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Prevalence and Risk Factors of Intimate Partner Violence in Nepal

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Prevalence and Risk Factors of Intimate Partner Violence in Nepal

By

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Bachelor of Arts
Nankai University
2016

Thesis Committee Chair: Cari Jo Clark, Sc.D., MPH

An abstract of
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Abstract

Prevalence and Risk Factors of Intimate Partner Violence in Nepal

By

Xinfang Chang

Background: Intimate partner violence (IPV) is a significant public health issue that affects 1 in 3 women globally and a similarly large number of women in Nepal. IPV brings severe trauma to women both physically and mentally. Although over the past decade, important policy and programmatic steps have been taken to address violence against women in Nepal. There is still a gap on IPV research in Nepal. Therefore, this thesis will focus on the research on the prevalence and risk factors of IPV in Nepal.

Objectives: This thesis will address the current situation and the knowledge gap of IPV in Nepal by studying the prevalence and risk factors of IPV experienced by women in Nepal.

Methods: The study is a secondary data analysis of baseline data from a cluster randomized trial testing a primary prevention intervention for IPV. The baseline data include 1,800 women from Nawalparasi, Chitwan, and Kapilvastu districts in Nepal. Variables include age, wife education, husband education, marriage type, income stress, and husband drunkenness in past 12 months. Descriptive statistics, bivariate and multivariate regression were used to estimate the prevalence and risk factors of exposure to physical and / or sexual IPV in the prior 12 months.

Results: Of 1,800 valid participants, 455 (25.28%) participants were exposed to IPV. In bivariate analyses, caste, wife employment, income stress, quarreling, husband frequently drunk, wife exposed to IPV as a child, husband exposed to IPV as a child, in-law violence were significantly associated with IPV. In multivariate analyses, caste, wife employment, income stress, marital communication, quarreling, husband frequently drunk, wife exposed to IPV as a child, husband exposed to IPV as a child, in-law violence retained their significance.

Conclusions: IPV has its basis in dire economic conditions, traditional belief systems and the exposure of the boy child to incidences of violence in the family. Based on the fact that IPV is cyclic in nature, there is a need for intervening measures to address the key underlying constructs of socio-historical IPV contexts, traditional male roles and masculinity and cultural based suppression of women.

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Chapter 1 Introduction

Introduction and Rationale

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans, and more and more people in the whole world. The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse, and this type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (CDC, 2017). Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that nearly 1 in 4 adult women (23%) and approximately 1 in 7 men (14%) in the U.S. report having experienced severe physical violence (e.g., being kicked, beaten, choked, or burned on purpose, having a weapon used against them, etc.) from an intimate partner in their lifetime (CDC, 2017). IPV is equally a significant public health issue that affects 1 in 3 women globally (World Health Organization, 2013) and a similarly large number of women in Nepal (Clark et al., 2017).

Persistent IPV makes it impossible to attain steady development, equality, and peace, and has serious health implications for women. According to WHO (2002), domestic violence causes injuries, disabilities, fear, anxiety, eating problems, trauma, sleeping disorders, and drug and alcohol abuse. The health implications of IPV can lead to fatal consequences, such as maternal mortality, suicides, homicides, and sexually transmitted infections. Violence also has many economic costs. According to UNIFEM (2004), women experiencing IPV have more job turnover, poor job performance, generally lower output, and unemployment.

Women experiencing IPV have low participation in society. Their fear of violence limits their movement. They are afraid to go out or social with others. They dress up to hide proof of being assaulted, and hence become more vulnerable. Women who have been physically abused

only come out of the house to run important errands (Naved, 2003). Children who witness violence are at risk of becoming perpetrators in the future (Children's Defense Fund, 2009). They experience anxiety, weight loss, depression, low academic performance, and have low self-esteem (Children's Defense Fund, 2009).

Women experiencing IPV are at risk of sexually transmitted infections and other reproductive tract diseases. According to a study by Joshi et al. (2008), 40 out of 60 women have experienced health problems because of gender based violence. Out of this, 20% have suffered reproductive health problems, with pelvic inflammatory disease being the most common. In India, 16% of the maternal mortality during pregnancy was associated with IPV (Naved, 2003). IPV during pregnancy is dangerous, since it is likely to compromise the health of the mother and of the infant. Violence toward women led to unwanted pregnancy. Injuries during pregnancy compromised a woman and gave a greater risk of complications.

