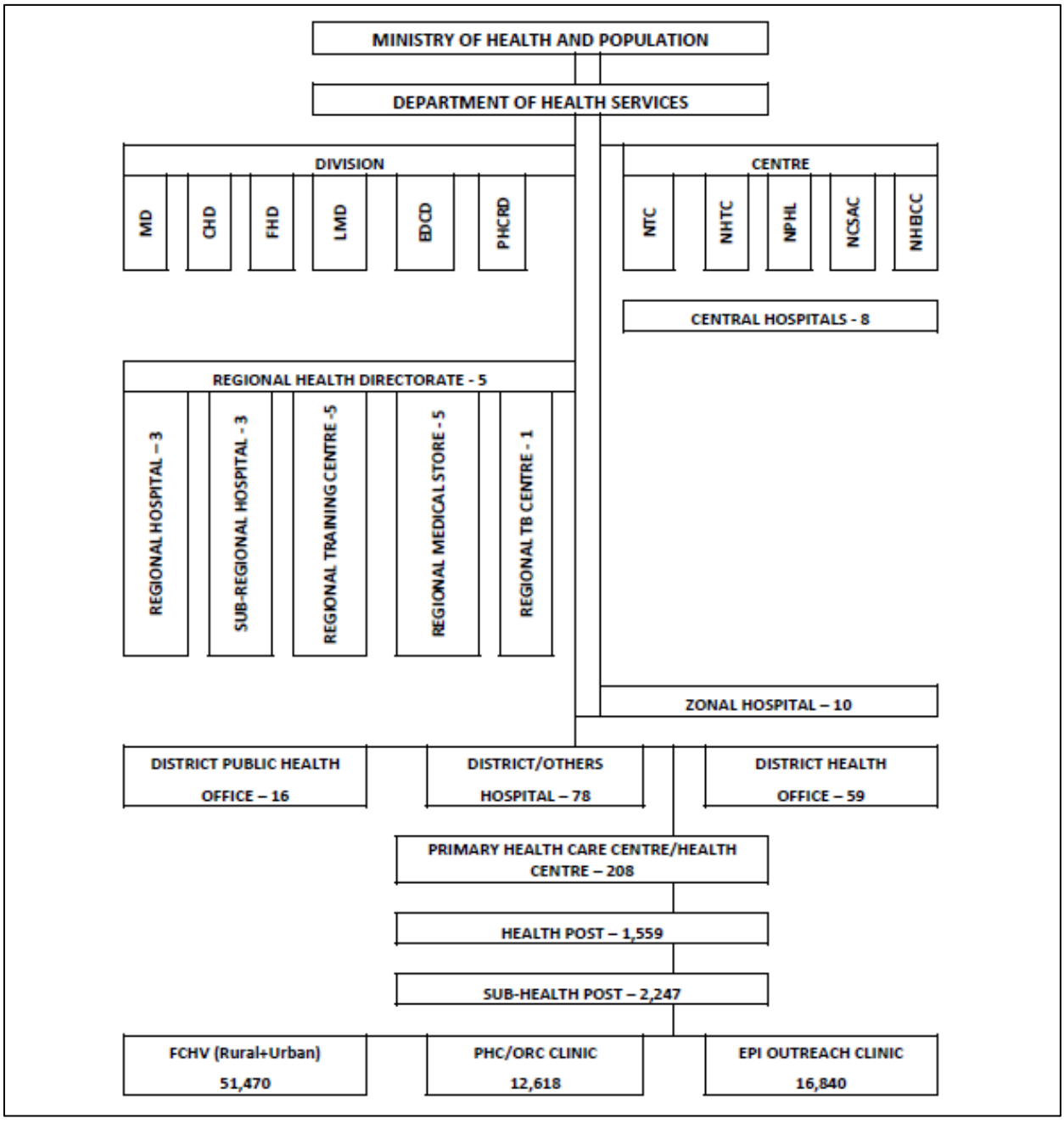
