VIOLENCE AGAINST WOMEN IN NEPAL
PREVENTION STRATEGIES IN THE FIELD OF PUBLIC HEALTH

ANITA SHRESTHA
NEPAL

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Violence against women in Nepal

Prevention strategies in the field of public health

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

By
ANITA SHRESTHA

NEPAL

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ABBREVIATIONS

CBS	Central Bureau of Statistics
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
DFID	Department for International Development
DHS	Demographic and Health Survey
DOH	Department of Health
DV	Domestic Violence
FPAN	Family planning Association of Nepal
GBV	Gender Based Violence
GoN	Government of Nepal
HSPs	Health Service providers
IP	Intimate partner
ICRW	International Center For Research on Women
MDG	Millennium Development Goals
MOHP	The Ministry of Health and Population
MOWCSW	Ministry of Women, Children and Social Welfare
MOH	Ministry of Health
NCD	Non-Communicable Diseases
NDHS	Nepal Demographic and Health Survey
NGO	Non-Governmental Organization
NHSP	Nepal Health Sector Plan
NLSS	Nepal Living Standard Survey
NMC	Nepal Medical Council
NNC	Nepal Nursing Council

NP	Non-partner
NPHC	National Population and Housing Census
NWC	National Women Commission
OCMC	One-stop Crisis Management Centre
OPMCM	Office of the Prime Minister and Council of Ministers
SOWC	The State Of The World's Children
STDs	Sexually Transmitted Disease
TYIP	Three Year Interim Plan
UN	United Nations
UNICEF	The United Nations Children's Fund
UNDP	United Nations Development Programme
VAW	Violence Against Women
WHO	World Health Organization
WOREC	Nepal Women's Rehabilitation Center

Definitions

Health

The World Health organization (WHO) defines "Health is a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity".

Violence

WHO defines "violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, against a group or community that either results in or has high likely-hood of resulting in injury or death, psychological harm, mal-development or deprivation" (Krug et al., 2002).

Intimate Partner Violence

"Any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship".
(Krug et al., 2002).

The Domestic Violence (Crime and Punishment) Act 2066(2009) of Nepal defines domestic violence as "any form of physical, mental, sexual and economic harm perpetrated by a person to a person with whom he/she has a family relationship. It also includes any acts of reprimand or emotional harm" (GoN, 2009).

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ABSTRACT

Problem:

Violence against Women (VAW) is a public health concern and violation of human rights. Violence against women in Nepal is widespread, and may affect women of any age, caste, race or ability. Not enough measures are in place to prevent this abuse of women's human rights.

Objective/Method:

This thesis is an effort to identify the contributing factors associated with the ever increasing rate of VAW as well as prevention strategies based on best practices to prevent or minimize VAW. A literature review was done. The ecological framework was selected for identification of the multiple risk factors contributing to VAW.

Results:

Firstly, the society is still a son-preference patriarchal one that accepts the discriminatory harmful treatment of daughters in a family, a community and the society and women still hesitate to see legal remedies for VAW partially due to the lack of their own confidence and also lack of confidence in state systems. To overcome the increasing rate of VAW multiple sectors involving men, women and the community should be approached. Every sector has an equal responsibility to prevent VAW. Health sector can help to tackle VAW.

Conclusion and recommendations:

A community-based approach is the most effective in interventions to overcome the increasing rate of VAW and should be implemented in all necessary multi-sectoral interventions. In particular men should be involved in these interventions. The health sector can take a lead in identifying cases of VAW and providing appropriate services. Equally important are interventions focused on female empowerment such as educational and institutional reforms.

Keywords: Nepal, Violence against women, Prevention.

Word count: 12397

INTRODUCTION

Violence is a leading public health issue worldwide and is considered as one of the major causes of death. It is estimated that 1.4 million people died in 2011 as a result of violence,[1] . Many people are injured and suffer from negative health consequences of the violence they experienced. Violence against individuals does not only affect those individuals but also their families, communities and countries. Health consequences range from physical injuries to a mental and psychological impact on a person's life. Women face violence in every phase of their life in different forms. It is an important risk factor for women's health. It is a serious problem in each country in the world.

As a physician I frequently encountered women suffering from violence in my practice. While providing care to those women and hearing their touching stories, I always wondered why women have to suffer so much from violence used against them because they are women. Why wasn't there a way to prevent this suffering? This thesis gave me the opportunity to learn more in depth about prevention activities in the field of public health that can contribute to the elimination of VAW. In the future I would like to work as a public health specialist and contribute the knowledge and skills I acquired during my Master of Public health at KIT in the fight against VAW.

There are many forms of VAW. This thesis focuses in particular on intimate partner (IP) violence and non-partner violence among family members, which both mostly occurs in the home environment. Based on literature study, I will identify and discuss factors contributing to VAW and existing prevention strategies in Nepal and elsewhere in the world. While doing so, I will apply an ecological framework which organizes contributing factors at individual, relationship, community and society level. It is not possible to cover all prevention strategies applied in Nepal. Most prevention strategies I will present focus on more than one level as distinguished in the ecological framework. I will conclude my thesis with recommendations which are based on evidence of good practices.

The main goal of this thesis is to make a modest contribution to ensure a safe life for women through more sustained and effective prevention strategies that have the potential to contribute to the prevention and elimination of practices of violence against women. Chapter one will provide background information about Nepal, with a particular focus on the status of women in the country. Chapter two describes the problem statement and study methods. Ecological model will be introduced in this chapter. Chapter three presents factors contributing to Violence against

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[1] WHO estimates: http://www.who.int/violence_injury_prevention/violence/en/

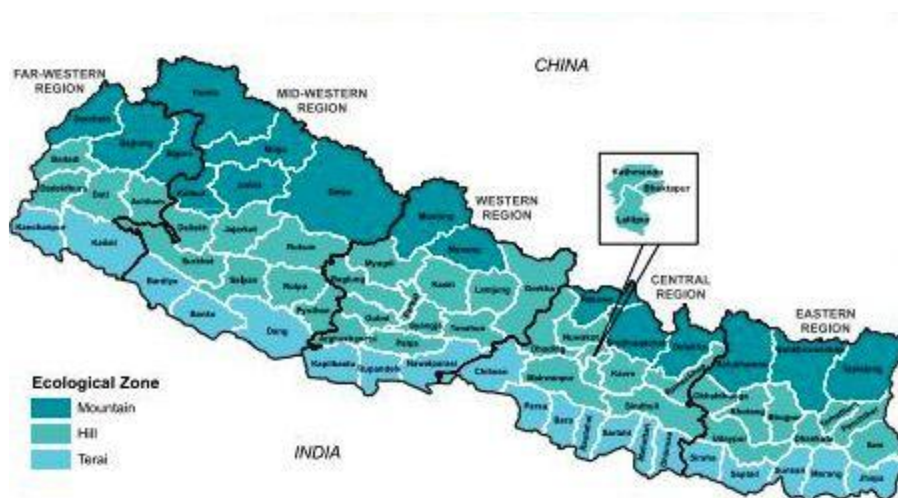
women (VAW). Chapter four gives an overview of current prevention strategies in Nepal and the gaps as well as possible solutions addressed to the government of Nepal to overcome these gaps. Chapter five discusses my literature findings. Chapter six presents conclusions and recommendations.

CHAPTER 1: COUNTRY PROFILE

1.1. Geography and demography

Nepal, a small developing and a landlocked country in between India and China, is also known to the world as "the Land of Mt. Everest" and "the birth place of Lord Buddha". With an area of 147,181 square kilometers, Nepal occupies 0.03% and 0.3% of the total land area of the world and the Asia respectively. Geographically, the country is divided into three ecological zones: Mountain, Hill and Terai. The country is also divided into 5 development regions or 75 administrative districts or 3915 Village Development Committees and 58 Municipalities. The country's geography ranges from the southern low lands 100 meters above the sea level to the high mountains rising over 8,000 meters (NDHS, 2011).

Figure 1: Map of Nepal



Source: NDHS, 2011

The total population of the country has reached about 26.4 million with an annual growth rate of 1.35 percent a decline from 2.25 percent in 2001. The composition of the population by sex shows that female population out-numbers that of male by 0.8 million resulting lower sex ratio of 94 (NPHC, 2011). Only one in four households, in average, is headed by female. The age structure of the population shows that the population is moving toward what United Nations called the once-in-a-lifetime demographic dividend stage. The age pyramid of the population shows the declining growth rate. The Female median age is estimated at 22.5 years and male median age at 20.7 years (CBS, 2011a).

1.2. Political system

Following 10 years of conflict, Nepal's political development marked a new phase particularly after signing the Comprehensive Peace Accord in 2006. Nepal shifted from a constitutional Monarchy to a Federal Republic in 2008. This long transition in politics made many political changes giving rise in domestic violence and through the conflict rise in women leaders arose making shift in gender roles (Banskota, 2011).

1.3. Economy

Nepal is among the poorest and least developed countries in the world with an annual economic growth rate of 3.56 percent (CBS, 2013). Agriculture is the mainstay of the economy, providing a livelihood for about 76% of the population and accounting for 34% of Gross Domestic Product. The increased percent of households receiving remittance from 23% in 1996 to about 56% in 2011 shows that foreign remittance has become one of the main sources of income for Nepalese households. The incidence of poverty fell from 42 in 1996 to 25% in 2010 (NLSS, 2011).

