INTIMATE PARTNER VIOLENCE (IPV) IN BHUTAN

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Bhutan

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Intimate Partner Violence in Bhutan

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by

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Table of Contents

List of Tables and figures

Figures

Tables

Abbreviations

ADB	Asian Development Bank
AA	Alcoholic Anonymous
AUSAID	Australian Aid
BHUs	Basic Health Units
BMIS	Bhutan Multi Indicator Survey
CBR	Crude Birth Rate
CDR	Crude Death Rate
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CPA	Chithuen Phendey Associations
CRC	Convention on the Rights of the Child
C4CD	Care for Child Development
DV	Domestic Violence
ECCD	Early Childhood Care and Development
FGD	Focus Group Discussions
GDP	Gross Domestic Product
GFR	General Fertility Rate
GNH	Gross National Happiness
GNHC	Gross National Happiness Commission
GVB	Gender Based Violence
HA	Health Assistants
HMIS	Health Management Information System
HIC	High Income Countries
IMR	Infant Mortality Rate
IMAGE	Intervention with Micro Finance for AIDS and Gender Equity
IPV	Intimate partner violence
LMIC	Low middle Income countries
MMR	Maternal Mortality Rate
MDG	Millennium Development Goals
MoE	Ministry of Education
MoH	Ministry of Health
NAPG	National Action Plan for Gender
NCWC	National Commission for Women and Children
NGOs	Non-Governmental Organizations
NSB	National Statistical Bureau
NSH	National Health Survey
NWAB	National Women's Association of Bhutan
ORCs	Outreach Clinics
PHC	Primary Health Care
PHCB	Population and Housing Census of Bhutan
RENEW	Respect Educate Nurture and Empower Women
RGoB	Royal Government of Bhutan

SAARC	South Asia Association for Regional Cooperation
SEAR	South East Asian Region
SIGI	Social Institution and Gender Index
SV	Sexual Violence
SVRC	Sexual Violence Research Initiative
TFR	Total Fertility Rate
U5MR	Under Five Mortality rate
UNDP	United Nations Development Program
UN	United Nations
UNICEF	United Nations Children's Education Fund
UNFPA	United Nation Population Fund
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
YDF	Youth Development Fund
WHO	World Health Organization

Glossary

Intimate Partner Violence – "Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" [(1)].

Sexual violence – "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, but not limited to home and work" [(1)].

Sexual violence by an intimate partner- forced sexual intercourse against women's wishes, or forced to do something sexual that women found degrading or humiliating [(2)].

Violence – "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" [(1)].

Violence Against Women – "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" [(3)].

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Abstract

Background
Intimate Partner Violence (IPV) is a significant public health problem and a violation of women's human right. 1 in 3 ever-partnered women in Bhutan experience IPV leading to physical injuries, emotional distress and indirect consequences like loss of productivity.

Objective and Methodology
This thesis identifies the main contributing factors for IPV in Bhutan through literature review. The ecological Framework is used to analyse and organise contributing factors and promising practices for addressing IPV.

Findings/Results
The risk factors for IPV takes place at different levels of the ecological model. The core drivers of IPV in Bhutan are gender inequality and power imbalance which is reinforced by discriminatory cultural norms and religious belief. While IPV cuts across all socio-economic groups, women from lower socioeconomic status, rural residents, with no formal education and whose partner abuse alcohol, are more vulnerable. IPV prevalence is higher among districts where patrilineal inheritance is practiced.
Promising interventions to prevent IPV includes community mobilization and advocacy, microfinance and gender transformative strategies, parenting and alcohol harm reduction programs and effective health care response.

Conclusion/Recommendations
The causes of IPV are multiple and complex. Initiatives to tackle IPV must expand beyond individual level and move towards transforming larger community and social norms around masculinities. Both long term and short term strategies based on participatory and gender transformative approaches are required to address IPV. There is need for more research to understand IPV burden and to explore effective interventions.

Keywords
IPV, VAW, GBV, contributing factors, promising practices.

Word count: 11618

Introduction

Violence against women (VAW) particularly Intimate partner violence (IPV) is a significant public health problem worldwide and it is considered one of the most systematic and fundamental violations of women's human right as well [(4)]. VAW is deeply rooted in "social structures and it cuts across age, socio-economic, educational and geographic boundaries affecting all societies and is a major obstacle to ending gender inequality and discrimination globally" [(5)].

Globally, 35% of women have experienced either IPV or non-partner sexual violence in their lifetime, 1 in 3 women who have been in relationship reported physical and/or sexual violence by their intimate partner and as many as 38% of murders of women are committed by an intimate partner. The highest prevalence of VAW is reported in South East Asian region (SEAR) with prevalence at 37.7% [(6)]. Besides the socioeconomic implications, VAW can result in severe physical, mental, sexual, reproductive health and other health problems, and may increase vulnerability to HIV [(6)].

In Bhutan, IPV is the most common form of violence with approximately 1 in 3 ever partnered women aged 15-49 years, having reported experiencing at least one specific type of violence in their lifetime(7).The main form of IPV likely to be experienced are emotional and physical violence resulting in severe physical injuries, emotional distress, suicidal thoughts and reproductive health problems [(7)]. In addition to consequences for women's health and well-being, IPV carries a heavy human and economic cost and hinders development. In Bhutan's context, the prevalence of such violence perpetuates the subordination of women and the unequal distribution of power between women and men. Despite its high prevalence, IPV is notoriously under reported as it is deeply ingrained in Bhutan's internalized culture and tradition.

During my 8 years of service in various clinical settings, I have come across many cases of IPV where women are disproportionately the victims. Many women do not access health care and other services from formal and informal institutes and about 40% of the victims do not tell anyone about their partner's violence [(7)]. Among those who seek help from formal institute for IPV and other forms of violence, there has been hardly any help from these institutes as it lack effective and organized preventative and treatment services. By focusing my thesis on IPV, I will critically review the underlying root causes and contributing factors, effective interventions and promising practices and come up with strategies to scale up efforts across wide range of sectors. For this review, the term IPV, GBV, DV and VAW are being used interchangeably.

CHAPTER 1: Background

This chapter provides key information on Bhutan's demographic profile, geography, administrative structures, culture, religion, economy, education and health systems which have impact on health.

1.1 Geography

Bhutan is a small landlocked country located on the eastern foothill of Himalaya with an area of about 38,394 square kilometres [8]. It is bordered by China in the north and India in the west, east and south. There are three major ethnic groups of people; Ngalops, Sharchops and Lhotsampas from the Western, Eastern and Southern region respectively. The country is divided into 20 districts (Dzongkhag) and Thimphu is the capital city.

Figure 1: Bhutan Political map showing the international boundary, districts boundaries and the capital (World map 2013)

Source: [9]

1.2 Demography

In 2014, the total population was projected at 745,000 with an overall sex ratio of 108 male per 100 female and the population density is estimated at 19.4 person per Sq. km [8]. The median age of population was 24.7 years. The total fertility rate is declining gradually over the years from 5.6 children

per women in 1994 to 2.3 children per women in 2013. The life expectancy at birth stands at 68.3 years in 2012 [10].

1.3 Government

Bhutan held the first general election in 2008 after transitioning from absolute monarchy to constitutional monarchy with the introduction of multi-party democracy. The government continues to accord high priority to social sectors like health and education with the allocation of 23.61% of 10th five year plan outlay budget to these two sectors [11]. Bhutan has already achieved four millennium development goals (MDGs) in halving extreme poverty, reaching gender parity in education, ensuring environmental sustainability, and reducing maternal mortality by three-fourths and it is on track for achieving the rest of the goals [11].

1.4 Culture and Religion

Bhutan has a rich culture and traditions which is deeply steeped in its Buddhist heritage. Buddhism is the state religion and majority of the people practice Vajrayana Buddhism followed by Hinduism which is the second dominant religion prevalent in southern part of Bhutan. The traditional inheritance practice are still prevalent and it varies from region to region but in most part of the country, the inheritance generally passes through the female rather than the male line [12].

1.5 Economy, Education and Employment

Bhutan is an agrarian country and the main source of livelihood for majority of the population living in rural areas are agriculture, livestock and farming [13]. The country's gross domestic product (GDP) per capita was USD 2440 in 2013 and the average economic growth was recorded 6.70 percent in the last five years [8] [11]. Despite drastic reduction in national poverty level from 31.7% in 2003 to 12% in 2012,disparities still exists between districts with poverty rate ranging from as low as 0.5% in western region to as high as 31.7% in some parts of southern and central regions [11].

In terms of jobs, the unemployment rates have been higher among women than men since 2009 and the quality of job for women is still an issue as job held by women are paid less and less secure compared to men [14][15]. In the public sector women accounted for 33% of all civil servants and fewer women hold high-level positions [15]. In 2013 elections, there were no women representative in the 20 elected seats of the national council and women gained only 3 of the 47 seats in the national assembly [15][14].

In education, Bhutan achieved closing gender gaps in primary and secondary levels of education but gap persists at tertiary level education. The education

statistics for 2012 showed that among students studying in tertiary level colleges and institutes, girl's enrolment is only 40% and among those receiving scholarship to study abroad, girls make up only 38% [15].