Purpose Statement

IPV brings severe trauma to women health, both physically and mentally. IPV affects women's physical and mental health through direct pathways, such as injury, and indirect pathways, such as chronic health problems that arise from prolonged stress (WHO, 2012). Although over the past decade, important policy and programmatic steps have been taken to address violence against women globally (World Health Organization, United Nations Office on Drugs and Crime, & United Nations Development Program, 2014) and in Nepal (Clark et al., 2017), there is still a gap on IPV in lower and middle income countries(Ellsberg et al., 2014), especially in Nepal. Therefore, this thesis will focus on the research on the prevalence and risk factors of IPV in Nepal.

Research Question

Specifically, I estimate the prevalence of IPV against reproductive age women in Nepal and examine the bivariate and multivariate correlates of its occurrence.

Significance Statement

This thesis will address the current situation and the knowledge gap of IPV in Nepal. By studying the prevalence and risk factors of IPV experienced by women in Nepal this thesis can contribute information that can be used to inform national and international NGO prevention and response efforts that are underway in Nepal.

Chapter 2 Literature Review

IPV is a serious public health issue and a violation of human rights. Health researchers across the global are gathering extensive data so that they are well positioned to address the health issue. Existing literature focuses on the risk factors, prevalence, consequences, costs, perceptions, manifestations, and health implications of IPV across the globe (Guruge, 2012). This section will review existing literature on IPV, and will focus on the situation in Nepal.

Definition of Intimate Partner Violence

Gill (2004) observes that the term IPV has been used interchangeably with the term domestic violence (DV) (WHO, 2012). However, the two terms are not interchangeable. The scope of domestic violence is larger than that of IPV, and can include all kinds of violence that take place in the home of a married couple, including violence between siblings and their parents, parents and grandparents, or grandparents and grandchildren (Gill, 2004).

According to Naylor (2013), IPV is defined as the use of psychologically, sexually, and physically coercive acts against an intimate partner. Psychological violence includes emotional abuse such as insults, belittling, intimidation, threats to take away the children, and humiliation. Sexual violence may include all acts of forced sexual harassment and coerced intercourse. Physical violence is the most visible form of domestic violence, and includes acts such as slapping, beating, hitting, and kicking. Controlling behaviours such as isolating an individual from their friends or family, stalking, and restricting a partner's access to resources, education, or finances can also be considered a form of IPV (WHO, 2012).

Ghimire & Fiona (2017) observe that unlike research on domestic violence, which has focused largely on women as the victims, IPV recognizes men as well as women as potential victims, regardless of the marital arrangement. In Nepal, men are the primary perpetrators of IPV

against women, and hence the focus of this paper. IPV is a relatively new concept in Nepal and is understood as "*gharelu hinsha*" or "*mahila hinsa,*" phrases which refer to domestic violence and gender-based violence respectively. These phrases infer other forms of IPV such as polygamy, extramarital affairs, beating, neglect, and verbal abuse (Ghimire & Fiona, 2017).

Prevalence of Intimate Partner Violence in Nepal

IPV is widespread in Nepal. Over 80% of women in Nepal have heard about domestic violence, and more than 35% of the girls have experienced some level of violence in their homes or communities (Puri et al., 2011). Studies show that IPV is the most prevalent violence in Nepal. Dalal, Wang, & Svanström (2012) found the prevalence of physical violence was 23.4%, while that of sexual violence was 14.7%. The countrywide presence of IPV was 32.4%. According to a study by the Ministry of Health and Population (2011), more than 35% of women have experienced gender based violence (GBV) at one time of their lives. The GBV was either psychological, economic, physical, or sexual. The study found that the most prevalent forms of gender based violence were kicking, slapping, scratching, beating with sticks, poking, punching, burning, and expulsion from home. Some reported throwing boiling water or food items. Women reported being deprived of economic resources, scolding, and mental torture. They experienced sexual abuse when they were forced to have sex with their husbands. These findings are similar to those of Paudel (2007), who reported that women in Nepal often start experiencing physical violence when they are 15 years of age.