There is a wide gender gap in the employment by the main sector: 76 percent of male wage earners are in non-agriculture while only 45 percent of female wage earners are in this sector. Women's access to property is comparatively low. Less than 20% of the households have female ownership of house or land (CBS, 2012b). Most women workers are confined to self-employment or to unpaid or low-wage informal sector activities. Only 20% of the households reported female-ownership of fixed assets (land or houses) (NDHS, 2011).

Table 1: Distribution of wage earners by main sectors of activity

	Wage in Agriculture	Wage in Non-agriculture	Total (Percent)
Male	23.6	76.4	100
Female	55.2	44.8	100

Source: NLSS, 2010/11

1.4. Literacy

According to the Population and Housing Census 2011, overall literacy rate (for population aged 5 years and above) has increased from 54% in 2001 to 66% in 2011. The female literacy rate of 57% is lower in comparison to male literacy rate of 75% (NPHC, 2011). The educational disparity for female is distinct in rural and urban areas as female literacy rate in urban (75.2%) is quite higher than those living in rural areas

(53.8%). Women's access to literacy and education is less than men. There are gender disparities in education in Nepal (NPHC, 2011). About two-thirds of children of primary-school who are not enrolled are girls (CBS, 2011b).

1.5. Socio-cultural

Nepal is a multi-ethnic, multi-cultural and multi-linguistic country with 125 caste/ethnic groups and 123 languages. Nepali language is the official language. Hinduism is the religion of majority of the people (81%) (NPHC, 2011). Nepalese society is pre-dominantly a son-preferring society. As a result, if the first born child is a girl, then it is highly probable that women get more children for desiring a son. Also, boys are likely to benefit from having first born sisters; the sister takes care of household work while the boys can focus on school. Some girls are basically domestic workers to the benefit of their brothers (Hatlebakk, 2012).

In rural areas, the women's work burden is considered to be 12%–22% greater than the men's, and these women must work hard in order to gain acceptance in their husbands' homes (NLSS, 2011). More than 16 percent of the ever-married female population married at the age below 15 years (NPHC, 2011).

1.6. Health system

Ministry of health and population (MOHP) controls the health system for over all national health development. National health policies, second long term health plan (SLTHP) works under comprehensive framework. The Nepal health system emphasizes the essential service package and responsible for delivering preventive, promotive and curative health services through private and public sector (NHSP, 2010). Table 2 shows the no. of health facilities and health workers under public sector.

The total expenditure of the government on health is 5.4 % (World Bank, 2012). The total budget allocated to health sector is increased to 33% in 2010/11 (NHSP, 2010).

There is common Governance and Action Plan for Gender Equity and Social Inclusion framework. MOHP and the Ministry of Women, Children and Social Welfare (MOWCSW) work together using the Nepal Health Sector Strategy as a guiding principle for women health. MOWCSW is responsible for overall activities of women child and social welfare. The National Women Commission (NWC) together with five member commission is responsible for legislation and investigation of cases of VAW (UNFPA, 2013).

Table 2: Health care facilities/Health workers under Department of Health

Health Manpower	2011/2012
Doctors	12571
nurses	19098
ANM	19222
Source NMC/ NNC	
Health facility under MoHP	2010/2011
Hospitals	95
Health centres	209
Sub health posts	3129
Hospital beds(available)	5644
Source MOHP	
Family planning users	
Methods	2010/2011
Temporary	580033
Permanent	62600
Source DOH,2010/2011	

1.7. Health situation

Despite of the long political instability in the country, Nepal has made improvement in maternal and child health, but still maternal mortality is one of the highest in the world (Malla et al., 2011). Health indicators are presented in the table 3.

During the past 10-15 years there is five-fold increase in health seeking behavior of women during Ante-natal (ANC) and delivery care. Almost more than 50% of women seek four or more ANC visits during their pregnancy from health service provider (HSP) (NDHS, 2011). Utilization of health services has increased with reduction in inequality for many services and for some health outcomes, but with severe inequalities with disparities between castes, ethnicities, and wealth quintiles. Immunization coverage of children has doubled 43% in 1996 to 87% in 2011. Boys are more likely to be fully immunized 87.5% for boys compared to 85.7% for girls in 2011 (NDHS, 2011).

Most of the health problems are related to poor living standards. The double burden of infectious diseases is in rise with lifestyle related non-communicable diseases (WHO, 2011a).

Table 3: Health indicators

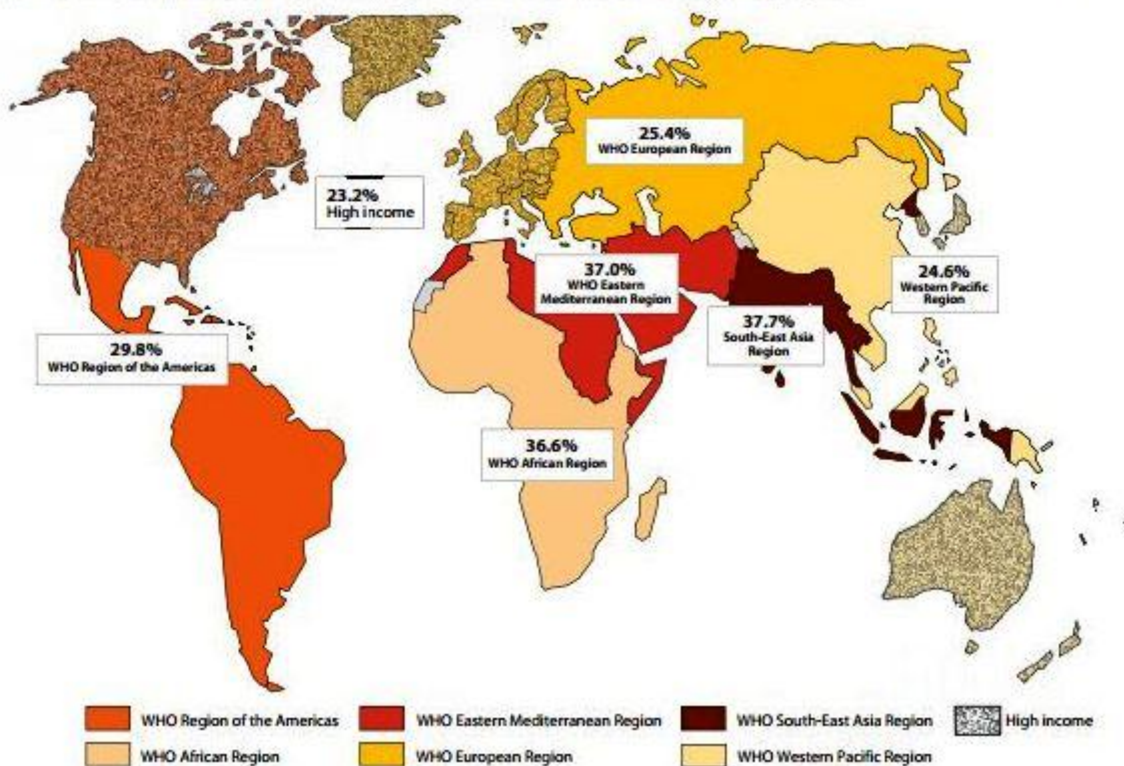
Health indicators	
Life expectancy at birth (SOWC, 2009)	67
HDI (Human Development Report, 2013)	157
Maternal Mortality Ratio (per 100,000 live birth) (NHSPIP,2011)	281
Under five mortalityrate/1,000(WHS,2011)	55
Infant mortality rate /1,000(WHS,2011)	43
Contraceptive prevalence rate (DHS, 2011)	43%
Total fertility rate (DHS,2011)	2.6 births
Adult HIV prevalence (SOWC,2009)	0.4
One- year old immunized against DPT3 (% age 12-15 months)	82%
One-year old immunized against measles (% age 12-15 months)	81%
Source:DHS,2011/WHS,2011/SOWC,2009	

CHAPTER 2: STUDY OVERVIEW

2.1. PROBLEM STATEMENT

Violence against Women (VAW) is now recognized as not only a major social issue but also a key public health issue and sighted as a violation of fundamental human rights (Krug et al., 2002). The Declaration on Elimination of VAW adopted by the United Nations (UN) General Assembly (1993) defines VAW as "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" (UN, 1993). VAW is also known as gender-based violence (GBV), which is defined as "any act or threats of acts intended to women suffering because they are women or affect women disproportionally'' (Richters, 1994).

Figure 2: Regional prevalence of IPV.



Source: WHO, 2013

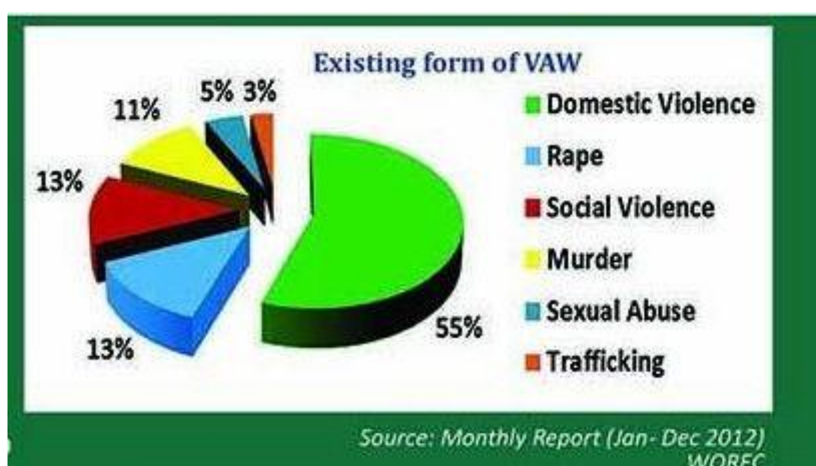
The first global systematic review estimates by WHO shows a prevalence of sexual or physical violence or both types of VAW in Intimate partner(IP) and non-partner (NP) is 35.6% (WHO, 2013).