1.6 Health system

In Bhutan, the government is the sole provider of both modern and traditional health care services which are mainly delivered through the three-tiered health care delivery system that comprise of regional and referral hospitals at tertiary level, district hospitals at secondary level and basic health units (BHUs) at primary level of care. All health care services are provided free by the state including referral services outside the country [16]. Currently there are 3 referral hospitals, 29 general hospitals, 205 BHUs, 514 outreach clinics (ORCs) and 49 indigenous dispensaries that provide both indigenous medicines (gSowa Rigpa) and modern health care services [8]. Over all, significant improvement has been made in all major health indicators as shown in table 1 [10].

Table 1: National Health Indicators of Bhutan (Annual health bulletin 2014)

Sl.	Indicators	Year					Source
		1994	2000	2005	2010	2013	
1	Life expectancy at birth [years]	66.1	-	66.3	68.9	-	NHS 1994, PHCB 2005, Population Projections of Bhutan 2005-2030, NSB.
2	Crude birth rate (CBR) [births per 1000 population	39.9	34.1	20.0	19.7	17.9	NHS 1994, NHS 2000, PHCB 2005, BMIS 2010 & NHS 2012.
3	Total Fertility Rate (TFR) [children per woman]	5.6	4.7	3.6	2.6	2.3	NHS 1994, NHS 2000, PHCB 2005, BMIS 2010 & NHS 2012.
4	General fertility rate (GFR) [births per 1000 women 15-49 years]	173	143	79.4	-	72.0	NHS 1994, NHS 2000, PHCB 2005 & NHS 2012.

5	Adolescent birth/fertility rate [births per 1000 adolescent women 15-19 years]	120	61.7	-	59.0	28.4	NHS 1994, NHS 2000, BMIS 2010 & NHS 2012.
6	Crude death rate (CDR) [deaths per 1000 population]	9.0	8.6	7.0	-	6.2	NHS 1994, NHS 2000, PHCB 2005 & NHS 2012.
7	Under-five mortality rate (U5MR) [deaths per 1000 live births]	96.9	84.0	61.5	69.0	37.3	NHS 1994, NHS 2000, PHCB 2005, BMIS 2010 & NHS 2012.
8	Infant mortality rate (IMR) [deaths per 1000 live births]	70.7	60.5	40.1	47.0	30.0	NHS 1994, NHS 2000, PHCB 2005, BMIS 2010 & NHS 2012.
9	Maternal mortality ratio (MMR) [deaths per 100,000 live births]	380	255	-	-	86.0	NHS 1994, NHS 2000 & NHS 2012
10	Sex ratio at birth [males per 100 females]	105	106	101	-	104	NHS 1994, NHS 2000, PHCB 2005 & NHS 2012.

Source: [17]

In terms of health response to VAW, there is no separate and specific program related to GBV in the clinical settings. Treatment and counselling services for IPV are usually integrated into general routine care. There is also no established system for systematic collection and analysis of GBV related data in health care centres that would link various other actors such as RENEW, NCWC, and Police. Only the tertiary hospital based in Thimphu has the Forensic Specialist where DV including sexual violence cases are either referred or consulted [18].

1.7 Gender Background/Policies

After becoming the signatory member of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC) in 1981 and 1990 respectively, Bhutan established the National Commission for Women and Children (NCWC) in 2004 with the main objective of enhancing the role of women at all levels of the development process and to monitor and coordinate all policies and activities related to protection of rights of women and children [19]. In addition, Bhutan also signed and ratified South Asian Association Regional Cooperation (SAARC) convention on prevention and combating trafficking in women and children for prostitution to reaffirm its commitment to the protection of women's rights [12].

Since then, efforts were made in mainstreaming women into social, economic and political development [12]. Furthermore certain important and relevant Acts/Bills such the Marriage Act of Bhutan (1996), the Child Care and Protection act of Bhutan, the Domestic Violence Prevention Bill (2012) and the Regulation on Sexual Harassment (2009) were enacted and passed which provided a legal basis for the protection of women's rights [7]. In addition, other non-government organizations (NGOs) such as National Women's Association of Bhutan (NWAB), Respect Educate Nurture and Empower women (RENEW), Youth Development Fund (YDF) and Tarayana Foundation were also established.

In terms of national policies and legislations, Bhutan has gender equity stand on most of its policies. The article 7 of the Constitution of the Kingdom of Bhutan, adopted in 2008 states that "all persons are entitled to equal and effective protection of the law and shall not be discriminated against on the grounds of race, sex, language, religion, politics or other status". The Constitution also has a provision to take appropriate measures "to eliminate all forms of discrimination and exploitation against women including trafficking, prostitution, abuse, violence, harassment and intimidation at work in both public and private spheres" [20]. Similarly, the Penal Code of Bhutan (2004) also addresses many GBV issues such as assault, battery, and sexual offences [21]. Overall, the Gross National Happiness Commission (GNHC) plays leading role in stimulating and coordinating action in support of gender equality through policy formulation that direct all ministries and agencies to mainstream gender issues in their sector plans and policies. The National Plan of Action for Gender (NPAG) which was prepared by GNHC and the NCWC in consultation with gender focal points in government and stakeholders, sets out an action plan to address gender gaps [15]. The overall perspective on gender is summarized in the table below.

Table 2: Summary of overall perspective on gender in Bhutan based on statistical data from several gender related documents (Helvetas 2013)

Positive observations	Negative observations
Absence of overt forms of gender discrimination Political commitment (ratification of CEDAW; Beijing Platform for Action; Constitution proclaims it a responsibility of the State to take measures to eliminate gender-based discrimination) A competent National Action Plan for Gender Presence of state and non-state actors engaged in promoting gender equality	Socio-cultural perceptions generally hold women as less confident, less capable and having lower status Low representation of women in governance/public decision-making forums Gender disparities in higher education, technical and vocational institutes Gender disparities in employment situation, with more pronounced unemployment rate for women

Source: (22)

CHAPTER 2: Problem statement, Justification, Objectives and Methodology

2.1 Problem statement and Justification

It is generally portrayed that overt discrimination against women does not exist in Bhutan. According to the OECD Social Institution and Gender Index (SIGI) 2009, Bhutan is ranked 64th at 0.162 among 102 countries in the world and 1st in South Asia region, indicating that Bhutanese women enjoy more gender equality than other Asian women [7]. Despite the progress, a study on the situation of VAW in 2012 showed that about 1 in 3 women who ever partnered experienced at least one form of IPV in their life time, 3 in 10 experienced at least one act of violence by non-partner, 2 in 100 women aged 15-49 were sexually abused before the age of 15, 4 in 100 have their first sex below the age of 15 with more than half against their will, 8 in 10 experienced controlling behaviour and 6 in 10 women are subjected to economic abuse by their partner [7].

The main forms of IPV are emotional and physical violence. In terms of violence during pregnancy, 7 in 100 pregnant women were likely to experience physical violence with 4 in 10 among them either being punched or kicked in the abdomen [7]. The Bhutan Multiple Survey (BMIS) highlighted that 70 percent of Bhutanese women accept that they deserved beating if they neglected their children, argued with their partners, refused sex or spoiled meal and most of the women treated IPV as a non-issue due to the privacy of the matter [23]. There is acceptance among a significant section of women about their inferior status within marital relationship which is mainly associated with traditional beliefs, socio-cultural norms, men's economic and decision making power, and power relationship between man and woman [12]. Although IPV is prevalent among general population, two studies on situation of VAW indicated that rural women experienced more violence compared to their urban counterparts [24][7]. Furthermore, IPV was more common among women having lower level of formal education with financial dependence on their partners [7]. The gender statistics report showed wife battery by husband as the most common cases being reported while rape, incest and child molestation or sexual harassment were reported in negligible numbers [25].Moreover SV within marriage is hardly discussed or debated in public spheres as it's perceived as men's right over women's body[7]. The most common contributing factors behind IPV were difficulties at work place, financial problems, alcohol use by man, jealousy, and early marriages [7] [10].

VAW especially IPV is an area of genuine concern for Bhutan, as the issue centres on changing people's perceptions that is often deep-seated within internalized culture, social norms and values. This study attempts to determine factors influencing IPV in Bhutan through literature review by

focusing on underlying personal, relationship, socioeconomic and cultural factors, and identify effective and promising practices so as to come up with appropriate recommendation for relevant stakeholders.

2.2 Overall Objective

To determine factors influencing occurrence of IPV and analyse effective interventions in order to formulate recommendations for relevant stakeholders in Bhutan.

2.2.1 Specific objectives

- To describe the magnitude of problems of IPV and analyse the evidence on what influences contributing factors with attention to individual, relationship, community and societal factors in Bhutan's context
- To analyse the current strategies applied to prevent and respond to IPV
- To formulate recommendation to improve strategies for preventing and addressing IPV in Bhutan

2.3 Methodology and search strategy

This thesis consists of literature review that includes both published and grey literatures on VAW particularly IPV. The search strategies involved use of Google Scholar, Web of Science, Pub Med and VU University library database to search for peer reviewed articles on determinants, prevalence, reasons for and strategy to prevent IPV worldwide and in context of Bhutan. The search was repeated with different search term such as GBV, IPV, DV and SV. For additional information, the websites of MoH, NCWC, RENEW, NSB, UN women, SVRI, CEDAW, UNFPA, AUSAID and the WHO were searched. As delimiters, mostly systematic reviews were included which was further narrowed down by focusing on articles from South East Asia and Pacific region. Articles published only in English language from year 2000 to 2015 were referred. Since there is limited peer reviewed articles from Bhutan, grey literatures including unpublished reports and strategy documents were referred and wherever necessary, personal observations and experiences has also been included.