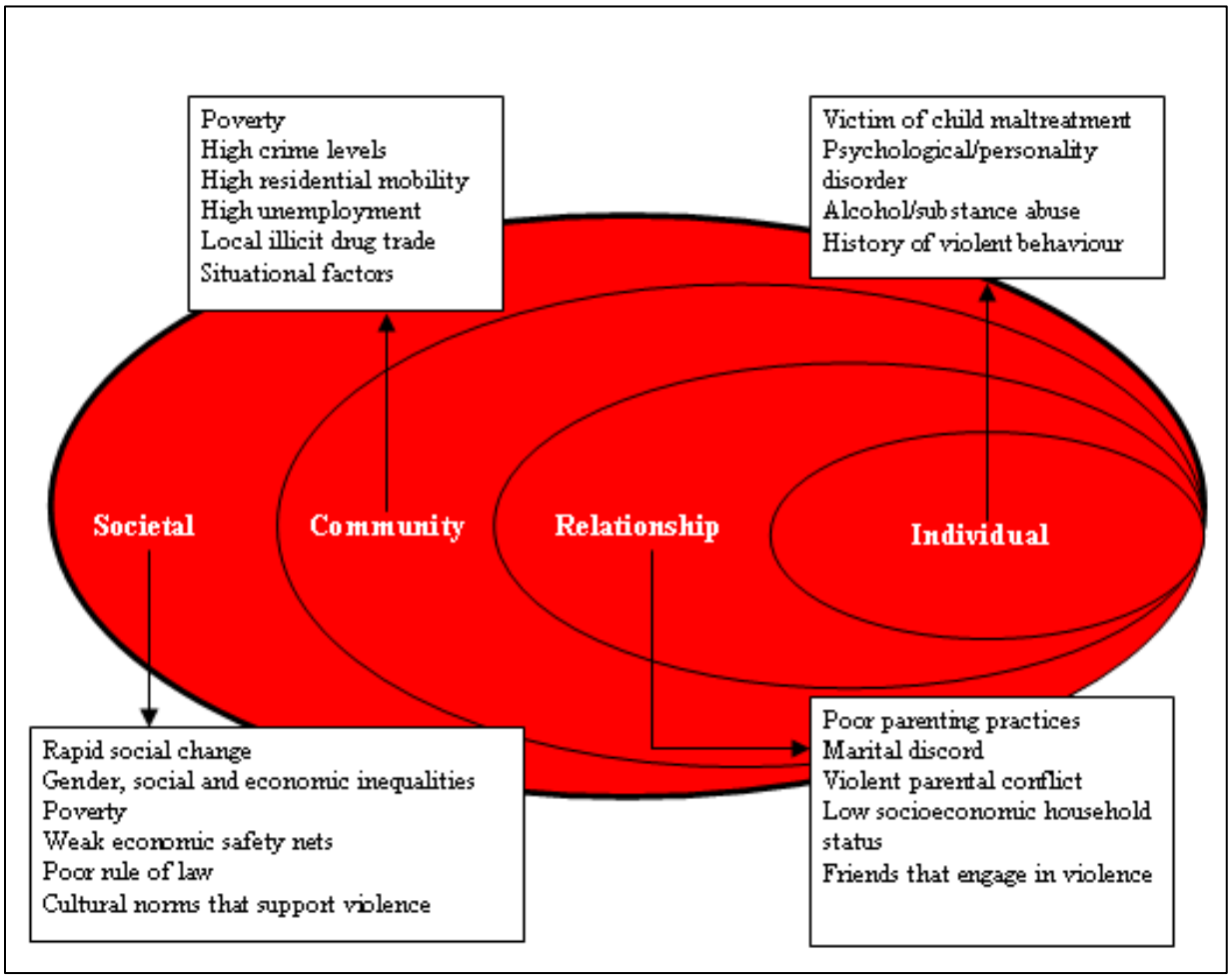
## 9. Annexes:

9.1. Annex 1: Organizational structure of Department of Health Services (DOHs), Nepal, 2011.



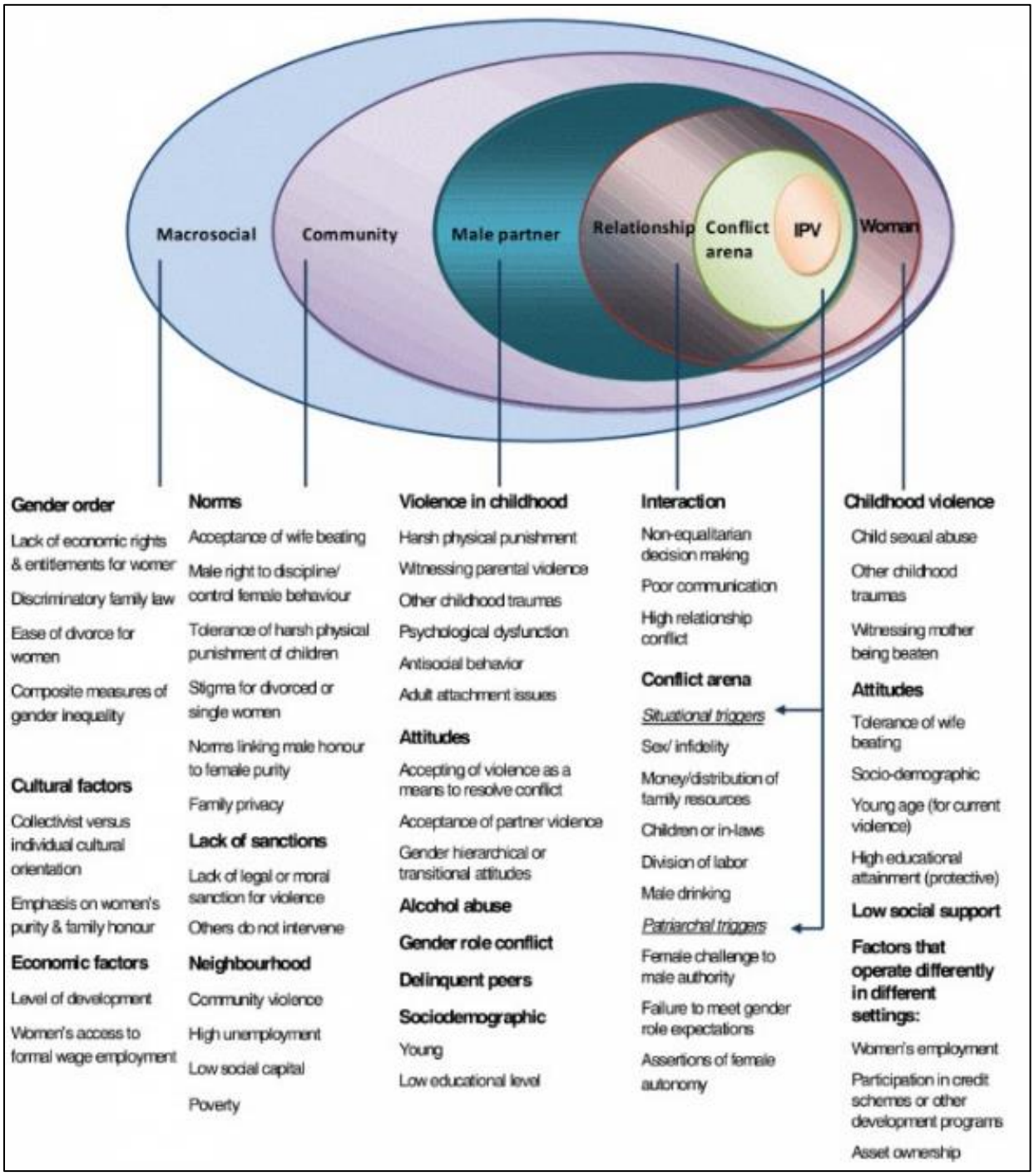

*Source: DoHS, Nepal, 2011*

9.2. Annex 2: Conceptual framework for evaluating different factors associated with IPV – The WHO ecological framework




*Source: WHO ecological Framework*

9.3. Annex 3**:** Conceptual framework for evaluating different factors associated with IPV **–** Revised conceptual framework for partner violence




*Source: Heise Lorie L. What works to prevent partner violence: An evidence overview, 2011.*