Characteristics of Intimate Partner Violence in Nepal

Researchers have identified several risk factors that can be used as a conceptual framework for evaluating IPV in Nepal. According to Heisi (2011), by the mid 1990s, several theorists began to argue for moving beyond single-factor theories to recognize the complex

nature of abuse. No one factor "causes" violence; rather, violence is more or less likely to occur as factors interact at different levels of the social ecology. The resulting paradigm became known as the "ecological framework." The couple is in a relationship that has its own dynamics, some of which may increase or decrease the risk of abuse and the relationship is embedded in a household and neighborhood context that affects the potential for violence. in addition, the entire system is embedded in a macro- system which refers to the cultural, economic and political systems that inform and structure the organization of behavior at lower levels of the social ecology. Center of Disease Control and Prevention (2012) also analyzed that the most widely used model for understanding violence is the ecological model, which proposes that violence is a result of factors operating at four levels: individual, relationship, community and societal. Some risk factors are consistently identified across studies from many different countries, while others are context specific and vary among and within countries. It is also important to note that, at the individual level, some factors are associated with perpetration, some with victimization, and some with both. Ghimire & Fiona (2017), classified these factors as individual, household/family, and community level factors.

Individual Level Risk

a. Exposure to Violence During Childhood

The intergenerational transmission of abuse is well established. The link between childhood exposure to violence and subsequent victimization or perpetration of IPV is explained by social learning theory (Bandura, 1977). Children exposed to violence in their home may recreate that behavior as adults through violent parent-child interactions or either as a victim or perpetrator of partner violence in adulthood. According to Naved (2003), children generally accept what parents or teachers teach them. They are likely to accept corporal punishment at school or

beatings as a corrective measure for wrongdoing. Such children are likely to carry such perceptions into adulthood, and through this means, a husband beating his wife becomes a normal behaviour. According to Ghimire & Fiona (2017), men who are likely to act violently towards their partners include alcoholics and the uneducated, those who grew up witnessing IPV in their homesteads, physically handicapped men, unemployed and underemployed men, and those who do not know that IPV is wrong. Adolescent boys and male migrants were also likely to show gender-based violence. As men grow older and participate in programs meant to reduce IPV, they become less violent.

b. Negative Attitudes Toward Women

Adinma & Adinma (2011) also observe that female gender attitudes may contribute IPV. Women in East Asia view actions such as wife beatings and refusal to have sex are justified in certain circumstances such as infidelity, nagging, and refusal to cook. Such attitudes are formed while the girl is growing up and has come to accept gender inequality (Adinma & Adinma, 2011). In addition, the acceptance of male privilege in Nepal increases chances of IPV. Ghimire & Fiona (2017) opines that boys may hold negative attitude towards their female peers. If boys view girls as spoilt or disobedient, they are likely to express resentment towards girls. Once they become men, they are likely to express their resentment toward women. They may perceive women as only intending to be taken out and given gifts, or seeking to enter into relationships with men in highly paying jobs. In a population-based survey of men and women in Nepal, 29% of women and 23% of men justified abuse against a wife (Ministry of Health, New ERA, & ICF, 2017). In research among couples in Nepal, no difference was found in the percent of husbands and wives that justified abuse (30%), however only men's justification was associated with perpetration of IPV (Yoshikawa, Shakya, Poudel, & Jimba, 2014). Among young-men in Nepal,

findings are similar. Approximately 28% of 15-19 year olds studied in Nepal justified wife abuse (Dalal, Lee, & Gifford, 2012). Wife beating, according to Puri et al., (2011) is acceptable in case the woman is unfaithful, rude to her in-laws, or fails to perform wifely duties such as cleaning or cooking.

Family/Household Level Risk

a. Young Brides

In Nepali families, a young woman once married takes a lower status below the brothers and sisters in terms of social, economic, and personal decision making, and mobility. The oldest male is the head of the household, followed by other younger males, the mother-in-law, and the rest of the in-laws, in that order. The mother-in-law has power, and the junior wife has to obey her orders. Luitel (2001) explains that the Nepali social structure is based on Hindu patriarchal philosophy, which empowers males and subordinates females. Women are seen as dependent on males through laws of property ownership and inheritance. This inequity is exacerbated by the young age at which many women are married in Nepal. Nepal has one of the highest rates of child marriage in the world, although the practice is on the decline (UNFPA, 2012); 39% of women ages 18 to 22 years were married before age 18; whereas, 59% of women ages 41 to 49 years were married as children (Malé & Wodon, 2016). Although illegal, child marriage remains widespread, especially in rural areas, and among less-educated, lower socio-economic, and is certain caste-ethnicities (Malé & Wodon, 2016; Pandey, 2017).