The key words included violence against women, domestic violence, gender-based violence, intimate partner violence, sexual violence, wife abuse, wife battery, in combinations with other terms like determinants, contributing factors, risk factors, patriarchal, inheritance, culture ,strategies, prevention, promising practices, effective interventions, Asia, SEAR, Bhutan etc.

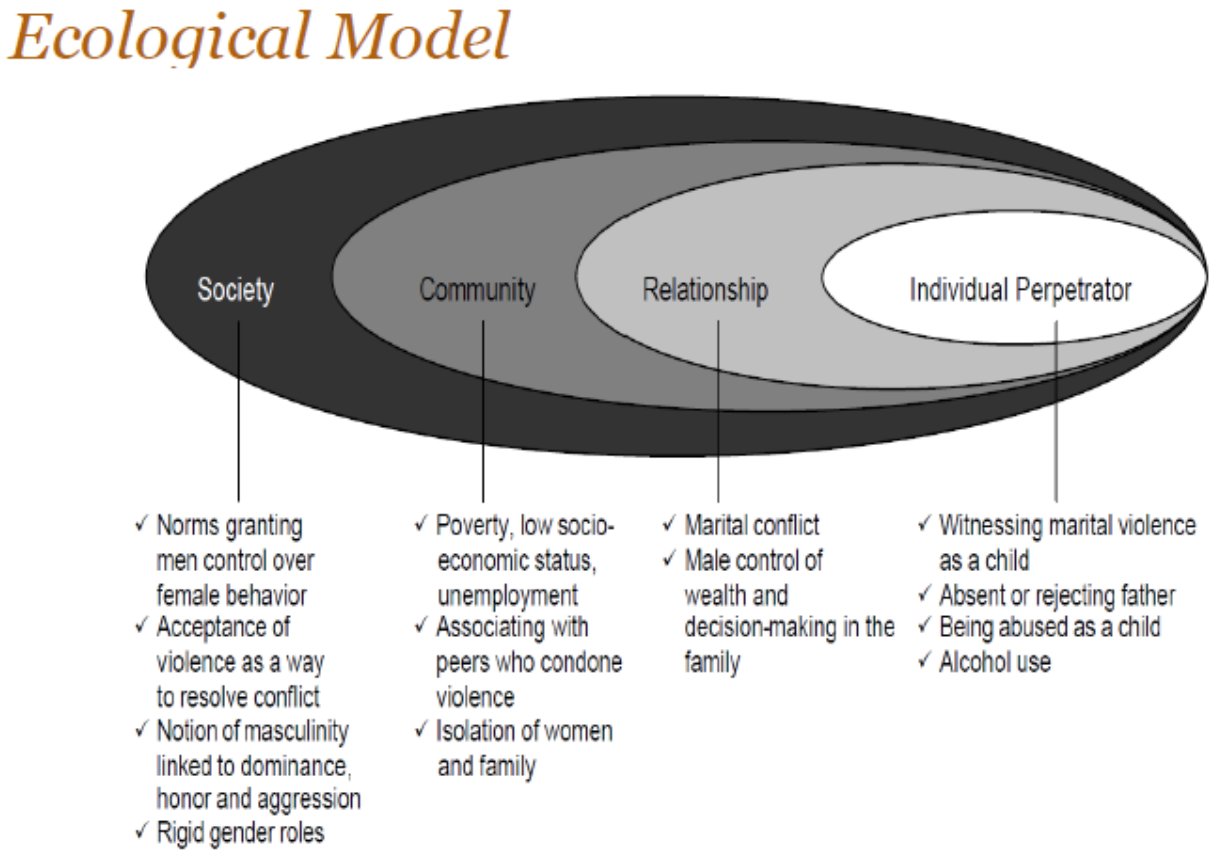
Table 3: Search strategy table

Search strategy	Objective 1	Objective 2	Objective 3
	Key words		
VU library		Determinants, contributing factors ,risk factors for IPV,VAW,DV,SV patriarchal, inheritance, culture, gender stereotypes, socio-culture, ecological model, child abuse, Asia, SEAR,	Strategies, prevention, promising practices, effective interventions for IPV, systematic review
PubMed			
Web of Science			
Google Scholar			
Regular Google for grey literatures, websites of government like MoH, NSB, NCWC, RENEW, GNH, ADB, WHO, UNICEF, UNFPA, CEDAW and other organizations like IPPF, SVRI.	VAW,IPV,GBV, DV,SV Incidence, prevalence wife abuse, wife battery, Asia, SEAR, Bhutan,		
Bibliography of selected articles			

2.4 Conceptual framework: The ecological framework

For the purpose of this thesis, the integrated Ecological Framework from Heise is used to guide the analysis, and the findings are organized under subheadings that correspond to the analytical framework [26]. This framework looks at the interplay of personal, situational, and sociocultural factors that combine to cause GBV [26]. The framework has been chosen because it looks at the risk factors for IPV from a broad holistic perspective. While Social Relations approach focuses mainly on the unequal power relations between men and women as the root cause of GBV, the ecological model is more robust as it includes both social relations of gender related causes as well as presents risk factors at the individual level, within relationship or the family, the community and at the broader societal/institutional level [26]. In context of Bhutan, there is no single cause for IPV as it is a combination of various factors mentioned above. Thus this model is very appropriate to assess as well as to address the condition across different levels.

Figure 2: Ecological Framework for GVB (Heise 1998)



Source:[26]

The model consists of four levels of analysis of which the innermost level stands for individual factor, followed by relationship, community and the largest outer circle representing the societal factor. At individual level, having an absent or rejecting father, witnessing marital violence as a child, experiencing abuse during childhood and alcohol abuse increases the risk of becoming perpetrators or victims of IPV. At relationship level, risk factors include marital conflicts, male control of family wealth and decision-making and age and education disparities between spouses. At community level, poverty, low socioeconomic status, negative influence of social peers, women's isolation from family and unemployment are the main contributing factors, whereas at the societal level, norms granting male control over female, acceptance of violence, rigid gender roles and dominant notions of masculinity are all linked to violence [26]. By using the framework, the contributing factors can be organized in a systematic way so that proper preventive strategies can be identified and directed at each level.

CHAPTER 3: Contributing factors for Intimate Partner Violence

In this chapter, the Ecological framework is used to analyse contributing factors for IPV across different levels.

3.1 Individual/Personal factors

At an individual level, witnessing marital violence at home during childhood, history of abuse as a child, absent or rejecting father and alcohol abuse are the associated with IPV.

3.1.1 Witnessing marital violence as a child and having an absent or rejecting father

A systematic literature review on factors related to DV in Asia showed that IPV appears to be linked to factors of past observation and history of witnessing violence as a child [27]. Other studies also affirm that women who witnessed violence as a child are more likely to experience IPV and boys who had rejecting father with history of exposure to violence during childhood, have a greater risk of becoming perpetrators [28][29]. Similarly, men who had seen their mother being abused were more likely to indulge in IPV including SV in three countries of China, Bangladesh and Sri Lanka [30]. In Nepal, women who witnessed violence in childhood were 2.5 times more likely to experience physical IPV [31].

Personal factors contributing to IPV have not been systematically studied in Bhutan. However a qualitative and quantitative study on VAW in Bhutan showed that out of 118 children interviewed, 56% of the respondents have seen their parents fight while 44% witnessed these fights ending up with violence, leaving the child feeling sad, depressed and scared [24]. Likewise, another study on situation of VAW revealed that 28.4% respondents who experienced violence, witnessed their mother being beaten by their father and another 56.6% have seen their mother being scolded indicating that the abused women were exposed to violence from an early age [7]. Although there is no official record, the prevalence of child having rejecting or absent father is a common phenomena in the rural areas of eastern Bhutan where the practice of "Night hunting" (a practice where unmarried men visit women at night and indulge in sexual acts with or without women's consent leading to unintended pregnancy) is prevalent.

3.1.2 Being abused as a child

A UN-multi country study in Asia and the Pacific showed that at least one form of childhood abuse was strongly associated with IPV perpetration in Bangladesh, China, Indonesia, Papa New Guinea, Cambodia, and Sri Lanka with emotional abuse or neglect, and sexual abuse being the most common [30]. Similarly studies from various countries within Asia also revealed that women who were abused as a child were more likely to experience abuse in

their intimate relationship [32] [28] [33]. However not all men who experienced childhood abuse will become perpetrators. But in general, the literature on developmental psychology has clearly established that history of being abused as a child has impacts on brain development leading to lower self-esteem and empathy, more anger and insecurity which results in increased violence [30][4].