A study done from analysis of 10 multi-countries estimates that between 15 to 71% of women will be victims of some form of violence in their life time (Garcia-Moreno et al., 2005). In public health perspective, VAW has direct health consequences and has significant threats to women's health (Ellsberg et al., 2008). In addition to causing injury, VAW increases women's long-term risk of a number of multiple health problems (Campbell, 2002).

VAW also has a huge impact on reproductive health which adds to a high maternal mortality, preterm birth and high perinatal mortality leaving a long term impact on the health of women (WHO, 2013). It can have direct and indirect effects in women's life with excess use of services and high medical cost (Plichta, 2004). Furthermore, women with history of IPV have significantly higher health care utilization cost of 20% higher even 5 year after abuse (Rivara et al., 2007). VAW is not only a health and a human right issue but also a developmental issue. VAW resulting in health problem ultimately hinders women's participation in developmental activities (Richters, 1994). Countries cannot reach their full potential as long as women do not participate fully particularly in the labor market (Mikton, 2008).

VAW in Nepal has been a serious public health concern (Banskota, 2011). Nepal Demographic Health Survey (NDHS), among the 4197 women aged 15-49 years interviewed, 22% of have experienced physical violence within the 12 months prior to the survey and 12% of women reported sexual violence at least once in their lifetime. Overall, one-third of women reported physical, sexual and psychological violence (NDHS, 2011). Domestic violence (DV) is the most common form of VAW in Nepal. Refer figure 3 for forms of VAW in Nepal. More than 80% of DV are from the family members (Dhakal, 2008).

Figure 3: Forms of VAW



Source: WOREC, 2012

A household quantitative survey of 900 women aged 15-59 years women found that more than half of the total women (51.9%) experienced violence in their lifetime; whereas about half (46.2%) of the total surveyed women reported sexual violence and one fourth (25.3%) of the total women faced physical violence. Sexual violence is more prevalent about 74% of women have experienced sexual violence within marriage (DFID, 2012).

NDHS survey 2011 shows that women who are ever married are found to experience physical violence more than unmarried women. This finding indicates that partner violence is prevalent in Nepal. Similar finding from another study also reveals that most women who are married experience more violence than unmarried women (Poudel, 2007). Refer to table 4 for details.

Table 4: Among women age 15-49 who have experienced physical violence since age 15, percentage who report specific persons who committed the violence, according to their marital status, Nepal 2011.

Person	Ever married women	Never married
Current husband	84	Na
Former husband	6.9	Na
Father/step father	3.2	36.3
Mother /step mother	3.6	30.1
Other relatives	4.3	11.2
Mother in-law	4.6	Na
Father in-law	4.2	Na
Teacher	0.3	7.7
Number of women	846	57

Source: NDHS 2011

Violence against Women is a serious social issue in Nepal with severe public health impact (Joshi, 2008). A Study by SAATHI revels that all women of sexual violence suffer from psychological problem and it occurs inside the home. The scope and extent of violence against women are reflections of the degree and persistence of discrimination that women have been continuously facing throughout her life as physical, sexual, psychological violence (Deuba & Rana, 2001).

Harmful traditional practices are forms of VAW that have been committed against women in certain communities of Nepal for so long that they are considered part of accepted cultural practice and has placed women’s life in danger. VAW has been a major form of discrimination (Dhakal, 2008).

VAW in the community is accepted as family affairs hence cases are not reported (NDHS, 2011). Community members such as health service providers, law enforcers and community leader's attitudes towards wife beating show that wife beating is acceptable and NDHS report also indicates that 23% of women and 20% men believe wife beating is acceptable (NDHS, 2006). As a result, majority of the women (about 61%) are still unaware about the laws for addressing VAW and most women has not shared with anyone. Most married women were found to have low knowledge about the existing laws and where to seek for services (OPMCM, 2012). Most women rely on neighbors and the community for support (Paudel, 2007).

In Nepal, suicide is the leading cause of death among women (Karki, 2012). Suicide among married women with children was found to be common and associated with alcohol and violence (Pradhan, 2011). A strong relationship exists between VAW and adverse health consequences. A study reveals that 93% of women are exposed to mental torture, 82% were beaten, 30% raped and 28% forced in prostitution (Deuba, 1997). VAW is also an important cause for poor health outcome and service utilization of mother and children in Nepal (Tuladhar et al., 2013).

Furthermore, the rise of voice particularly by the women activist in the community seemingly resulted to conduct numerous awareness programs on VAW but VAW continues (Dhakal, 2008). The impact of VAW in women's life is massive as evidenced by the above literature. Studies in VAW are very scarce in Nepal. Considering the discussed facts and figures above, this thesis is an effort to study in Nepal in exploring the major contributing factors associated with the ever increasing rate of VAW and prevention strategies to suggest policy implications and to prevent or minimize VAW. This study is designed to review a wide variety of studies on VAW with the main focus on intimate partner violence and non-partner violence on contributing factors and prevention control strategies.

2.2. OBJECTIVES OF THE STUDY

2.2.1. Overall objective

Explore the factors contributing to VAW and prevention strategies of VAW with the aim to suggest recommendations for further development of national policies and national plan of action to contribute in preventing or minimizing the scale of VAW in Nepal.

2.2.2. Specific objectives

1. Review and identify the contributing factors of VAW in Nepal.

2. Explore and review the current prevention strategies and their effectiveness in preventing VAW in Nepal.

3. Formulate recommendations aimed at improving prevention strategies addressing VAW in Nepal.

2.3. STUDY METHOD

2.3.1. Search strategy

An extensive literature review that includes both published and grey literature was performed in order to collect information as per objectives. Review of various statistical survey reports on VAW in Nepal is also done. Relevant reports and articles were obtained.

Literature search was done using different database search engines like Google, Google Scholar, Science Direct with the help of key words. Literatures available in English are searched. Pub Med search was performed using Mesh (Medical Subject Heading) terms and their combinations. Mostly VU library was used to search reference. Websites of Government of Nepal (GoN), WHO, United Nations populations Fund (UNFPA), Committee on Elimination of Discrimination against Women (CEDAW). Similarly, in other search engines, key words and combinations were used. A conceptual framework was adapted and findings are organized systematically.

2.3.2. Key words

Violence against women, Nepal, WHO report, human right issues, developmental issues, violence and health, gender-based violence, domestic violence, low-income countries , strategies, prevention, risk factors, contributing factors, education, alcohol, laws, policy, household and community, intervention, gender norms, politics, women empowerment, health sector response.

2.3.3. Conceptual framework

A conceptual framework is a tool which helps to analyze relevant literature systematically. For my purpose I chose the ecological model constructed by Heise (1998).

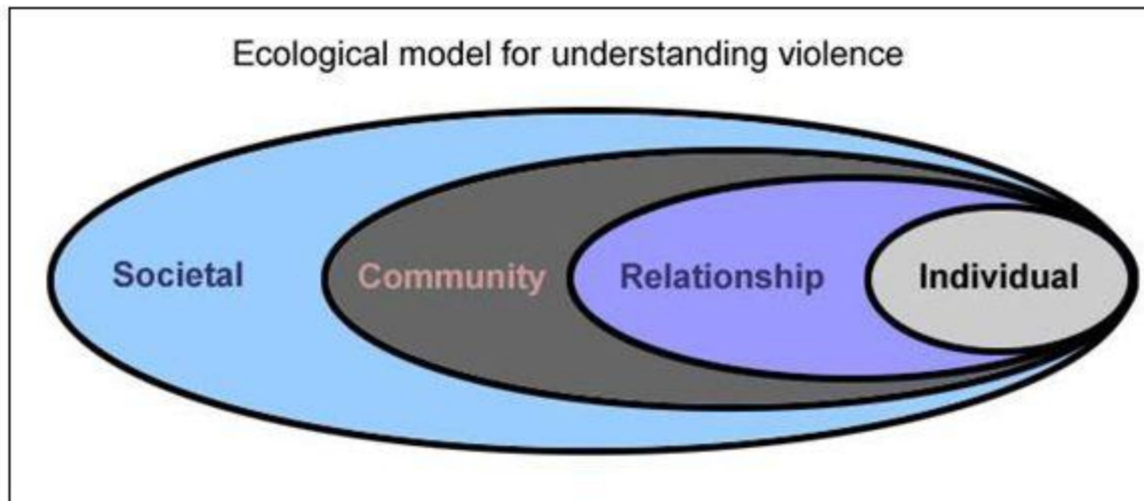
The purpose of this ecological framework in the context of Nepal is for understanding the risk and protective factors of VAW. In perspective of public health, the concept for developing prevention strategies should be related to addressing the root causes of VAW based on evidence and the integration of different sectors.

In this regard, prevention strategies based on four different levels from the literature review in the proposed concept approach for effective prevention of VAW were searched. Different factors on different levels were not equally important based on the evidence and this model helped me identify why some women are at high risk and why some are not. There is no single factor responsible for VAW. The complex interaction between different factors plays an important role in influencing the occurrence of VAW. To understand the public health approach to prevention of VAW based on the factors in the different levels (Krug et al. 2002). Hence, this model has helped me to identify different factors responsible for causing VAW and identify its prevention strategies based on the different level of the ecological model. Refer figure 4 for Ecological model.