Early marriages result in incompatibility between spouses, which can lead to tensions, extramarital affairs, or physical abuses (Ghimire & Fiona, 2017). The Gauna marriage system contributes to this phenomena, which is common among Tharu communities (Ghimire & Fiona 2017). Children undergo arranged marriages at very eary ages (8-14). The system states that the

girl is sent to the boy's house later, when she is between 17 and 18 years, when the Gauna ceremony happens. The girl drops out of her education and starts learning wifely duties. During this extended time, boys have other girlfriends. Some families bring the wife to the family house in fear of being fined for failure to complete the marriage, but their boys continue pursuing other girlfriends. When some girls ask their husbands about such affairs, it can lead to beatings and emotional abuse. Boy, on the other hand, continue with their education while girls drop out to become wives (Puri, Shah, & Tamang, 2010). This trend reinforces incompatibility. Early marriages bring increased chances of IPV and IPV during pregnancy (Das et al., 2013).

b. Type of Marriage

Arranged marriage is popular among Hindu culture in Nepal and the Hindus' believe that the marriages are made in heaven (Rijal, 2017). But since the couple do not know much about each other, quarreling and violence often happen after getting married. Another type of the marriage is love marriage, it is becoming more popular in Nepal these days as there are not options of choosing the life partner in arranged marriage, the new generation have started to choose their life partner them self and if the parents of the both families are agree with their choice then they will arrange the wedding and if any of the family is not agree then they leave the family and elope (Rijal, 2017). But leaving the family sometimes causes financial stress, and strained relationships with family members who may therefore refuse to support or assist their daughter or son when problems arise in their relationship potentially contributing to the occurrence of IPV.

c. Women's Socioeconomic Dependence on Husband

Fewer women are employed (57%) than men (78%) in Nepal. Married men are more likely to be employed (97%) than married women (68%) and are nearly 3 times more likely to be paid for

their work than married women and when they are paid, most (73%) earn less than their husbands (Ministry of Health et al., 2017). These disparities are mirrored by differences in home and land ownership, which is half that of men and educational attainment --only 50% of women compared to 71% of men have some secondary school education (Ministry of Health et al., 2017).

Women's dependence on their husbands has been reported as a main risk factor in IPV across various ethnic groups in Nepal (Ghimire & Fiona, 2017). In their study Ghimire & Fiona (2017) found that the economic difficulties women would experience if they had no financial support from their husbands outweighs the IPV they may experience. They fear that their children may be thrown out if they report incidences of IPV (Ghimire & Fiona, 2017).

Community Level Risks

A number of features of the cultural and legal and social environment have been shown to increase the likelihood that IPV will be perpetrated. Social norms that justify IPV that stigmatize divorce, making it difficult for women to leave an abusive relationship, and that give primary of family privacy and familial prestige over the safety of individuals within the household support the perpetration of IPV (L. Heise, 2011). These norms have been substantiated in Nepal (C. J. Clark et al., 2018; A. Ghimire & Samuels, 2017) A lack of legal sanctions, or in the case of Nepal, the lack of enforcement of those sanctions (A. Ghimire & Samuels, 2017; Hawkes & Puri, 2014) ensures that IPV, if perpetrated, has few consequences for the perpetrator (L. Heise, 2011).

These barriers lead to a lack of reporting and support seeking for IPV. The vast majority of IPV victims do not seek help (Ministry of Health and Population (MOHP) [Nepal] et al., 2012). According to Silwal (2012), women do not report IPV in Nepal because of stigma and

trauma. Women underreport incidences of domestic violence to save the family image, privacy, and prestige. Others fear their mother-in-laws and husbands. Love and affection toward family members, fear of broken relations, sociocultural consequences, marginalization, further beatings, and uncertainty of justice are other reasons that Nepalese women do not report IPV (Joshi, 2009).

Chapter 3 Methods

Ethical Considerations

Institutional Review Board (IRB) approval has been received from the University of Minnesota, where the PI or the trial was based when the study was funded, Emory University, where the PI is currently based, and the Nepal National Health Research Council (NHRC). Permission was also received from the District Development Committees representing Nawalparasi, Kapilvastu and Chitwan (Clark et al., 2017). In addition, the author has been added to the project as an analyst.

Data Collection

This secondary data analysis is a part of the *Change* program with the overall goal of exploring the prevalence and risk factors of IPV in Nepal. The original study was conducted in the three districts of Nepal, which have the highest IPV prevalence, including Nawalparasi, Kapilvastu, and Chitwan. All three districts are over 80% Hindu and have similar profiles in terms of ages at first marriage and levels of female land ownership, but levels of female literacy are different. Figure 1 shows the basic characteristics of women in three study districts.