In Bhutan, most of child abuse takes place at homes and in schools [7]. Though corporal punishment is banned, it is still practiced in schools and monastic institutions across the country. Male acquaintances including teachers were identified as common perpetrators of child sex abuse [7]. The records from National Referral hospital revealed that out of 27 sexual assault cases reported in 2007, 18 involved minors with youngest victims being 3 years [18]. In addition child abuse in the form of child labour exists in Bhutan, as 18.4% of children aged 5-14 were found working as a child labour, mostly as domestic helper where abuse take place [23]. In addition, harsh parenting is widely accepted as a way to discipline children in many homes.

3.1.3 Alcohol Abuse

Alcohol abuse does not cause violence directly but it is a major contributing factor, as its over consumption is associated with harmful behaviours leading to IPV and SV [28]. Literature suggests that alcohol contributes to violence by "enhancing the likelihood of conflicts, reducing inhibitions and providing a social space for punishment" and acts as triggers for violence [30]. Evidence from IMAGE study indicated that man having least gender equitable norms and attitudes abuse more alcohol than others [34]. Moreover alcohol abuse and violence are intertwined as alcohol not only facilitates men's use of violence but there is positive association between women's experience of IPV and subsequent alcohol use leading to more violence from partner [5].

Alcohol use is deeply engrained in Bhutanese culture and with rapid social transition and economic growth, drinking alcohol in excess is becoming a source of social problems in the country [35]. In 2010, out of 6.9 million litres of liquor produced in the country, 97.3% of the liquor was sold for domestic consumption. The adult per capita consumption of alcohol in 2010 was 8.47 litres which was much higher than the global per capita consumption of 6.2 litres [35]. Alcohol was found to be a triggering factor for IPV at the household level in Thimphu [24]. Similarly, the findings from the nationwide study on the situation of VAW in Bhutan also cited alcohol as one of the main contributing factor for violence as IPV prevalence among women whose husband drank regularly was as high as 43% compared to 20% among those whose husband never drink [7]. Furthermore, the proportion of women who experienced SV was highest (5.2%) among those whose husband drank on daily basis [10] which is in line with findings from other countries where men involved in IPV and SV were more likely to have abused alcohol [30].

3.2 Intimate Partner Relationship

At the level of couple and family, marital conflict, male control of wealth including inheritance and decision-making and disparities in age and education between spouses are associated with IPV.

3.2.1 Marital conflict in relationship

IPV is mainly driven by factors related to gender inequality and power imbalance in relationship which leads to frequent quarrelling and high level of discord within marriage [30]. In many literature, marital conflict emerges as the strong predictor of IPV [26]. Several studies on men's reason for spousal's abuse in Bangladesh and India showed that men who feel insecure about their wife's fidelity, longer duration of marriage, greater number of children and women's financial contribution to family income are associated with IPV [36] [37] [32]. In Nepal, women generally accept violence from their husband and treat it as private matter as their cultural norms require women's submissive role in family and relationship [31].

In Bhutan marital conflict is very common in relationship. The most common situations leading to quarrel and subsequent IPV are financial problems, difficulties at work, jealousy, family problems and drinking [7] [24].There are regional variations but the prevalence of lifetime IPV in rural area is 40.4%, almost double that of urban areas at 25.2% [7]. Further analysis showed that in the rural areas of Samtse and Tsirang in south, where majority of people are of Nepalese ethnicity, an alarmingly high rates of lifetime IPV were reported which could be due to acceptance of IPV by both men and women in the communities [12][7].

3.2.2 Male control of wealth including inheritance and decision-making in the family

In many parts of Asia-Pacific region, gender division of labour exists, which consider man as the main breadwinner and decision maker of the house where as women and girls are expected to be responsible for household chores and child care [30]. Men are often discriminated and verbally abused by peers when they do not conform to dominant definitions of masculinity [30]. In household where man is the decision maker and women lacked decision making autonomy, women were more likely to experience IPV [31].

In Bhutan's situation, inheritance follows matrilineal family in western, central and some parts of eastern Bhutan and as a result more than 60% of rural women inherit land and have land registered in their names and 45% of urban women have properties registered in their names [14]. The prevalence of ever experienced IPV in the district which practice matrimonial inheritance ranges from 21.85% in Zhemgang to 49.2% in Punakha [7]. However in the Southern

and eastern Bhutan where patrilineal inheritance norm is practiced, the prevalence of ever experienced IPV reported is very high ranging from 58.35% in Samtse to 69.75% in Tsirang, indicating that inheritance practice and males control over wealth is associated with IPV [7] [14].
Although women inherit land which protects them from IPV to some extent, men in matrilineal cultures are still the ultimate decision makers in 62% of the cases and considered better, more literate and experienced in public dealings and better placed to be decision makers [7] [12] [38]. In households where men are controlling decision-making, a link with IPV was established [38] [14] [24].

3.2.3 Age and education disparities between spouses

Male perpetration of IPV was strongly associated with low level of education as man with no high school education was found to be a significant factor for IPV perpetration in Bangladesh and Cambodia [30]. On the other hand, men with higher educational attainment had more gender equitable attitudes which acts as protective factors for partner violence [34]. In Nepal, illiterate women were 2.26 times more likely to experience IPV compared to those women who completed secondary and higher education and early marriage was positively correlated with IPV victimization [31]. Similarly women with high level of education were less likely to experience physical violence in eastern India as educated women are more autonomous and possess necessary skills and resources to move out of abusive relationship [37]. Furthermore, evidence from studies in Asia suggests that the age disparity between spouses provide a context for husband to be abusive in Hong Kong, Bangladesh, Malaysia and Nepal [27] [30]. With increased age, male's dominance and experience with being abusive builds over time and thus allows them to exert their power over younger women. On the other hand, younger women have less experience in handling and dealing with potential abusive situations [27].

This pattern is similar in Bhutan as well. In terms of early marriage, 30% of women first married when they were below the legal age of 18 years and the highest prevalence of current experience of IPV was reported within age group 15-19 years of the ever-partnered women [23] [7]. The findings from both studies suggest that women who did not attend any formal education or with lower level education were at higher risk of violence [7] [10]. Similarly, the prevalence of physical and sexual violence was less among women whose partners had high school or higher level of education compared to those with primary or lower level of education [10]. Likewise, many victims during FGD associated disparity in education and age to IPV and linked education to women's autonomy and independency [24].

3.3 Community level

At the community level; poverty, low social economic status and unemployment, negative influence of social peers who condone violence, and isolation of women from family and peers are identified as factors contributing to IPV.

3.3.1 Poverty, low socioeconomic status and unemployment

The economic inequalities which can be found at an individual, community, national and global levels can be a causal factor for IPV as it acts as an enabling conditions for violence [4].The discriminations and inequalities especially in areas of employment, income, and access to economic resources affect women's empowerment and reduce their capacity to act and make decisions leading to increased vulnerability to violence [4].

Findings from the logistic regression analysis of Indian national family health survey showed that low socio-economic status, rural residence, inadequate income and difficulties in meeting basic needs were significantly related to women being at risk for IPV [32]. Similar findings were reported from population based cross sectional study in eastern India and Nepal [37] [31]. However, it was also found that while high occupational status of women acts as protective factor for IPV, if women's occupational status exceeded that of husband's, it can have the opposite effect and increase the likelihood of IPV [37]. Women engaged in business and farming in eastern India were more likely to be abused compared with housewives or those having equal occupational status with the husband, indicating that increased women's empowerment may exacerbates the risk of violence [37]. The authors concluded that the demand for equality and independence from financially competent women could be the cause of the rising spousal conflict [37]. The findings from quantitative household survey carried out in seven countries of Brazil, Chile, Croatia, India, Mexico, Rwanda and South Africa and the UN-multi country study of men and violence in Asia also claim that high percentage (between 34 to 88 % vs 12-53%) of man from lower socio-economic status experienced significant work related stress leading to depression, suicidal ideation, and perpetration of IPV [34] [30].

In Bhutan's situation, work related stress, difficulties at work and financial problems were identified as the main factors leading to IPV [24] [7]. 63.9% of women aged 15 to 49 years are subjected to at least one act of economic abuse by their intimate partner and rural women are more likely to experience IPV than urban women [7]. In addition, with rapid rural-urban migration, as evident from high population growth rate of 7.3% in urban area, young rural women from low socioeconomic background, who migrate and solely depends on partner's earning were increasingly vulnerable to IPV [23] [24]. The qualitative study findings further affirmed that women with acute financial

dependency on her husband were hesitant about reporting any kind of household violence to police and relevant authorities as this could deprive them of any kind of support if their abusive husband is sent to prison [24]. Thus, there is under reporting and the victims are prone to repeated IPV [24]. On the other hand, there might be likelihood of under reporting in higher social economic classes as IPV is less accepted and shame keeps women from reporting it.

3.3.2 Isolation of women from family and negative influence of social peers

Evidence suggests that women in India who were isolated from families and friends were more likely to report severe lifetime IPV than women who were married and staying with the family of origin [32]. Other study also suggests that when a women leaves her family and goes to live with husband's family, women loses a level of protection against IPV from her family member [27].