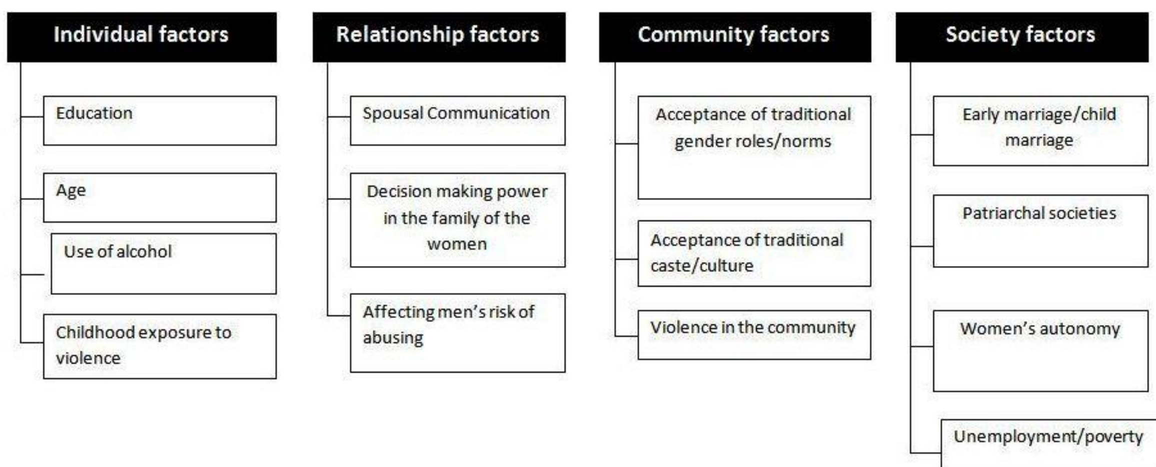
2.4. Study limitations

The study was constrained by the availability of the relevant and quality literatures in Nepal. In spite of the growing magnitude of violence in armed conflict, trafficking these topics was not focused in the study. Intimate partners violence is within the study but not exclusive. Due to the availability of data from DHS report and WHO reports the age group of 15-49 years women has been considered mostly. There are very few studies done in factors contributing to VAW in home environment in Nepal. While obtaining the factors in married women, some important factors for VAW in the context of Nepal might have been missed. Search was limited to english articles.

Figure 4: Ecological model



Source: Heise et al., 1999; Krug et al., 2002; CDC, 2004



Adapted from Heise et al., 1999, Krug et al., 2002

CHAPTER 3: CONTRIBUTING FACTORS FOR VAW IN NEPAL

This chapter reviews the literatures in order to identify the factors contributing to the occurrence of VAW in Nepal. The ecological model with its four levels is used to present the findings in a logical order. Understanding how these factors are related to VAW is one of the important steps in the public health approach to prevention (Krug et al., (2002).

3.1. INDIVIDUAL FACTORS

3.1.1. Low level of education

The few studies available point out that low education is linked to VAW as discussed below. However one study found that women's education was not significantly associated with the experience of violence. This result could be explained that in male dominated country like Nepal women with higher education may not accept traditional gender roles (Lamichhane et al., 2011). This finding will require further investigation in the context of Nepal.

A cross sectional survey of 1536 married women shows that literate women had 28% less chance (adjusted odds ratio (aOR= 0.72, 95% CI = 0.55-0.94) of experiencing violence than illiterate women (Adhikari & Tamang, 2010). Thus, increased education is linked to lesser risk of women to be violated. Only 13% of women with secondary level of education experienced violence compared with 49% of women with no education. The higher caste women in the study were better educated and less violated. On the other hand women from the lower caste were with lower education with high risk of violence (Poudel, 2007).

The national survey among 4,197 married and unmarried women found out that experience of violence decreases with the increased level of education. The study shows that 33% of women with no education experience violence compared with only 9% of women with secondary and higher education (Tuladhar et al., 2013). Women's education was not found to be protective while the education of the husband was found to be highly protective from another cross-sectional study among 1296 married women (Puri, 2012). Women's education was not related to the violence while the education of husband was found to be significantly associated with violence. Women with low education were found to have low knowledge about the existing laws and policies (OPMCM, 2012).

3.1.2. Age of women

The NDHS (2011) shows that sexual violence during the last 12 months preceding the survey differs with the age of women. Highest proportion of women aged 30-39 years reported the incidence of sexual violence than any other age groups. The reporting of sexual violence increases with the increase in age from 15 to 39 years and then slightly decreases in the age group 40-49 years. Older women reported more experience of spousal violence than younger women (NDHS, 2011). Another study also revealed that the younger women are the least likely to experience sexual violence compared with older women. This could likely describe the power relationship where women are considered inferior then men (Tuladhar et al., 2013). However, in WHO multi-country study women of age 15-19 experience higher risk of physical or sexual violence (García-Moreno et al., 2005).

3.1.3. Alcohol

Husband's alcohol use was also strongly related with VAW. Women whose husband consumed alcohol were more likely to experience violence than whose husband did not consume alcohol (Adhikari & Tamang, 2010). Sexual violence after alcohol consumption during festival is a risk factor in Nepal (Puri 2011). A woman with alcoholic husband was three times more likely to be abused (DHS, 2011). Alcohol use by husband has association for the marital conflict even after confounding was adjusted (Oshiro et al., 2011).

Alcohol abuse and GBV are intertwined issues. The hostile environment in presence of the offender is often aggravated under the influence of alcohol; at the same time alcohol abuse among women subjects them at many fold higher risk of being the victim of GBV. Alcohol abuse also has direct consequence on women's health, premature birth and unsafe sex which in turn produce catastrophic health outcomes and sometimes even fatal outcomes such as homicide, suicide and AIDS related deaths (Garcia-Moreno et al., 2005).

3.1.4. Affecting men's risk of abusing

Husband having more than one wife, polygamy relationship in Nepal is one of the risk factors for VAW (Deuba & Rana 2001). Factors such as Husband's age, education were also found to be significantly associated with VAW (Lamichhane, 2011). Women whose husband had higher education level were found to be protective. Older husband were highly associated with violence. This finding could be explained with the perspective of lack of interpersonal communication due to the difference of the age between the partners which eventually predispose women to be violated. Husband's education was highly protective for VAW from another cross-sectional study among 1296 married women (Puri, 2012).

3.1.5. Childhood exposure to violence

A child who witnessed violence in the family is more likely to report violence than child who had not witnessed violence in the family (OPMCM, 2012). In a study by WHO in Nepal it reveals that punishment at home and at school is an accepted in Nepal. During a focus group discussion when it was asked with teachers and parents it was reported that it was a way to discipline children (UNICEF, 2004). Children who are subjected to physical punishment are found more aggressive than those who are not punished, and those children learn it is acceptable for problem solving (Heise, 2011).

3.2. RELATIONSHIP FACTORS

3.2.1. Spousal Communication

A regional population based study shows the odds of experiencing violence was six times higher (77% vs. 31%) among women who had no communication than women who report discussing with their husbands (Lamichhane et al., 2011). A study has shown low spousal communication could be due to early and arranged marriage where women are not prepared and do not know each other which leads to lack of communication (Choe et al., 2004).

3.2.2. Decision making power of women in the family

NPHC 2011 shows that only one fourth of the total households in Nepal are headed by females giving them power of decision making in their households. In three-fourth of the total households in the country, it is the men who make the decision in all the activities. Hence, decision making power of women is very low in a family. Women who have power to make decision together with their husband were 36% less to experience violence (Adhikari & Tamang, 2010). One reason could be the women will not have freedom to decide jointly about their own problem regarding sexual matters or when to have sex, and hence women predisposing to sexual violence.

Women who were jointly involved in decision making with their partners (OR= 0.52; CI = 0.28-0.97) were significantly less likely to have suffered recent violence (OPMCM, 2012). Women’s low decision making power in the family affects women’s and children’s health as well as access to health care services. Moreover, VAW can affect the health of women as well as children. Women’s need for access to health services increases as a result of VAW, although ability to access services is reduced (Tuladhar et al., 2013).

3.3. COMMUNITY FACTORS

3.3.1. Traditional caste/culture/norms

Lower caste women were significantly more likely to report violence (odds ratio 1.8, CI 1.09-3.13) compared with women from the upper caste (OPMCM, 2012). However, causality cannot be inferred from the above finding. Lower caste women experience violence but it could also be that they report it openly while higher caste women silence it. This needs further research and analysis since literature shows that VAW occurs in all cultures (Poudel, 2011).

Traditional customary practices predispose women for violence such as Dowry, Chhaupadi, and Deuki/devaki. Dowry (money or property brought by a bride to her husband at marriage) is practiced near the border of India in the mid western region. Dowry-related violence continues (Jaishankar & Ronel, 2013). Dowry involvement was reported by 41.3% (Oshiro, 2011).

Chhaupadi (isolated in a shed like unhygienic room with no ventilation or window during menstruation) is a traditional practice which affects women both physically and mentally with some facing fatal incidents. Deuki/Devaki, where girls are sent to served at the temple including and they are even forced into prostitution (Ras-Work, 2006).

3.3.2. Violence in the community

VAW among many Nepalese communities on a regularly basis goes unreported. It could be explained that VAW in a community is accepted as family affairs (NDHS, 2011). The finding from Action Aid revels that around public transportation, women's safety and mobility are restricted. The insecurity of the women in the community could be due to unawareness of gender sensitivity in the society and in the public sphere (Action Aid, 2013).