The original study uses a concurrent mixed-methods design. The quantitative aspect of the evaluation is a pair-matched, repeated cross-sectional 2-armed, single-blinded cluster trial, comparing a social behavior change communication (SBCC) strategy to radio programming alone for its impact on physical and / or sexual IPV at the end of programming (12 months' post-baseline) and 24-months post baseline) (Clark et al., 2017). Figure 2 shows the research design of the original study.

Sample

For female survey participants , there are four eligibility criteria. First, if they are of reproductive age (between 18-49 years). Second, if their husband is at least 18 years of age. Third, if both the wife and husband reside regularly in the study area. And fourth, if the wife and husband live together. In addition to the eligibility criteria outlined for the survey participants, participants in treatment group activities must also commit to 9 months of weekly programming.

Measures

There are 1,800 participants in this study. Socio-demographic variables assessed included district of residence, age at marriage in years, type of marriage (love marriage with and without parental blessing and arranged marriage with and without participant's blessing), and the participants and their husband's educational levels (none, primary, some secondary, and School Leaving Certificate) modeled continuously given prior research showing a graded relationship across these categories(Ministry of Health et al., 2017) Survey respondents were also asked if they had earned money for work or trade during the past 12 months and if so, if they made more, less or the same amount as their husbands modeled as a categorical variables. Respondents were also asked if they or their husband were frequently felt stressed because of not having enough income (dichotomous) Caste/ethnicity was categorized into upper caste and relatively advantaged Janajatis, disadvantaged non-Dalit and Janajatis, and Dalit and religious minorities as previous research in Nepal has found lower caste and religious minority status to be associated with a higher risk of IPV (Atteraya, Gnawali, & Song, 2015).

The frequency of communication between the respondent and her husband in the prior week (never, once, few, many times) was assessed with items from the World Health

Organization' Multi-Country Study on Health and Domestic Violence Against Women (WHO MCS) (World Health Organization, 2005). Topics assessed included "things that happened to him during the day", "things that happened to you during the day," "his worries or feelings," and "your worries or feelings." The score was calculated as the mean across the items. The frequency of quarreling (never, sometimes, often) and husband's inebriation (never, once a month or less, at least weekly) were assessed with one item each from the WHO MCS (World Health Organization, 2005). Both were modeled dichotomously denoting quarreling at least sometimes and being drunk at least weekly.

The measure of in-law violence was developed for this study but based on research in South Asia, including Nepal, highlighting the role of in-laws in women's risk of IPV (Samuels, Jones, & Gupta, 2017) and prior research measuring in-law violence (C. J. Clark, Silverman, Shahrouri, Everson-Rose, & Groce, 2010). The participant was considered to have experienced violence by an in-law if she responded affirmatively to items assessing emotional (called names, insulted, humiliated or prevented from leaving the home) or physical (hit, kicked, punched or otherwise physically hurt) abuse, or reported that her husband's family encouraged him to hit, kick, punch, or otherwise physically hurt her (Clark et al, 2018). Exposure to IPV as a child was assessed with a single item. Given the high percentage of "don't know" responses regarding husband's exposure, the husband's exposure to IPV as a child was categorized as no, yes and don't know.

Gender equitable attitudes were measured with 10 items derived from the Gender-Equitable Men scale (Pulerwitz & Barker, 2008). A score was calculated as the mean across the items, with a higher score representing more gender equitable attitudes. The Partner Violence Norms Scale (PVNS) was developed for the study (C. J. Clark et al., 2018) to measure normative

expectations with items measuring traditional gender role expectations (2 items), intra-familial dynamics (1 item), acceptability of violence (1 item), silence and tolerating violence to preserve the family and family honor (2 items), non-interference in family affairs (1 item), and appropriate expressions of women's sexuality (1 item). The score was calculated as a mean across the 8 items with higher scores representing more gender equitable norms in their community.

Data Analysis

Descriptive analysis of the study variables showed an overview of the general demographics of the population and displayed. Logistic regression is used to assess the relationship between IPV and all other covariates first using bivariate statistics then including all variables in the model for a multivariate analysis. Odds ratios (ORs) and 95% confidence intervals (CIs) are also presented in order to show the association of the risk factors between the exposed and unexposed groups. P-value <0.05 was considered to be statistically significant. All statistical analysis was performed via SAS 9.4.

Chapter 4 Results

Table 1 shows the number and proportion of. In the past 12 months, there were 282 (15.67%) women exposed to physical violence from husband in Nepal. In the past 12 months, there were 325 (18.07%) women exposed to physical violence from husband in Nepal. In the past 12 months, there were 455 (25.28%) women exposed to IPV (either physical violence or sexual violence from husband).