Likewise, unemployed Bhutanese women who migrate to town with their husband were more likely to experience IPV as there is no relatives or close neighbours to seek help from [24]. In contrast, back in the rural community, families, neighbours and friends intervened and acted as mediator and counsellor which acted as protective factor for IPV [38] [24]. Other negative influence by social peers which lead to conflicts and violence within family includes gambling, social outing and drinking alcohol together [38].

3.4 Society level

At the societal level: the norms granting male's control over female behaviour; acceptance of violence as a way to resolve conflict; notion of masculinity linked to dominance, honour and aggression; and the rigid gender roles that entrench male dominance and female subordination are all linked to IPV.

3.4.1 Norms granting male control over female behaviour

IPV is one of the key mechanism used to control and maintain men's authority over women in many societies [4]. By subjecting women through punitive and controlling behaviour for transgressing social norms, the use of partner violence serves as a means to reinforce prevailing gender norms and cultural practices that entrench women's unequal status [4].

Both qualitative and quantitative evidence suggest that men who exhibit controlling behaviours such as limiting women's social and family interactions and expecting wife to seek permission before accessing health care service etc. are more likely to commit IPV, and subsequently it can "limit women's ability to control their sexual and reproductive decision-making, their access to health care, or their adherence to medications, which can have adverse health effects" [6] [29]. The UN multi-country study found that large majority (81-98%) of both men and women believed in the abstract idea of gender

equality. However, when asked about specific norms related to family and women's position, more than 72% of both men and women in these countries believed that " a women should obey her husband" [30].

The results from the national health survey and population-based survey on VAW in Bhutan corroborate with the above findings. The two most common controlling behaviours reported in both the studies were 'expects her to ask permission before seeking health care' (55.4-58.2%) and 'wanting to know where she was' (22.8-64.9%) [10] [7]. Overall, 60.3% of the ever-partnered respondents reported experiencing at least one form of controlling behaviour with higher prevalence reported in rural (59.1%) than in urban areas (47.1%) and in terms of districts, the proportion ranges from as low as 8.3% percent in Dagana to as high as 69.3% in Haa district [7] [10]. The VAW study found significant correlation between partner's controlling behaviour and IPV as more than three quarters (80.8%) of women who experienced IPV reported that their partner displayed controlling behaviour [7].

3.4.2 Acceptance of violence as a way to resolve conflict

One of the strongest factors that predicts the prevalence of IPV across sites and countries is the degree to which wife beating is perceived as acceptable [29] [4]. In many settings, IPV is viewed as a "disconnected events, taking place in the private sphere of relationship conflict" and women are often blamed for deviating from the accepted social roles and gender norms which led to violence [6]. Evidence suggests that women in some Asian countries often held more conservative or gender-inequitable views than the men. This was particularly demonstrated in Sri Lanka, Bangladesh and Cambodia indicating that gender norms contributing to inequality and men's use of violence can be reinforced by women as well as men [30]. In India and Cambodia, acceptance of violence by women further increased the odds of severe physical violence victimization, and women who sought formal and informal help were more likely to experience further IPV [32] [39]. In Pakistan, women victim who speak out and get their husband convicted, reported facing severe consequences including ostracism and bodily harm from husband's family and being shunned by their own family [40].

In addition, WHO multi-country survey found that between 6 to 59% of women have experienced SV from their husband or boyfriend, more than one in five women were forced into sex by intimate partner in 10 of the 15 sites, and overall sexual coercion by an intimate partner was much more common than rape by non- partner [41]. Similarly in India, 36% married men surveyed disclosed having been sexually violent in marriage while this figure varied from 10 to 15 % in Bangladesh [42]. A systematic review of African studies on IPV against pregnant women found prevalence rate ranging from 2.7 to 26.5% [43].

In Bhutan, 74% of women in NHS and 70% in BMIS justified husband's beating for at least one of the varieties of reasons, such as not completing household work, disobeying, refusing sex and for infidelity with high proportion of such attitude being reported among rural and uneducated women [10] [23]. In terms of women's attitude towards acceptance of IPV, 47.6% women agreed that a "good wife obeys her husband even if she disagrees" and 4 in 10 believed it's "wife's obligation to have sex with her husband even if she doesn't feel like it" [7].

Many IPV victims do not seek formal or informal help as they are too scared of further beating, risks of husband going behind bar, lack of financial support, child's involvement, and 82.4% believed IPV is a private matter that should not be discussed with outsiders [7] [24]. The FGD findings also indicated that IPV is usually accepted in silence due to cultural belief in "karma"- the fate of being born as a female which is associated with sufferings [24] [12] [18]. Thus, only cases involving serious physical injuries are usually registered and reported to police and health authorities, and among them, more than 50 % of the registered cases are later withdrawn by women victim themselves [18].

3.4.3 Notion of masculinity linked to dominance, honour and aggression

The root cause of VAW has been historically linked to unequal power relations between men and women. The patriarchal power disparities, discriminatory cultural norms, traditions and religious beliefs have been long cited as contributing factors for violence committed against women [4]. The findings from UN multi-country survey reaffirmed that IPV is fundamentally about pervasive gender inequality and it reflects influential narratives of masculinities that "justify and celebrate men's strength, toughness, heterosexual performance, and men's dominance over women" [30]. Evidences suggest that men having hostile, negative attitude and rigid views that supports traditional images of masculinity are more likely to use violence against their partner [26] [30].

In Bhutan, various studies associate IPV to certain traditional norms and religious belief which is discriminatory towards women [24] [18]. Findings from studies on gender and GBV indicated that the Bhutanese society tends to consider women biologically inferior from both cultural and religious perspectives, while men's use of violence is at times praised for being tough, strong and dominant over weaker sex [12] [38]. The religious belief of 'kerab gu' considers men nine 'noble"-i.e., human birth higher than women (*Pho dha mo gi bana keraap ghu yoe*) and thus men are perceived to be more confident, capable and on higher platform in society than women [38] [12]. Although educated women increasingly refute these, the findings from both gender pilot study and gender stereotype survey showed that majority of the women preferred to be born as male in their next life as being born as men is

considered to be an "embodiment of lesser suffering body" and therefore less prone to violence [38] [12]. In the FGD survey, 95% of the female participants in the rural and 70% in the urban area, expressed their desire to be born as a man in the next life and even among educated participants, 65% of women share the same view [12].

In addition, there are some religious text where prayers recited by women begin with "*I pray to Buddha, let me be a man in my next life.*" [38]. Though in-depth interview with religious personnel/practitioner indicated that core doctrine of Buddhism attaches no sex differences or associate women with inferior sex, culturally women's body has been associated with impurity linked to women's menstrual and reproductive cycle commonly referred to as *drib.* Thus, women are, for example, restricted from entering into 'Gyengkhang" an inner sanctum of a temple as they are considered contaminated and unclean [12] [18]. All these religious and cultural belief about being born as a female and their subordination has been directly associated with IPV [24].

3.4.4 Rigid gender roles

IPV is correlated to socially constructed rigid gender roles that associate masculinity with men's dominance and power over women [4] [37]. Survey research in numerous setting in developing countries has shown how inequitable and rigid gender roles influences men's use of violence against their partner [34] [30].

In Bhutan, the perception that women are less capable than men is deeply rooted in its socio-cultural and traditional beliefs [38]. While these perceptions have not been barrier to women's participation in agriculture, evidence show that it limited women's participation in tertiary education, governance, decision making process, vocational training and economic activities [22] [12]. Despite evolving gender roles, there are certain pockets of communities under Chukha, Tsirang and Sarpang districts, where stringent traditional norms are still prevalent [12]. In these communities, household chores such as cooking, home maintenance and child care are entirely done by women besides their routine farm work [38] [12]. Furthermore, in Trongsa, Wangdi and Paro districts, carrying *Lue* (Manure) in the fields is exclusively women's job and it is unusual and unacceptable for a man to carry *Lue*, as it is considered a low and inferior task. Although this practice may not be rampant everywhere, it validates male superiority and has a huge bearing on how community views women's gender role within household [12]. Survey findings from other study also revealed that even among working women in urban areas, women's traditional responsibilities of house work and childcare impedes career development prospects and their ability to stay in work force. Among both partner who were working, although men share certain household chores, women still bear double burden of working both inside and outside the home [14].

The findings from research studies in Pakistan and India indicated that women earning equal income and contributing to the household did not elevate their social status or mitigate violence within household as they endure jealousy and suspicion over their activities and are subjected to constant harassment and abuse for failing at domestic responsibilities [40] [37]. These results corroborate with findings from the research studies in Bhutan which showed that jealousy and suspicion of women's activities while working outside home and failing at household chores contributed to IPV [24] [7].

CHAPTER 4: A review of current evidence on effective interventions for addressing Intimate Partner Violence

This chapter reviews current evidence on interventions to prevent and reduce VAW, especially IPV followed by a brief discussion on existing interventions for GBV in Bhutan. Referring back to the framework, it is clear that partner violence emerges from the interplay of multiple factors at individual, relationship, community and societal level [26]. The criteria for selecting various interventions are based on either its strength of evidence or its impact on preventing IPV, as well as its applicability in local context. Only those interventions, which were found to have either promising or effective impact to reduce risk factors and prevent VAW backed by at least fair strength of evidence, are chosen from systematic literature reviews. The summary of evidences for various interventions are and adopted and reflected in table 4.