Community members such as health service providers, law enforcers and community leader's attitude towards wife beating shows that wife beating is acceptable (Asia Foundation, 2010). The NDHS, 2006 also indicates that 23% of women and 20% men believe wife beating is acceptable. Women do not report against violence which predispose from violence again (Puri et al., 2010).

3.4. SOCIETY FACTORS

3.4.1. Patriarchal societies

The study shows that women who were highly controlled by their husbands were more likely to face violence than who were not controlled. The women who experienced low and high levels of patriarchal control were about twice (aOR= 1.99; 95% CI = 1.58-2.52) and 7 times (aOR = 7.24; 95% CI = 4.79-10.94), respectively, more likely to experience violence compared to those who had no male patriarchal control (Adhikari & Tamang, 2010).

Women are seen as weak and dependent on men and derive their social status (access to property, inheritance right) from male members of her family (Luitel, 2001). Women's work burden in rural areas is considered to be 12%–22% greater than the men's, and these women must work hard in their husbands home to gain acceptance (Earth & Sthapit, 2002). This affects the health seeking behavior of the women.

3.4.2. Women's autonomy

NDHS 2011 shows direct relationship between women's empowerment and occurrences of VAW (NDHS, 2011). About 45% of women with lower autonomy reported violence compared to 28% of women in higher autonomy class who experienced violence in past 12 months. Higher autonomy was protective of the violence whereas lower autonomy increased the odds of violence experience (Lamichhane et al, 2011).

About one-third of Nepalese women are not empowered (Tuladhar et al., 2013). This indicates that women's autonomy is protective at both the individual and community level (Puri et al., 2012). Women who are less empowered is likely to experience partner violence than the women who are more empowered. Empowered women tend to immunize their children more and utilization of services by women was also increased. Over all, finding revels positive health outcomes in the absence of spousal violence. Women level of empowerment effects the service utilization of maternal health (Tuladhar et al., 2013).

3.4.3. Arranged marriage/Early marriage

Early marriage is a customary practice which is a major risk factor for VAW (Puri at al., 2011). It is a societal norm and is common in Nepalese society (Gazmararian et al., 1996). Moreover; the decision to get girls married at an early age is also a reflection of underlying patriarchal values in Nepal. Early marriage is still prevalent and common in Nepal (Oshiro et al., 2011& Choe et al., 2005). In arranged marriage, relationships between families over-ride individual preference, often with dowry expectations that perpetuate the treatment of females as commodities

and preference for sons who bring dowry wealth into the family (Onslow, 2010).

3.4.4. Unemployment/poverty

The major role of Nepalese women is mostly confined to 3C – Cooking, Cleaning and Caring within their own households which are categorically non-economic activities. The role of men is that of "Bread-winner". NLFS 2008 showed that largest proportion of currently economically active female works in subsistence agriculture. In Nepal, VAW has been significantly related to regional variation following socio-economic condition of the district. In a district namely Bhaktapur, near the capital city which has a good economic development due to industries and growing employment, only 5% of women are reported violence at home whereas in a far western hill district where there is no employment in off farm sector, nearly half (48%) of women are reported experiencing violence at home (Poudel, 2007).

CHAPTER 4: REVIEW OF PREVENTION STRATEGIES ADDRESSING VAW IN NEPAL AND BEST PRACTICES

The first part of this chapter describes current prevention strategies with gaps identified in Nepal. The second part will present best practices in the area of prevention based on the four levels of the ecological model. In contract to the previous chapter, I start in this chapter with the societal level since strategies implemented at this level are needed to facilitate, support, sustain and strengthen strategies (to be) implemented at the other levels.

4.1. SOCIETAL LEVEL

Commitment of the government

Nepal has made several commitments to address VAW and has signed almost all of the international conventions on women's rights (GoN 1999). In fact, it was the first South Asian country to develop a National Action Plan based on the United Nations Security Council resolution 1325 and 1820 (GoN 2013). The Domestic Violence (DV) Crime and Punishment Act was passed in 2008 to criminalize the act of domestic violence (GoN, 2009).

Although the DV Act has been passed, local governments and victims are not able to utilize it (OPMCM 2012). As a result, 53% of the women do not seek care due to embarrassment. Justice for women is becoming difficult due to a long formal process and delay in decision making (Jaishankar et al., 2013). However, the law is rarely enforced, and society tends to blame rather than support the victim (Puri et al., 2010).

As a part of its response of high incidence of VAW in the country, 2010 was declared as the Year to End GBV. The 2010 Action Plan for GBV was formulated. A special hotline number (1111) has been provisioned to report directly the incidents of VAW to the prime Minister's office (GoN, 2010). Female members from all political parties, created a environment for identifying and then eliminating any discriminatory laws and traditional practices in the country (UN, 2012a).

The government adopted the policy of representation of 33% women in different government and political sectors (Banskota, 2011). But women are not able to get this policy implemented, it was neglected. A poor data collection mechanism has made it difficult to identify the magnitude of the exact problem with improper reporting mechanism (HURDEC, 2007). Recently a national database for VAW information management system has been organized under the office of women commission. This system has helped in the reporting of GBV (WOREC, 2012).

Micro finance has been started since long time in Nepal from 1980s. In some areas, micro finance has helped women to exercise small scale credit and saving (Bhadra & Thapa, 2007). Women are able to contribute financially to their household activities and hence it has empowered women to some extent (UNDP, 2011).

But still the scale of micro finance is very limited and in small scale. Services are not sustainable and do not provide skills trainings without address gender sensitive issues as well. There is no enabling environment for micro-finance for women (Sharma, 2007). Women's empowerment initiatives are still lacking. Mostly poor and rural women are not reached (Hurdec, 2007).

4.2. COMMUNITY LEVEL

A number of awareness programs on VAW are implemented in the community. Women rights forums are formed challenging the attitudes and behaviors in the community and local women are trained in different fields to combat VAW and providing front line support (UNDP, 2011).

Voices projects have implemented community awareness through a national radio program for (UN, 2013). The radio programs such as "Most understanding husband campaign" and "Samajhdari" (Mutual Understanding) are initiated to provide positive male role models in the community. Such programs target changing community traditional harmful cultures and practices. Awareness raising and advocacy using facebook, YouTube and flash mobs has also been initiated (Action Aid, 2013).

NGOs and INGOs are involved in awareness and advocacy programs. Several mass media campaigns are being organized. Most organizations are limited to raising awareness and advocacy programs. Most awareness programs know they are working for women but they are not sure whether their programs are inclusive for all women, including lower caste, vulnerable, and marginalized women. They even do not keep any record of the activities they carry out (Asia Foundation, 2010).

Most organizations are operating in urban areas and not designed specifically to meet women of lower castes and ethnicities who in Nepal are mostly violated. Events that are organized are mostly one time and lack of wider coverage due to lack of resources and no services as per demand. Due to lack of sharing of information there has been a duplication of programs. Financial resources for gender programs are very limited (Hurdec, 2007).

Community members such as health service providers, law enforcers and community leaders' attitudes towards wife beating show that wife beating is acceptable. The NDHS report indicates that 23% of women and 20%

men believe wife beating is acceptable (NDHS, 2006). VAW in the community is accepted as a family affair hence cases are not reported (NDHS, 2011). Traditional practices still persist in the community harming the life of the women (Oshiro, 2011).

As a result, the majority of the women (about 61%) are still unaware about the laws for addressing VAW. The finding from a community-based survey showed that 61% of women who experienced violence had not shared or discussed with anyone (OPMCM, 2012).

With all the laws and policies women hesitate to seek care due to fear of being rejection in the home or in society. Most women rely on neighbors and the community for support. However, people in the community are not educated (Paudel, 2007). Women do not seek care due to embarrassment and fear and society tends to blame rather than support the victim, which discourages reporting (Puri et al., 2010). The financial dependency of women on husband for livelihood also does not encourage the women to go against their husband (NLFS, 2008).

Survivor care

In co-ordination with safe motherhood program in Nepal the health sector has outlined VAW as an integral component of health care provision. Hospital based One-stop crises management centers (OCMC) in 15 districts with service center for survivors have been established. OCMC mainly provides physical health care, referral system, psychological counseling and legal support (OPMCM, 2012).

The MOH has also implemented a program of care and support to survivors of violence at Maternity Hospital in Kathmandu. Protocols on the management of VAW, including sexual abuse, have been developed. 151 providers are trained. The Family Planning Association of Nepal (FPAN) provides services such as screening and counseling in 38 villages through an in house trainer. A community reproductive health center (PHECT, Nepal) also provides screening and counseling services. Due to lack of training health service provider (HSP) are not able to support patients who suffer from VAW (UNDP, 2008).

There are no proper health care services and counseling for women who suffer from violence and referral system is not well managed. The roles and responsibilities among the HSPs are not clear (OPMCM, 2012). Women are not even aware of the available services (GoN, 2007). HCP does not acknowledge the special need of the victim and survivor, do not identify the cases and are not aware of the signs and symptoms (CEDAW, 2011). Hence, Overall coordination between survivor centers and other health sectors is also low without any proper referral mechanism. Without proper supervision there is high chance of duplication of programs (Asia Foundation, 2010). OCMC lacks well managed reporting system, women

still face problem on reporting and further referral system and OCMC do not function as holistic approach (WHO SEARO, 2010).

4.3. RELATIONSHIP LEVEL

The intervention approaches on relationship level should target both husband and other family members. Most interventions target only the victims but not the family members and perpetrators. A community center provides couple counseling services. The program has a good response and women experience less abusive relationship (UNDP, 2008). However, the program is launched in only one hospital.