Table 2 shows sociodemographic characteristics of the sample and bivariate and multivariate association with physical and / or sexual IPV. In bivariate analysis, caste was significantly associated with IPV (Disadvantaged non-Dalit and Janajatis, OR 2.02, [95%CI=1.60, 2.54], Dalit and religious minorities OR 2.20, [95%CI=1.51, 3.21]). Participants whose marriage was arranged without their consent were more likely to expose to IPV (OR 1.84, [95%CI=1.31, 2.59]) compared to other marriage arrangements. Higher levels of education for both respondents (OR 0.78, [95%CI=0.71, 0.87]) and their husbands (OR 0.72, [95%CI=0.65, 0.80]) were both associated with reduced risk of IPV. Participants who earned less money than their husbands (OR 1.34, [95%CI=1.05, 1.72]) and who earned the same as their husbands (OR 1.47, [95%CI=1.09, 2.00]) are more likely to expose to IPV compared to women who were unemployed. Experiencing financial stress is associated with a higher likelihood of IPV (OR 2.11, [95%CI=1.70, 2.62]).

Couples who quarreled are more likely to be exposed to IPV (OR 5.33, [95%CI=3.91, 7.28]). Alternatively, couples with good communication had a lower risk of IPV (OR 0.67, [95%CI=0.59, 0.75]). Husbands who were drunk frequently were more likely to hurt their wife (OR 3.83, [95%CI=3.03, 4.84]). Wives who were exposed to IPV as a child (OR 2.24,

[95%CI=1.76, 2.86]), and who had husbands who were exposed to IPV as a child (OR 2.46, [95%CI=1.85, 3.25]) were more likely to be exposed to IPV. Participants who received in-law violence in past 12 months were more likely to expose to IPV (OR 4.30, [95%CI=3.15, 5.87]). Individuals reporting more gender equitable attitudes also had a reduced risk of IPV (OR 0.71, [95%CI=0.57, 0.88]). Similarly, respondents who perceived their communities to be more gender equitable also had a reduced risk of IPV (OR 0.55, [95%CI=0.45, 0.68]). There were minimal differences across districts in the occurrence of IPV; however, there was some suggestion that the risk of IPV was lower in Chitwan than in Nawalparasi.

When examined simultaneously in a multivariate logistic regression model, most, though not all, socio-demographic characteristics lost significance except for the higher risk of IPV among those of a lower caste/ethnicity, women who were employed, or experienced income stress. Further, risk of IPV among women in Chitwan remained lower than that of women in Nawalparasi in the fully adjusted model. Couple communication, quarreling, and husband drunkenness remained strong correlates of women's risk of IPV in the fully adjusted model. Prior exposure to IPV as a child for both the wife and the husband and concurrent exposure to violence from the respondent's in-laws retained their significance. Normative expectations about the degree of gender equality and the acceptability of IPV remained strongly protective in the multivariate model; however, the participant's gender equitable attitudes did not retain its significance in the final model although remained suggestive of a protective effect on the occurrence of IPV.

Chapter 5 Discussion

The findings in this paper show that there are several factors that contribute to IPV in Nepal as they do elsewhere in the world, especially related to poverty or financial stress, which is a well-recognized risk factor for IPV (Abramsky et al., 2011; Atteraya et al., 2015; A. Ghimire & Samuels, 2017; L. Heise, 2011). Further, poor communication, alcohol abuse, and quarreling were robustly associated with IPV risk (Capaldi, 2012), highlighting features of individual and relational behavior that are fundamental to the prevention of IPV. Also similar to the broader IPV literature is the consistent and robust relationship between exposure to IPV in childhood and subsequent involvement in IPV as an adult, further substantiating the intergenerational transmission of abuse. Sociodemographic characteristics, on the other hand, were among the least robust correlates of IPV in this study, despite being among the most studied correlates of IPV (Cari Jo Clark, 2013).