Table 4: Summary of evidence for different types of interventions to prevent VAWG-adopted from Fulu et al 2014.

IMPACT OF INTERVENTION				
	EFFECTIVE (Impact on VAWG)	-Microfinance and gender transformative approaches -Relationship-level interventions -Group education with community outreach (men/boys) -Community mobilization – changing social norms	-Collectivization and one-to-one interventions with vulnerable groups - Alcohol reduction programs (limited evidence from LMICs)	
	PROMISING (Impact on risk factors	-Parenting programs	-Whole-school interventions -School curriculum based interventions	-Transforming masculinities
	CONFLICTING	- Bystander interventions		

	INEFFECTIVE		-Single component communications campaigns -WASH interventions in schools	
		Fair evidence	**Insufficient evidence**	**No evidence**
STRENGTH OF EVIDENCE				

Source: [44]

4.1 Community Mobilization and Advocacy Interventions for changing social norms

The primary approaches used to change social norms to date have generally focused on strategies which include *Communication and Advocacy Campaigns* and *Community Mobilization through Multi-component interventions,* with former being funded as the most common strategy in low and middle income countries [29] [45]. Although *Communication and Advocacy Campaign* for example by UN (UNiTE to end Violence) succeeded in raising public awareness and "breaking the silence", experts considered the intervention ill-suited in shifting norms and changing actual behaviours, as it's not intensive enough and sufficiently theory driven [29]. Likewise, recent evidence also indicated that media and awareness raising campaigns led to an increase in awareness and knowledge, but there is little evidence about its impact on prevalence or incidence of IPV and in changing behaviours [44].

In Bhutan, since violence is often considered a private issue and is accepted as a part of relationship, the current interventions mostly focus on basic awareness raising campaign implemented through NGOs like NCWC and RENEW. Most activities include raising general awareness about IPV through radio, television, newspapers, and few printed publications [7]. No evaluation has been done so far to assess the effectiveness of the intervention.

However, *Community Mobilization and Advocacy*, a multi-component interventions, which attempts to empower women, engage men and change gender stereotypes and norms at a community level could be explored in Bhutan, as there are evidences that such intervention can have promising effect to change risk factors for IPV particularly violence condoning attitudes and beliefs as well as perpetration of violence [44] [45]. For example, Oxfam's "We Can" campaign aimed at achieving shift in social attitudes and belief, launched in Bangladesh, India, Sri Lanka and Pakistan in 2004,demonstrated

significant gains in reducing acceptance of VAW in the community [46]. In this campaign, people from community were trained as change makers and then tasked to implement the campaign mandate using street theatre, workshops, print and video materials. The campaign encourages individual to reflect on gender inequality and violence, take actions to reject violence, followed by signing of pledges to become change maker and pass on the message to 10 other individuals [46]. A non-randomized control trail of the campaign in Bangladesh found that the campaign reduced IPV when implemented intensively [29].

Therefore the government and various NGOs in Bhutan could explore similar intervention. The government and funders need to support NCWC, RENEW, YDF and other NGOs to select and train some existing volunteers/members in each district as change makers and guide them to implement the intervention in the community through use of various medium like street theatre, workshops, print media, internet, TV, radio, along with some face to face engagement through open discussions, reflections, debates and actions.

4.2 Intervention for Women's economic empowerment- Microfinance and Gender Transformative Interventions

There are evidences from many countries that poverty and lack of economic autonomy make women financially dependent on men and make it more difficult for women experiencing IPV to exit abusive and violent relationships [29] [44]. Women's economic empowerment programs which are aimed at equalizing power and opportunity between men and women include a wide spectrum of strategies from financial literacy, vocational training, and microfinance programs to conditional cash transfers [29].

Among these, the combination of *Microfinance and Gender Transformative approaches* were found to be very effective in preventing IPV [44]. Evidence suggests that standalone microfinance program increased women's negotiating power in the family through greater participation in household decision making but there is little impact on reducing IPV [29]. However, the combination of microcredit and gender transformative initiatives adopted by IMAGE demonstrated success in reducing physical and sexual violence by halve among program participants [34]. IMAGE program includes group lending and saving schemes to women along with participatory training on understanding gender, domestic violence, HIV and sexuality which was implemented in South Africa through a local NGO. Men and boys were also included in the program. After two years implementation, the evaluation result showed that compared to controlled group, women who partnered with IMAGE intervention group reported 55% less IPV. In addition, participants and their partner reported increased autonomy in decision-making, greater self-

confidence and financial confidence, more progressive attitudes toward gender norms and improved relationships [34] [29].

In Bhutan, the Asian Development Bank (ADB), since 2011 has been supporting the NCWC, focusing on the economic empowerment of women and girls [47]. The Project "Advancing Economic Opportunities for Women and Children" which was started in 2011, aimed at improving the economic status of vulnerable women and girls in selected urban and rural areas through enhancement of their capacity to access livelihood (including microenterprise) and employment opportunities [47]. Similar program initiated by RENEW provides temporary loan at minimum interest to victims and survivors of IPV to assist in developing their own income stream and become economically independent [48]. Both the interventions implemented with support from partners like UNDP, UNFPA and Save the children, focus mainly on increasing economic benefits of women. However, there is hardly any participatory training on understanding gender and domestic violence with complete exclusion of men in the interventions. The impact of the intervention is not yet evaluated. Nevertheless, there is an opportunity to integrate gender-transforming training into the current economic interventions to harness maximum impact and benefit out of the initiatives.

4.3 Interventions with families –Parenting Program

Families are often the site of IPV and an important entry-point for interventions. Poor and harsh parenting is a major risk factors for IPV with evidence from many countries linking childhood abuse particularly in the early years to violent behaviour later in life [44]. Evidence from high and lower middle income countries suggests that parenting program can reduce child aggression, conduct disorder, and anti-social behaviour which are found to be future predictor for IPV [29]. The systematic review of reviews indicated that parenting education which focused on increasing parent's child rearing skills, parent's knowledge of normal child development and how to discipline and manage child's behavioural problems, demonstrated promising result in addressing child's maltreatment [49]. Likewise, the parenting program in China, Chile, South Africa and Ethiopia which included interventions delivered to individuals or group, all demonstrated promising impact in reducing harsh or abusive parenting and improving parent –child relationship [29].

In general, parenting programs target all parents with emphasis on those who have abused or neglected their children through individual counselling, group discussion, role play and educational communications on positive parenting behaviour, either at home, community or in health settings [44]. One such program "Raising voices, Uganda" successfully used discussion on the use of power to encourage individuals and communities to question their assumptions around child and wife beating. Through open discussion on the

concept of abusive power and its negative effects, alternatives options were explored based on empathy and respect for the children and it ultimately led to reduction of child beating in the community [29].

For Bhutan, parenting program interventions through home and community visit by health providers or counsellors is not feasible given the high cost, acute staff shortages and cultural barriers, though these interventions produced strong evidence of preventing child maltreatment in HIC [44]. However, there are already few programs initiated by the Ministry of Health (MoH) and Ministry of Education (MoE) that cover some aspects of parenting program. The Care for Child Development (C4CD) package developed by WHO and UNICEF is currently being implemented in all health care settings to improve parent's child rearing skills and knowledge for proper child development with topics on child maltreatment and abuses as well [50] [51]. The C4CD service which targets parents and children under 5 years and currently being integrated into maternal and child health service is a very good platform for health care providers to reach all mother because74.6% women deliver at health facility and 95-98% of all mother visits health centres at least once for antenatal care and child's immunization [50] [10]. With most primary care workers already being trained on the parenting concept, the interventions could be successfully implemented through MCH services. The MoE has also introduced the concept of Early Childhood Care and Development (ECCD) in schools focusing mainly on holistic approach to child's physical, intellectual, social and emotional development. Both C4CD and ECCD programs are still in implementation stage and it's role could be further strengthened for effective prevention of child maltreatment [50] [51].

4.4 Individual level interventions – Addressing alcohol abuse

The interventions for harmful reduction of alcohol can be divided into four categories, which consist of brief interventions, structural interventions, community interventions and the treatment and self-help support of the alcoholics.

For brief intervention, the focus is on early screening and detection of problems associated with drinking followed by immediate feedback and counselling on alcohol harm reduction at primary health care setting. There is extensive evidences from systematic review of controlled trials showing effectiveness of early detection and brief advice for people with harmful alcohol use who are not severely dependent [29] [44]. The finding from a pilot study implemented in slum community of Mumbai showed that a brief intervention by trained provider led to significantly less alcohol use among the alcoholic clients than those seeking help from untrained providers [29]. For Bhutan, since most of the PHC providers are trained on early identification, basic treatment and counselling skills on alcohol harm reduction, this

intervention if implemented properly, can have impact on reducing harmful drinking. However, it benefits only those clients visiting health centres and misses out others in the community. To reach out to the communities, the existing services provided by RENEW, NCWC, YDF's Drug Education and Rehabilitation and self-help support group like Chithuen Phendhey Association (CPA) could be expanded and their current role in coordinating treatment and recovery services for the addicts, could be further strengthened through proper coordination with MoH.