4.4. INDIVIDUAL LEVEL

Education

The Family Planning Association of Nepal (FPAN) introduced a project for comprehensive sexuality education ensuring its integration into national curriculum which addresses gender sensitive issues (IPPF, 2011). Women's education is conducive to gainful employment which is likely to lower the chances of VAW. The financial dependency of women on their spouses is likely to increase the VAW which will be discussed in detail in the following sections (NLFS 2008).

The NPHC 2011 shows that gender gap in education still persists (75% male literacy rate vs. 57% female literacy rate). Even though the three year interim plan (TYIP) report shows progress in gender equality in terms of school enrolment, the continuation of school attendance is still a challenge in Nepal (GoN, 2010). More than 60% of girls are still out of school (Dhakal, 2008). Not much evaluation has been done in Nepal. In other parts of South Asia there is evidence that one of the reasons for girl child school dropout is fear of insecurity in the school (UNICEF, 2004b).

Alcohol use

Interventions by government agencies in controlling the alcohol use is confined to increasing sales taxation and regulating alcohol advertisement, sales and promotions, which seem not effective in preventing alcohol abuse in the society (UN, 2006). The government's initiative to ban the use of alcohol in public areas and restricting the availability of alcohol has certainly helped to reduce the cases of GBV associated with alcohol use. But it has not been incorporated in policy yet (WHO, 2011b).

4.5. EVIDENCE OF BEST PRACTICES

4.5.1. SOCIETY LEVEL

Laws and policies are in place in Nepal but traditional practices still persist in the society harming the life of women and girls. Only laws and policies cannot help VAW to be eliminated. It certainly is the initial important step of success. Evidence shows only legal reform is not sufficient for prevention of VAW (Daro et al., 2004). However, the National Research Council considers Laws prohibiting acts of domestic violence the initial important step of success to elimination of VAW (NRC, 2004).

A study from Kerala exploring the status of women's property in relation to VAW showed that women's empowerment in a form of ownership of property reduces the risk of violence (Panda & Agrawal 2005). The effectiveness of a micro-credit scheme has been studied well. The evidence shows that in some settings a micro-credit scheme to empower women decreases women's vulnerability for violence. A study from Bangladesh suggests, however, that empowering women with a micro-credit program alone is not sufficient (Schuler et al., 1998).

Survivor care

Women who are abused usually first visit health facilities before they visit other institutions (Campbell, 2002). Most women don't disclose their problem when they seek health care. Nevertheless, the health service provider should be in the front line in identifying problems of VAW, referring women to appropriate care and providing care themselves for women who are abused (Velzeboer et al., 2003). Women who suffer from violence have multiple health needs (WHO, 2013). The need to tackle VAW within the health system is recognized already for quite some time. Training of health workers to do so is important but at the end of the day the root causes have to be identified (Ellsberg, 2006).

The 'critical path' study of the Pan American Health Organization (PAHO) points to a good example of a community-based network and multi-sectoral collaboration aimed to stop VAW by strengthening the health sector response and by working with different sectors in a holistic approach (Velzeboer et al., 2003). Other effective interventions to change gender norms in society include involvement of community members, engagement activities behavior change and communications (WHO, 2010).

4.5.2. COMMUNITY LEVEL

Social change theory says programs aiming to change social norms should be “injunctive not descriptive” (Heise, 2011). Other effective interventions to change gender norms in society includes the active involvement of community members, which motivates also the engagement of women in "Edutainment Program" resulting in behavioral change and improved communication of women with their partner (WHO, 2010).

Evidence shows that awareness campaigns alone might not have a huge impact on the prevention of VAW but will change attitudes and behavior in society. As gender norms are deeply rooted in the patriarchal structure, the identification of these norms as root causes of VAW is crucial to prevent further VAW (Keleher, 2007).

A good example of an effective intervention involving community is the “CANTERA” program in Central America. This program encourages men's involvement in the prevention of VAW by first reflecting on their own masculinity with the help of stories about violence practices and then later relating the content of those stories to feminine injustice. This reflection has helped men to change themselves and understand the injustice of gender inequality. This program was effective due to the good effect it had on men who changed their relationships at home and at work for the better and became aware of the importance of gender equality (Peacock, 2003).

Most women seek help when needed from their friends and neighbors or within the informal sector. There is evidence that reforming a community’s informal justice system is successful in helping people in the community to settle the cases (ICRW, 2002). This may also be effective in Nepal where women living in isolated places have to travel long distances which is costly. This may prevent them from seeking the necessary care and support and continues to expose them to further abuse.

4.5.3. RELATIONSHIP LEVEL

Counseling can contribute to a change in violent behavior of a man who abuses his wife (Julie &Coffey 2011). Interventions promoting inter-spousal communication may help prevent violence perpetrated by husbands. Evidence shows that some men due to counseling can change their harmful attitude towards their wife and hence can have good impact on reducing VAW (Heise, 2011).

4.5.4. INDIVIDUAL LEVEL

Education

To achieve continuation of secondary school education for all children is a challenge in Nepal. Its importance in the fight against VAW is confirmed by evidence that continued secondary education with involvement of parents and teachers can help children to reduce future risk of violence (Hawkins et al., 1999). To improve economic independence primary education is not enough (Lutz et al., 2008).

Successful intervention for increase attendance from India, providing daily cooked meals in the school has increased the school attendance (Afridi, 2011). The intervention in the field of school education, particularly revisiting the school curriculum, would probably help to support the change in behavior (UNICEF 2011). Reform in education by introducing life skills and family life education may not directly influence GBV but can address gender parity (Bott et al., 2005). To achieve the MDGs goals there is a need to work for gender parity (UN 2005).

Some promising practices which have worked are the institutional reforms making schools safe for girls and gender sensitive (Bott et al., 2005). Initiation of safe date training program is another promising practice in reducing VAW (Foshee et al., 1998). Evidence shows that an individual behavior change program is less effective than community behavior change programs involving men and boys. Hence, a program for behavior change should align with interventions at community level with wide participation of all sexes, even though there has been very little evaluation of individual level behavioral change programs and their effectiveness (White et al., 2003).

Alcohol use

Effective strategies for the prevention of harmful use of alcohol include restricting alcohol availability, regulating the price of alcohol, treatment of those addicted to alcohol, and banning advertising for alcohol (WHO, 2010). There is strong evidence that the implementation of a policy aimed at lowering alcohol use is a promising strategy to reduce VAW. Alcohol control by restricting alcohol availability, regulating alcohol price, banning alcohol advertising has been cost effective strategies for prevention of VAW. Counseling in a health facility can also contribute to the reduction of harmful use of alcohol and as such to a reduction of the frequency and severity of partner violence (Anderson et al, 2009).

In Nepalese context, alcohol consumption increased during festivals and feasts resulting in increased domestic violence incidents. The effectiveness of brief intervention for one to four sessions in primary setting especially for man is well measured by randomized controlled

trials. In this regard, brief intervention lowers weekly alcohol consumption in men which could be effective than longer duration counseling (Kaner et al., 2007). Alcohol abuse and GBV are intertwined issues. The hostile environment in presence of the offender is often aggravated under the influence of alcohol at the same time alcohol abuse among women subjects them at many fold higher risk of being the victim of GBV.

In this regard, the prevention strategy at the individual level should mainly focus to encourage healthy attitudes and behavioral change through educating and counseling particularly the male youth. The aim of such counseling should target first to changing attitude and behavior in childhood and then changing attitude and behavior of the perpetrators (Krug et al., (2002).

CHAPTER 5: DISCUSSION

VAW is a severe form of violation against the human rights of women. VAW has been a prime issue for the government in Nepal, which adopted several laws to prevent VAW and signed a number of international agreements.

Based on the literature review in previous chapters, the proposed public health strategy adopts a multi-sectoral intervention approach for the effective prevention of VAW. Prevention strategies should include a continuum of activities that address the multiple needs of survivor of VAW and potential targets of VAW. On the one hand, a change of the mind-set of key players in the patriarchal society of Nepal is necessary whereas on the other hand, women's empowerment is equally important. This integrated approach is more likely to sustain over time than any single intervention. Hence, the involvements of different sectors are needed to address the multiple factors contributing to VAW which were identified in chapter 3.

Against this background, the development of prevention strategies will be discussed. I have selected to discuss those strategies that I find most relevant for the country as Nepal. In this chapter I do not follow the logic of the ecological model anymore. Most strategies I present focus on more than one level of the model.

5.1. Survivor care

A health care response to VAW is not well developed in Nepal. Women who are abused have multiple health needs (WHO, 2013). But women are financially dependent, uneducated and lack decision making power and are not able to speak up. Health seeking behavior during ANC and delivery visits has increased to five-fold in Nepal. In this regard, when women visits the health center HSP should be aware of the socio-cultural practices to understand the victim better and try to be conscious of the realities of the women and adapt their approaches to these realities (Kasturirangan et al., 2004).

The need to tackle VAW within the health system is recognized already for quite some time. In the context of Nepal most HSP were found to be unaware of how to handle patient of VAW. Patients are not able to get proper care and cases are not identified. There is no adequate training, HSP do not acknowledge the need of the victims. Providing training to HSP is essential and teaches them how to handle the cases and make them aware of the problem and the consequences of VAW. Integration of training in in-service and in the medical school curriculum is another import step to take (Ellsberg, 2006).

Protocols to address VAW in clinics are developed. But in practice the response to VAW is poor. When women seek care HSP should be able to provide her with appropriate services including legal and psychological help. Women who are abused visit health facility more often than any other support sector in society or visit a health facility before they visits other sectors (Campbell, 2002).