While a number of socio demographic factors were associated with IPV in bivariate models most did not retain significance in a final model. Exceptions to this include women's greater risk of exposure to violence if they work and caste/ethnicity which has been found in prior research in Nepal (Atteraya et al., 2015; Ministry of Health et al., 2017). Reese, Asa & Parker (2016) state that around the world, men are taught from an early age they are supposed to be the primary breadwinners in the family. It is their responsibility as fathers and husbands to provide economically and even to support their wives and partners in the pursuance of their economic dreams. This means therefore that when men cannot provide for their families due to unemployment or poverty, they get frustrated. That causes them to lash out in frustration and physical violence on a partner becomes an outlet for their anger. Caste-based systems are a contributory factor for the same reason outlined above. The lower a person is in terms of caste,

the greater the likelihood that they will be of a lower socio-economic status which is well documented in Nepal (World Bank & Department for International Development, 2006) and potentially explaining the lack of significance of education in the fully adjusted model as caste and socioeconomic status are interlinked. The problem is compounded for low caste women who face the double burden of gender and caste discrimination (Asian Development Bank, 2010). In simple terms, even if one removes the other negative factors, the idea that some people were born to exist at a certain level and destined for specific indignities, will always compound the problem. This caste issue gets even worse in the rural settings where the government presence may be minimal and people remain rooted in strict and conservative traditions.

Finally, a measure of gender norms was also a strong correlate of women's risk of IPV, in alignment with a growing body of literature which is beginning to quantify this important relationship (C. J. Clark et al., 2018; L. L. Heise & Kotsadam, 2015; Yount, James-Hawkins, Cheong, & Naved, 2016) and inform the growing body of prevention interventions specifically targeting social norms. The linkage between individual attitudes and broader social norms is complex and worthy of further study. In this particular study, women's individual attitudes toward gender equity and the acceptability of IPV were not robust correlates of women's risk of IPV. However, measures of women's attitudes have been shown in prior research in Nepal to be poorer predictors of IPV than men's attitudes (Lamichhane, Puri, Tamang, & Dulal, 2011; Yoshikawa et al., 2014) and men's attitudes were not examined in this study.

Limitations

The study was fielded in only 3 districts in Nepal suggesting that it may be too population specific in terms of geographical distribution. It may also be that the culture of silence could mean that in some locations the women could not speak freely for fear of retribution or to avoid

social embarrassment. Therefore the prevalence estimate may underestimate the true prevalence of IPV. Further, the study is cross-sectional and therefore causality should not be inferred.

Conclusions

The study aimed to (a) measure the prevalence of IPV in Nepal and (b) explore the main risk factors that affect the prevalence of IPV in Nepal in order to address the knowledge gap of IPV in Nepal. IPV has its basis in dire economic conditions, dysfunctional interpersonal interactions, gender inequitable norms and in the intergenerational transmission of attitudes and behaviors supportive of IPV. Based on the fact that IPV is cyclic in nature, there is a need for intervening measures to address the key underlying constructs of socio-historical IPV contexts, traditional male roles and masculinity and cultural based suppression of women.

Implications

Looking at the information extracted from this research study, one can say that the possible implications of this study tie in with the social dynamics of male and female Nepalese. Nepal is a poor country and this means that by extension, its people suffer from the harsh vagaries of poverty. Data shows that currently, the country is ranked as the poorest country in the South Asia region and as of 2017, the 12th poorest nation on earth (Borgen Project, 2017). One must, however, give the government and international partners' credit for reducing poverty though. Still, in the urban areas, poverty levels range as high as 20%. Most Nepalese live in the rural areas away from the major urban centers and this means that the overall poverty rate could be much higher. Some figures suggest that over 43% of those in the rural areas live in extreme poverty (Borgen Project, 2017). Poverty also has its roots in adverse cyclical economic situations, retrogressive cultural traditions and low industrial bases.

The poverty that ravages the people compounds the other factors identified in the assignment as causes of IPV. These include low education levels, rampant substance abuse (alcoholism in particular), and a pattern and history of gender violence in families. The combination of poverty and the issues outlined above mean that there is a need to not just create tailor-made programs for men to reduce IPV. Rather, any interventions should come up with solutions that empower both men and women economically. Collaborative solutions in health practice should look at bringing about an end to IPV and reducing the negative social, economic and physical effects that afflict the abused spouse and children.

Recommendations

Existing interventions have not been successful in eliminating intimate partner violence, but progress has been made. Laws have been changed, formal support systems have been devised and while not implemented fully or functioning perfectly, there are signs of success. Importantly, according to the most recent Demographic and Health survey, IPV has decreased by 6 % over the past 5 years (Ministry of Health et al., 2017). Building on this success seems to be a feasible approach forward.

Mahapatro et al. (2011) recommend policies and reforms that focus on changing the culture and practices in Nepal. Joint collaboration between the government and NGOs have shown significant success in the empowerment of women. For instance, the formation of Mother's Groups (*Aama Samuha*) is helping women to come together to discuss social problems with health outreach workers at the village level. The Nepalese provide funding to help victims of domestic violence. This practice has been successful in other countries such India (Silwal, 2012). Given that healthcare providers are the first to come to contact with women experiencing

intimate partner violence, such intervention efforts should be centered within the healthcare system.