At structural level, evidence suggests that the interventions that focus on laws and policies to make alcohol more expensive and less available reduce alcohol related harms including violence. A meta-analysis study on the effects of increased taxation on alcohol confirmed that when taxes go up, the drinking pattern among both problem drinkers and youth go down leading to subsequent reduction in violent crimes [52]. Furthermore, the strict enforcement of laws restricting sale and purchase of alcohol to only adults and regulating the timing of alcohol sale also brought down alcohol consumptions significantly [29]. A coupon based program to limit adults to 72 beers per month in Greenland resulted in 58% reduction in number of police calls related to IPV [29]. In addition, limiting outlet density is another strategy to restrict alcohol availability as findings from high income countries (HIC) indicated that the density of alcohol outlet is positively associated with alcohol consumption and alcohol related IPV [29].

In Bhutan, there is no comprehensive alcohol control policy at national level but there are certain policy measures taken at structural level to reduce the negative consequences of alcohol in the society [35]. These interventions include legal provisions and policies through increased taxation on alcoholic beverages, setting drinking age limit, reducing alcohol outlets, and observing dry days. The bar licensing is controlled, license fees are being raised and Tuesday is declared as dry day to limit alcohol consumption [35]. Despite sound policies, there are gaps and challenges in implementation due to poor monitoring and reinforcement. The structural interventions haven't been successful in curbing alcohol abuse so far as its misuse is on the rise. Therefore, the on-going debate about strict licensing and plan for further alcohol tax raise must be studied in detail, as it may not be effective in Bhutan's context as long as home-based illegal alcohol production and its sale is not curbed.

At the community level, interventions most commonly used include activities such as social campaigns, education in schools and public dialogues and debates on pros and cons of harmful alcohol use. The RISHTA (relationship) project which is being implemented in the outskirts of Mumbai, India uses various medium like community and street dramas, group reflections,

community meetings and follow up discussions to convey message related to harmful use of alcohol and sexual health outcomes including domestic violence. Videos, banners, posters and direct conversation with men at public gathering places, tea stalls, and bars were used to reach wide range of audiences. The evaluation result showed a significant drop in overall alcohol use in the community and even among those who still continued drinking, there were report of more gender equitable attitudes and reduced domestic violence in the household [29]. Similar campaign strategies could be introduced in Bhutan through involvement of local NGOs by targeting men at bars, clubs and public gathering. The use of members from self-help groups could be explored to reach out to communities through open discussion and meetings.

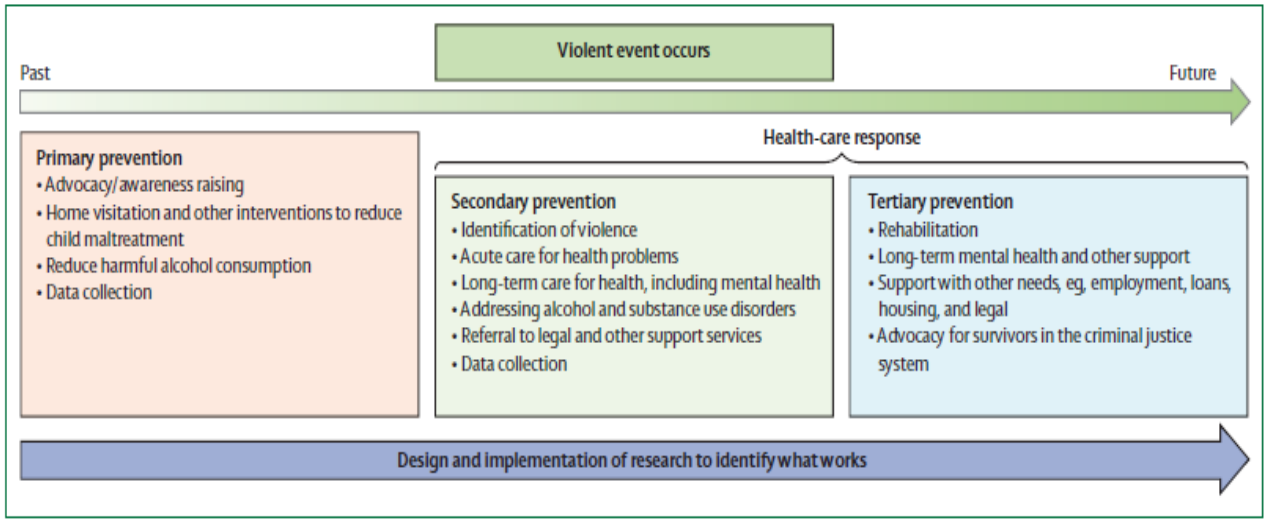
Finally in terms of treatment and rehabilitation support for alcoholics, evidence from HIC suggests that treating addicted alcoholics and helping them to stop or reduce their consumption can help reduce IPV [29]. For low and middle income countries (LMIC), the low cost detoxification treatment package and counselling approach that is being adopted and recommended by WHO are found to be very effective in preventing alcohol relapse and maintaining sobriety [53]. In Bhutan, the problem directed policies are generally aimed at specific alcohol related problems, such as drink driving and alcohol related crimes. However, MoH has introduced the alcohol-dependent detoxification service in all hospitals with plans for expansion till PHC level. The role of self-help groups could be further enhanced to trace men in the community and bring them forward for treatment. In addition, since Bhutanese culture is strongly influenced by its religious beliefs and traditions, the role of monastic community and religious leaders in advocating for alcohol harm reduction must be explored through partial adoption of program like Alcoholic Anonymous (AA). The AA is a simple low-cost project which works well in culture with strong religious traditions for individual with drinking problems. Evidence in Latin American countries suggests that despite certain selection biases, the overall AA program was found to be very effective in alcohol harm reduction and abstinence and its parallel meeting program provides family members to discuss and seek help around domestic violence issues [29]. For Bhutan, alcohol related problems are complex issues which cannot be solved with single intervention but rather require multilevel interventions at various level as discussed above.

4.5 Health System Interventions

The main role of health – care systems especially in clinical setting is to provide immediate and on-going supportive care for women and their children who are facing the health effects of violence, as health providers are often the first non-family members to see the signs of violence when victims visit health centres [54]. The identification of women and girls subjected to violence in the

initial stage is critical for providing appropriate treatment and care and timely referral services to specialized centres. As a first line support, WHO does not recommend universal screening but rather stress on training all health care providers on how to identify and respond effectively to DV [55]. The findings from various randomized clinical trials that tested universal screening programs showed no evidence of reduction in violence or improvement in health outcome through universal screening program [54]. However, evidence from a meta-analysis of qualitative studies suggest that disclosure of violence is more likely if women are asked by trained health providers in a compassionate and non-judgmental manner where their confidentiality is protected, and provide them help to access referral services [54]. In addition, it is found that children who have been exposed to IPV are more likely to benefit from referral for psychotherapeutic interventions [56]. Although training of health care provider is central to addressing VAW, evidence suggests that the process should not be confined to a single training event because brief educational interventions improve knowledge but do not change behaviour of providers [54]. Health system in general can play vital role in preventing and responding to partner violence through effective primary, secondary and tertiary prevention intervention as described in figure 3.

Figure 3: The role of the health system to address violence against women(Garcia-Morena,2014)



Source: [54]

Evidence suggests that an effective health-system response needs comprehensive system approach involving multiple sectors and agencies to provide safety, social support, economic security, shelter, and legal protection to women and children affected by violence [54].

Despite its key role in multi-sectoral response, the role of health system remains unfulfilled in Bhutan's setting. The issue of VAW needs higher priority in health policies, budgeting and capacity building for health care providers. Despite scarce evidences, there is global consensus that health providers should be trained on how to identify patients and provide first line supportive care and referral services [54].

In Bhutan, health care providers mostly treat IPV as a private matter or a matter of criminal justice system and solely focus its role in treating injuries instead of being part of coordinated prevention strategy. The biomedical model that is being practiced in most health-care settings misses out potential IPV victim. The MoH needs to establish enabling conditions such as effective referral networks, standard operating protocols and sustained capacity building for care providers to address VAW effectively. Furthermore, instead of delegating responsibility of IPV to NCWC, RENEW and other NGOs, MoH should show leadership and raise awareness on the public health burden of IPV and the importance of prevention among health-care providers, managers, and the general public. The IPV topic should be integrated into nursing, public health and in-service training curricula to ensure that the care providers know how to respond appropriately and effectively to IPV, followed by on-going supervision and refresher training. More research should be encouraged to quantify the health burden associated with IPV in order to scale up interventions.

CHAPTER 5: Discussion and limitations

5.1 Discussion

The findings from literature review revealed that Bhutan is no exception to the worldwide prevalence of IPV as 1 in 3 ever partnered women aged 15-49 years are likely to experience at least one act of specific type of violence [7]. The main forms of IPV likely to be experienced are emotional and physical violence. Women from rural areas, low or no formal education, and from lower socioeconomic status were more likely to experience violence. A considerable section of women accept violence as a part of relationship and the main situations leading to violence are financial problems, alcohol use, work stress and jealousy. More than half of ever-partnered women are likely to experience at least one form of controlling behaviour by intimate partner with most common forms being wanting to know her whereabouts and controlling access to health care. Moreover, SV in marriage which is an important issue has not yet emerged in public debate in Bhutan.