That makes it even more pertinent that HSP should be able to identify their problem. When women do not seek care, laws and policies also will not have any effect. Because of the circumstance women live in they are not able to express themselves even when they are in pain. OCMC was established with the aim to provide physical health care, referral system, psychological counseling and for legal support to run as a multi-sectoral approach. Due to lack of a proper referral system women are not able to get proper care. When a victim visits a health facility, health personnel can be the front line to identify abuse early and provide victims with necessary treatment and appropriate referrals services (Velzeboer et al., 2003).

Family planning Association has a survivor care center with in-house trained personnel with well set clinic in 38 districts. However, women are not aware of the available services due to, for instance, low education. Public health interventions in Nepal only treat the patients but do not try to go to the root causes of VAW. Only training and application of protocols will not help the women. The root causes have to be identified and tackled in order to effectively help victims of VAW (Ellsberg, 2006).

VAW during pregnancy is common in Nepal. VAW not only hampers women's health but also the health of their children. Maternal mortality and child/infant mortality is one of the highest in the world in Nepal (Malla et al., 2011). Abused women face long term health consequences such as depression, suicide, chronic pain and sexually transmitted diseases. Furthermore, VAW is the leading cause of the death among 15-45 year old women (Krug et al., 2002).

HSP in Nepal are not aware of the signs and symptoms of victims. The effectiveness of screening in the health facility is not well justified for improved outcome of VAW (Ramsay et al., 2002). Regular screening is practiced however; regular screening might not be the effective way to screen the survivor. Rather than psycho behavioral method could be the appropriate method to treat women who are abused (Jewkes, 2013).
Regular screening might be unethical unless women are being treated (Garcia-Moreno, 2002). In the context of Nepal where 93% of women are exposed to mental torture, 82% beaten, 30% raped and 28% forced in prostitution, a more appropriate method than screening could be a psycho-behavioral intervention.

From the randomized control trials, training to HSP and administrative staffs in primary health setting improved referrals and cases were identified more. This also shows that screening of women is not an appropriate solution for identification and referral (Fedar et al., 2011).
Economic cost of health care of VAW was 20% higher even after 5 years of violence. Excluding health costs, legal costs, and the costs of social services is US$ 4 billion per year (Rivara et al., 2007). The cost of VAW is high but most women in Nepal are workers as self-employment or to unpaid or low-wage informal sector activities.

If the health system does not tackle VAW there will be great missed opportunity and violation of human rights.

5.2. Community participation

Overall coordination between survivor centers and other sectors in society that should provide services for victims of VAW is low. Women are not even aware of the available services.

An effective community-based intervention requires the involvement of the legal, education, health and social sector and a good cooperation between these sectors. There are multiple factors contributing to VAW hence in addition to a multi-sectoral community-based approach a multiple level intervention is needed to address all the risk factors of VAW. It includes the training of police officers and health personnel in order to provide comprehensive services within the community. The quality of the training provided should be high (Morrison et al., 2007).

The increasing number of incidents being reported makes clear that only laws and policies are far from sufficient to prevent VAW. Undoubtedly, the legal provision that criminalizes the acts of domestic violence is an important initial step to eliminate VAW. Only addressing legal reforms for VAW is not sufficient but should also address its root causes. In the context of Nepal, based on the previous chapter of factors, situation for women is characterized by low levels of access to education, healthcare, economic, social, and environmental opportunities. In this regard, intervention targeting all these crosses cutting factors by dissemination of practice and policy innovations that could be effective intervention (Daro et al., 2004).

There has been evidence for successful elimination of traditional practices by a multi-sectoral approach, involving religious leaders and youth, and carefully providing information and training to women about the harmful effect of VAW so that women can decide what is right or wrong for her (Ras-Work, 2006).

In a patriarchal society like Nepal where a woman has to depend on her husband financially women hesitate to seek care due to fear of being

rejected within the home or in society. Women do not seek care due to embarrassment and fear and the fact that society tends to blame rather than support the victim.

From a feminist perspective, social and environmental inter-sectoral factors are responsible for a patriarchal society. Culture and gender roles should not support abuse, but a patriarchal society where women are in a low position compared to men women are not able to seek help. Reporting violence will contribute to further abuse. Culturally sensitive interventions at different levels will help women to overcome violence (Shankar et al., 2013). Hence, in all programs aimed to challenge traditional gender norms and values in the deep rooted patriarchal society of Nepal, engagement of men and the community in a multi-sectoral approach will support women and contribute to ending VAW in the society.

VAW has been a prime issue for the government of Nepal; hence it not only adopted several laws to prevent VAW but also signed a number of international agreements. Voices against incidents of VAW started to come up openly during the last decade. Consequently, a number of NGOs working in this field of VAW facilitated the change in mindset of particularly women and made the society aware of the need to break the culture of "remaining indifferent or silent" regarding VAW. The rise of the voice of particularly by women activists in the community seemingly resulted in numerous awareness programs focused on the elimination of VAW.

“The Health of Women and Girls Determines the Health and Well-Being of Our Modern World” (Davidson et al. 2011). Hence, the next step for Nepal should be increasing collaboration between multiple sectors aimed at educating a girl child, empowering women through access to education, increase of women’s health and employment and justice for women. All this measures must occur simultaneously with each other with helping hand. Now it’s the time to change, to show up improvements with all the resources we have (Davidson et al., 2011).

There is no co-ordination between health centers and other sectors women have difficulty to assess justice. It is a holistic approach aimed at the elimination of VAW focused on implementing care following procedures and protocols developed for this purpose and training of service providers in this respect. This program has helped the women to learn lessons from their own experience and break the silence. HSP can help the women prevent violence in the community where support for women does not exist. The success of the program will depend on the services provided. Key in this program is gender equity, participation and partnership (Velzeboer et al., 2003).

In the context of Nepal successful multi-sectoral approach could be intervention as promoted by the Pan American Health Organization (PAHO) based on the evidence from PAHO's "critical path" study which was piloted in 10 countries. Since women are afraid of the perpetrator, involving community and family members will help them overcome the risk of accessing appropriate services. This approach is a good example of the engagement of a community-based network and multi-sectoral collaboration. The overall goal of the PAHO program is to stop VAW by strengthening the health sector response through working with different sectors.

Although the Domestic Violence Act has been passed in Nepal, it has not been implemented by the state and victims do not act according to the rights given to them through this Act. Women do not seek help from the justice sector. This help seeking is difficult for women due to the long judicial formal process and the delay in decision making. As a result women are discouraged to seek further help after an initial attempt to seek justice due to their lack of confidence in state mechanisms (police, court) for justice. Laws and policies should be embedded into the framework of human rights. Women should not be discriminated because they are women.

The court and the support services should "place the victim at heart of the process" state Cook et al. (2004) in their plea for a fast track court. The result of the fast track the evaluated was that the victim was satisfied with enhanced and effective court and support service. Victims were able to gain confidence in the justice system and information sharing was also easier. DV is a family issue so the cases were handled with sensitivity and understanding of the victim. The court's personnel were trained in these issues by improving information sharing and advocacy. The overall result was public confidence in the state mechanism; victim's participation and satisfaction were also increased (Cook et al. 2004). This could be an effective intervention for Nepal where justice for women is very difficult.

5.3. Transforming culture and tradition

Most interventions at community are awareness programs in Nepal. Those interventions do not have well defined goals and objectives. They were not even clear about their target groups.

Social norms theory believes that programs that target change in social norms should be injunctive not descriptive. Community education and media campaign is not effective in changing behavior in which community and public opinion will dominates. In other words, descriptive intervention follows the norms prevalent in society.

In the context of Nepal where society is based on Hindu hierarchal system, where people accept wife beating and do not consider it as a

crime, where police thinks VAW is a family matter, descriptive awareness programs will definitely be less effective than injunctive ones. Campaigns have minimal effect in changing behavior in the short term and would be more effective with enforcement message (Synder et al., 2004).

Lower caste (Dalit) women are most affected by VAW but the existing programs in Nepal do not recognize caste-based discrimination. The coverage of the programs is low and mostly centered in urban areas, whereas most of the people live in rural. There are 125 caste/ethnic groups and 123 languages in Nepal but most programs are conducted in the national language which may not reach the target groups. Awareness raising in media and face book has been circulating but most people are illiterate and do not have access to these communication channels.

There is no coordination between different organizations and sectors in Nepal. However, a multifaceted response involving community participation, building capacity and involving all the sectors of society such as the health, education, justice is most effective in the fight against VAW (Jewkes, 2002). Unless the community, and particularly men in the community, is not involved, there will be no change in the society.

There are many successful interventions that have been able to change men's behavior elsewhere in the world which also Nepal could implement. The "CANTERA" program in Central America, involving men by reflecting on their own experience of masculinity and subsequently on gender injustice, has helped men to change themselves and understand the injustice of gender inequality. It has helped men to improve their relationships with their partners and be aware of women's rights to gender equality (Peacock, 2003).

Another successful intervention is the "Stepping Stones" program which integrates gender issues into HIV/AIDS. It has been widely implemented across Asia and Africa that focuses on community participation to promote communication between men and women and life skills of both men and women. It mainly focuses on life skills, discrimination and problem issues in gender relations. The program was successful in bringing change in the society and improving the status of women through improved spousal communication (Bhattacharjee, 2000).

Hence, programs in Nepal should not be limited to awareness raising and advocacy but should involve community in order to introduce changes in the society. To change gender norms, involvement of community members, engagement activities, behavior change, communication and edutainment programs might work (WHO, 2010).

Active involvement of community members for prevention through community approach network has been proved to be the effective intervention rather than passive single awareness programs. Active

participation from multiple sectors will be more effective and fruitful contribution than from the single sector. The shared responsibility from different sector will help to contribute strong response (Mancini et al., 2006).

Recently though, some good practices engaging men have been initiated in Nepal. The radio program 'Most understanding husband campaign' has made an impact in the attitude of men towards women. Another radio program Samajhdari ('Mutual Understanding') is also a unique initiative to provide positive male role models in the community. These radio programs have recently been evaluated as good practices in Nepal.

The WHO states that "culture and tradition should not be the justification for VAW nor can it be the excuse for elimination of violence" (Osotimehin, 2013). Culture is one of the reasons for VAW in Nepal but it should not be the hindrance for the health and human rights of women.

5.4. Income generation

Microfinance as a form of income generation organized on a small scale is not able to reach poor and vulnerable women in the rural areas. More women should be exposed to informal sectors where they have to challenge the traditional rigid gender norms. This can be justified by the exchange theory and feminist backlash hypothesis. The exchange theory points out that if women have low resources, violence will increase, whereas the backlash hypothesis points out that women can be abused even when their resources increase (Riger & Kriegistein et al., 2000).

Hence, microfinance only programs are not enough. Most programs in Nepal are small without skills training and do not addresses gender sensitivity. So, women who are exposed to informal sectors themselves have to challenge the traditional gender norms.

In the neighboring country Bangladesh with a similar traditional rigid gender norm as Nepal has well studied the effectiveness of income generating projects. Strengthening women's economic roles through empowering them with only a microfinance program is not sufficient. Awareness programs to staff and family members of women involved in these programs will help to reduce VAW. Hence women economic empowerment programs should also require awareness raising among their staffs and family members of the women who participate in these programs (Schuler et al., 1998).

Less than 20% of the households have female ownership of a house or land. Only 15% of the women have access to household property. In this regard, evidence from the neighboring country India, exploring the women's property status in relation to VAW showed that women's empowerment in the form of property access reduces risk of violence and

also contributes to women’s increase of status in the social group and neighborhood they are part of (Panda et al., 2005).

Hence, in the context of Nepal women empowerment in terms of increased access to household property could help to increase the status of women in the society. It was also found in India that dowry-related problems decreased due to increase in property ownership of women. In Nepal, the traditional practice of dowry is criminalized by law but it is still in practice. Hence, increasing women’s property ownership could also reduce the violence related to the dowry practice. Cash earning is a component of women's empowerment as it offers women a kind of "financial freedom". In this context, women's economic activities particularly related to cash earning carries paramount importance in terms of empowering women and hence may support the fight to minimize VAW.

Nepal can learn from the successful program Micro Finance and Gender Equity training (IMAGE) in South Africa. In this program poor and rural women were targeted by combining micro finance and skills building sessions focused on a change in gender norms and cultural beliefs, as well as on encouraging men to participate in community activities. This helped in communication between intimate partners (Kim et al., 2007).

Empowering women with skills may sustain throughout her life even when the programs are not sustainable.

In Peru the program ReproSalud, which is a rural reproductive health program working with community based groups, also established a micro-finance program for women to provide more equitable gender relations. The evaluation of the program showed positive changes in women’s relations with men as well as increased knowledge and communications on gender issues. The other result was men’s changed attitude in inter-spousal relationships which decreased VAW (Alberta et al., 1998).

All the interventions mentioned above in place in other countries, could be adapted by Nepal in order to provide more equitable gender relations and increased knowledge and communication on gender issues between intimate partners throughout the country. These factors have been a major factor contributing to VAW in the home environment where women are not safe while they should feel most comfortable in their own home.

5.5. Education

To improve economic independence primary education is not enough but never the less relevant in the fight against VAW (Campbell et al., 2002). The wide literacy gap between men and women is an indication of gender disparities in the Nepalese society. One dimension of female empowerment is female education. Female empowerment is strongly

associated with development. Educating only males is not enough for a country to develop. Female empowerment through education and employment will bring a significant change in cultural gender norms (Wyndow et al., 2005).

Most women are not aware of the services available due to low education. Effectiveness of education is reflected over time particularly in employment and income data, and sexual and reproductive health including fertility control and eventually leads to decrease in infant mortality and more people will be aware of more preventive measures and also about availability of health care facilities which eventually delay early marriage which lead to decreased fertility rates. To improve economic independency, primary education is not enough (Lutz et al., 2008). The need for education of women can be explained based on feminist theory. When women have the same education as men, men will accept women as equal with them and the threat of violence against women will be less (Yodanis, 2004).

Continuation of school attendance is a challenge in Nepal while continued secondary education with involvement of parents and teachers can also help children to reduce the future risk of violence (Hawkins et al., 1999). In India, providing daily cooked meals in the school has increased the school attendance of primary school girls reducing the gender disparity. The attendance rate increased with 12.4% compared to before the intervention (Afridi, 2011). Evidence has shown reform in education with life skills and family life education may not directly influences VAW but can address gender parity (Bott et Al., 2005). To achieve the MDGs goals there is a need to work towards gender parity (UN 2005). Some promising practices which have worked are the institutional reforms making school safe for girls and gender sensitive (Bott et al., 2005). In the context of Nepal comprehensive sexual education should be integrated to the curriculum which can address gender parity.

CHAPTER 6: CONCLUSION AND RECOMMENDATION

Conclusion

VAW is a severe form of violation against the human rights of women. It affects the health and development of not only women but also of children and the entire family. The situation for women is characterized by low levels of access to education, healthcare, and economic, social, and environmental opportunities. The society is still the son-preference patriarchal society that accepts the discriminatory role of sons and daughters in the family, community and society. Secondly, the deep-rooted harmful traditional and cultural practices such as early or child marriage and the dowry system still exist. Thirdly, women still hesitate to resort to legal remedies of gender based violence partially due to the lack of confidence in themselves and also lack of confidence in state systems. Considering the above three major risk factors of VAW and also the literature findings as presented in the previous chapters, the strategies for the prevention of VAW need to consider the root causes and nature of VAW.

Protocols have been developed, policies have been formulated, women activists, men and the community have woken up. Even if laws are in place and the community does not accept them, it will not work. To end VAW it needs a long term commitment and strategies involving different sectors in society. It is the health care system and the community which should support effective and efficient services within a human rights framework ensuring access to health care and justice for women. HCP should treat women with psychosocial therapy but not by screening them all and providing trainings to health personals. The girl child should have an equal right to education as boys and be able to story in a safe environment in school and in the community.

Overall, there is a need for a multi-sectoral approach to end VAW and care its victims. Unless multiple interventions on multiple layers in society targeting multiple factors contributing to VAW the fight against VAW will not have good results. Interventions should in particular identify the root causes of VAW and deals with them. We easily just blame culture and society for the high prevalence of VAW but they are not the only responsible factors. Every sector in society has an equal part in attempts to eradicate VAW and has to act according to it possibilities to help women who are suffering from violence. Now it’s time to thoroughly change society based on all the evidence of what is effective we have. What we need is a change in gender norms and traditional attitudes of men and in the community to build PEACEFUL VILLAGES AND A PEACEFUL NEPAL!

Recommendations

Based on the findings presented in this thesis the following recommendations are made for the context of Nepal

1. Strengthen the health sector response to provide effective and efficient services

The health sector should make more efforts to identify the high burden of disease as a result of VAW, raise awareness about this burden, and be in the forefront in making contributions to the necessary inter-sectoral responses to VAW. It is the health sector that, if attentive, encounters in particular the suffering of women due to VAW and the incapacitating effects of VAW in terms of women's contribution to a healthy family life and to the development of society. Therefore the health sector in particular has the responsibility to 'speak power' to the government, making the case that more attention needs to be paid to prevention strategies and mechanisms should be in place to implement these strategies effectively.

- Identify the high burden of disease and raise awareness in society about this high burden.
- Train health personnel to identify health problems as a consequence of VAW and how to give appropriate care to the women affected by VAW.
- Develop health services in a way that trained health workers can work effectively to provide effective quality services.
- Collaborate with referral centers to ensure a referral mechanism is in place if further care is needed.
- Play a key role in the promotion of inter-sectoral responses.
- Stimulate community involvement in the fight against VAW in its outreach community health work.

2. Strengthen community-based approaches and involve men in those approaches

The department of community development should engage Village Development Committees to mobilize the whole community, including all community institutions, in the fight against VAW and raise awareness of the available services in the community. Involvement of men, religious leaders and youth in the community is equally necessary to successfully eliminate traditional practices. Awareness programs should have a participatory mechanism with enforcement messages in place. The reproductive community health centers integration should be strengthened with services for VAW.

3. Provide economic, social and legal protection to women

The Ministry of Women and Child Welfare should enhance numerous skill-based trainings with participation of women mainly from lower castes and rural areas and promote the available services. The same ministry should ensure equal opportunities for women and men in having property rights and work. The Ministry of Defense should make services approachable through training all the responsible personnel in the provision of fast track services. Fast track courts should be introduced for easy and quick access to justice.

4. Ensure education to the girl child in order to empower her

The Ministry of Women and Child Welfare should co-ordinate with the Ministry of Education to ensure universal access to education for the girl child. There should be institutional reforms making school safe for girls as well as gender sensitive through introducing comprehensive education. More effort should be made to reduce school attendance and school drop-out by involving parents and teachers and by introducing attractive activities for children.

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