IPV is a rising public health burden in Bhutan. Most contributing factors for IPV takes place at individual, relationship, community and societal level .To address it effectively, a multi-level approach interventions targeting factors at different levels and sectors of society must be adopted with prevention intervention as one of the most critical component as majority of the risk factors for IPV can be changed. At individual level, harmful alcohol use is identified as one of the major contributing factor for IPV including SV due to prevailing drinking culture. To curb alcohol use, the structural intervention through increased taxation, which was found to be effective in other setting, may not be feasible in Bhutan unless the illegal production and sale of homemade alcohol is controlled. However, with a very good coverage of primary health care services, the brief interventions by trained health care providers through basic counselling and treatment could reduce harmful drinking pattern among alcoholics. For those difficult to reach, the role of existing self-help groups like CPA could be further strengthened through proper coordination with health sector and other stakeholders. In addition, community interventions through advocacy campaigns along with provision of simple detoxification treatment at BHU level could be very effective in reducing overall alcohol related problems including domestic violence.

Another risk factor at individual level that has been associated with IPV is the history of witnessing violence and being abused as a child, as findings from various studies within the country showed that significant proportion of the respondents who experienced violence have witnessed and experienced violence in their childhood. Furthermore harsh parenting and use of corporal punishment is also very rampant in many homes and schools. Therefore,

parenting program which focuses on increasing parent's child rearing skills and knowledge, and how to discipline and manage child's behavioural problems, that demonstrated promising result in other countries could be implemented in our setting. This intervention is very feasible as there are already few programs initiated by the MoH and MoE which covers some aspects of parenting program. The C4CD program currently being implemented in all health care settings could be broadened to include participation of men in parenting skills and integrated into routine ante or postnatal care visits to reach to all mothers. With most primary care providers already trained on basic parenting concept, the program could be relatively cheaper and easier to implement.

In terms of health care response, the routine screening for IPV including SV can help in identifying potential DV victims, however, in absence of specialized treatment and staff shortages, as is the case in many health centres in Bhutan, universal screening is not recommended. It is best to invest in improving effective referral systems through on-going training of care providers. Another missed opportunity is the absence of proper recording and reporting in HMIS for IPV and SV leading to under reporting of the problem.

All interventions described so far may not be effective on its own as IPV is linked with broader social factors which includes practice stemming from socio-cultural norms and religious beliefs related to gender and power. Hence, C*ommunity Mobilization and Advocacy*, a multi-component interventions, such as Oxfam's "We Can" campaign aimed at achieving shift in social attitudes and belief and change gender stereotypes and norms at a community level could be explored in Bhutan. This can be done through use of various mediums like street theatre, workshops, print media, internet, and television, radio, along with some face-to-face engagement through open discussion, reflections and actions. Since RENEW and Tarayana foundations already have good outreach in the community, media campaigns along with locally targeted outreach effort and training workshop delivered through these organizations could be very effective in changing norms and beliefs at community level. As most of their volunteers deal with gender issues, it will be easier to train them as a change maker and expand gradually into communities.

The final intervention includes the combination of *Microfinance and Gender Transformative approach*. The findings within the country suggest that poverty, low socioeconomic status, rural residence and inadequate income are significantly associated with IPV which is consistent with data from other countries in the region. Although few livelihood program have already been initiated in Bhutan by RENEW and NCWC through funding from ADB and other developmental partners, evidence in other countries indicated that livelihood program alone had significantly less impact than intervention that

combine economic interventions with gender training. Therefore, the government in collaboration with donor and local NGOs should together strengthen the existing program and expand it to include broad gender transformative components.

In summary, it is very clear that there are multiple contributing factors for DV at various level that require combinations of interventions to tackle multiple risk factors for violence. Different sectors like health, education, trade, legal and women's associations all dedicate resources to combat IPV, however, currently there is lack of proper coordination in terms of policies, programs and activities among these agencies. A national strategy on VAW that takes into consideration various types of promising interventions at each level, based on the ecological model through multi-level and multi-sectorial response could contribute to significant reduction of GBV especially IPV in the long run.

5.2 Limitations of the study

This study limits itself to partner violence against women and thus violence against men is not covered, as it has different dynamics, and moreover, the existing priority for GVB is mainly for women in Bhutan. There are discrepancies in prevalence rate for IPV between NHS and VAW situational studies with NHS reflecting overall lower prevalence of all forms of VAW. This is expected, as there could be reporting biases from respondents as NHS is part of general survey where sensitive private issues cannot be discussed openly. The specific VAW studies carried out by trained female interviewer could have less reporting biases and hence more reliable. However, most of contributing factors remain similar. There is limited published and grey literature on contributing factors and prevention strategies for IPV in Bhutan. Therefore, literatures from neighbouring countries are used which may not reflect true situations in Bhutan. The literature reviews were limited to articles published in English. Since most of the information were acquired through internet and library searches, local literature and possibly certain contributing factors and effective interventions addressing violence might be missed out.

CHAPTER 6: Conclusion and Recommendations

6.1 Conclusion

Despite being considered a liberal society, VAW and more specifically IPV is rampant in Bhutan with 1 in 3 ever-partnered women experiencing partner violence. Among different forms of violence, emotional violence and physical violence are the most common and sexual violence the least prevalent in the country. The contributing factors for IPV are multiple and complex and takes place at different levels of the ecological model. The core drivers of IPV are gender inequality and power imbalance that promote male dominance over women which is deeply ingrained in Bhutanese traditions, culture and religious belief. In addition women's own attitudes and acceptance of their inferior status further aggravates the problem. While domestic violence cuts across all socio-economic groups, the review indicated that women from lower socioeconomic status, rural residents, with low or no formal education, and whose partner abuse alcohol are at higher risk of IPV. Furthermore the prevalence of IPV is higher among districts where patrilineal inheritance is prevalent and in communities where stringent gender roles are still practiced.

In Bhutan's context, initiative to tackle IPV must expand beyond individual level effort and move towards transforming larger community and social norms around masculinities and gender hierarchy. Both long term and short term strategies are required to support better parenting, reduce childhood abuse and build more gender equitable masculinities. Evidence from vast body of research suggests that the combinations of different approaches for different levels of ecological framework through community mobilization and advocacy intervention, microfinance and gender transformative training, parenting and alcohol harm reduction programs and investment in referral system and capacity building of health care providers have promising effect in addressing and preventing IPV. As there is multi-sectorial involvement, the government and relevant institutions especially MoH and GNHC should take initiatives to streamline strategies and to avoid duplications of activities. To assure multi-level coordination and monitor progress, a proper guideline on the evaluations process for IPV must be developed and disease burden from IPV must be monitored by integrating into HMIS. Priority should be given for research to understand effective interventions and how to develop national prevention program for IPV.

6.2 Recommendations

The following recommendations are aimed at addressing GBV particularly IPV through multi-level approaches involving various stakeholders:

- GNHC could take the lead in formulating and streamlining policy on GBV through multi-sectorial involvement and ensure adequate allocation of national budgets and senior level commitment to address all forms of VAW

- MoH need to give higher priority towards issue of GBV in health policies, budgeting and capacity building. Standard operating protocols for GBV could be developed to ensure safe, accessible quality treatment for all victims of IPV. All clinicians, nurses and primary care providers should be trained to better identify IPV, provide first-line care and early referral services

- MoH need to initiate community mobilization and advocacy campaign like that of Oxfam's "We can" project, adapt it to Bhutan's context and implement it in collaborations with local NGOs to change gender stereotypes and social norms which condone IPV.

- MoH need to show leadership and raise awareness on the public health burden of IPV and the importance of prevention among care providers, managers and the general public. The GBV topic should be integrated into nursing, public health and in-service training curricula.

- The current C4CD program initiated by MoH could be adapted to incorporate positive parenting programs and integrated into routine antenatal and post-natal care.

- MoH needs to expand alcohol detoxification service till BHU level to address alcohol abuse in community.

- NCWC could link key stakeholders -policy makers, funders, and service providers to incorporate principles of effective prevention of VAW and strengthen implementation of existing legislation on gender and IPV.

- The GNHC and donors need to support NCWC and RENEW to invest in Microfinance *and Gender Transformative* interventions for economically vulnerable women through small group lending and saving schemes along with participatory training on understanding gender and IPV. Men and boys should be involved in the interventions as well.

- The MoH and the ministry of economic affairs need to initiate formulation of a comprehensive single national alcohol policy to address the issue of widespread use of alcohol and its negative consequences.

- The local NGOs like RENEW, YDF and CPA could initiate similar project like "The RISHTA" by targeting men at bars ,clubs and public gathering to reduce harmful alcohol use and subsequent IPV

- Monastic community and religious leaders could be involved in advocating for alcohol abstinence and shifting norms and belief condoning GBV. Programs program, if integrated into the yearly preaching event by the Abbot, could be very effective, as Bhutanese culture is strongly influenced by religion.

- MoH need to initiate more research to quantify the health burden associated with IPV in order to scale up interventions, identify what works, assess promising practices within Bhutanese context and develop new strategies for prevention and response to GBV.

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