Mass communication, the use of edutainment and community engagement has been shown to reduce the risk of IPV elsewhere (L. Heise, 2011). Clark et al. (2017) are currently employing these tools to change social norms and the risk of IPV in Nepal through the larger study of which this thesis is a part. The evaluation is ongoing, but is offering signs of success offering a potential model that might be scaled up for wider impact.

Pun (2013) recommend the use of education as an important intervention to reduce domestic violence. Education has been proven to reduce a woman's chances of intimate partner violence (L. L. Heise & Kotsadam, 2015). In Nepal, men's education has been shown to be a particularly strong correlate of a lower risk of IPV (D. J. Ghimire, Axinn, & Smith-Greenaway, 2015) necessitating a strong focus on supporting educational attainment for both boys and girls.

Ghimire & Fiona (2017) argue that best way to address intimate partner violence is the use of institutional mechanisms, improving pathways to justice, and addressing the environmental challenges that undermine efforts to reduce intimate partner violence. The Nepalese government, donors, NGO's, and local civil society groups have an important role to play in ending intimate partner violence. Dalal, Wang, & Svanström (2012) argue that the best way to address intimate partner violence in Nepal is a change of policy. Policy makers need to take immediate action to promote gender equality as an enduring approach to effective violence prevention.

References

Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., . . . Heise, L. (2011). What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health, 11*, 109.

Adinma, E. D., & Adinma, B. D. (2011). Gender issues in reproductive health: A review. Nigerian Journal of Medicine: *Journal of the National Association of Resident Doctors of Nigeria*, 20(1), 20-27.

Ali, P., & Naylor, P. (2013). *Intimate partner violence: A narrative review of the feminist, social and ecological explanations for its causation. Aggression and Violent Behavior*, 18, 611-619.

Atteraya, M. S., Gnawali, S., & Song, I. H. (2015). Factors associated with intimate partner violence against married women in Nepal. *J Interpers Violence, 30*(7), 1226-1246.

Asian Development Bank. (2010). *Overview of gender equality and social inclusion in Npeal*.

Borgen Project. (2017). *Why is Nepal poor? Cyclical Poverty, Industrial Stagnation & More.* Retrieved from https://borgenproject.org/why-is-nepal-poor/

Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A Systematic Review of Risk Factors for Intimate Partner Violence . *Partner Abuse*, *3*(2), 231–280. http://doi.org/10.1891/1946-6560.3.2.231

Centers for Disease Control and Prevention (2017). *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices.* Retrieved from https://www.cdc.gov/violenceprevention/intimatepartnerviolence/

Children's Defense Fund. (2009). *Children Who Witness Domestic Violence.* Retrieved from: http://cdf.childrensdefense.org/site/DocServer/children-who-witness-domestic-violence-ohio.pdf?docID=9961

Clark, C. J. (2013). Intimate Partner Violence. In M. B. Goldman, R. Troisi, & K. M. Rexrode (Eds.), *Women and Health* (Vol. 2nd, pp. 725-733): Academic Press.

Clark et al. (2017). Evaluating a multicomponent social behavior change communication strategy to reduce intimate partner violence among married couples: study protocol for a cluster randomized trial in Nepal. *BMC Public Health* (2017), 17(75), 1-14.

Clark, C. J., Ferguson, G., Shrestha, B., Shrestha, P. N., Oakes, J. M., Gupta, J., . . . Yount, K. M. (2018). Social norms and women's risk of intimate partner violence in Nepal. *Soc Sci Med, 202*, 162-169.

Clark, C. J., Silverman, J. G., Shahrouri, M., Everson-Rose, S., & Groce, N. (2010). The role of the extended family in women's risk of intimate partner violence in Jordan. *Soc Sci Med, 70*(1), 144-151.

Dalal, K., Lee, M. S., & Gifford, M. (2012). Male adolescents' attitudes toward wife beating: a multi-country study in South Asia. *J Adolesc Health, 50*(5), 437-442.

Dalal K, Lindqvist K. A National study of the prevalence and correlates of domestic violence among women in India. *Asia Pac J Public Health*. 2012;24(2):265-277.

Dalal, K., Wang, K., & Svanström, L. (2014). *Intimate Partner Violence against Women in Nepal: An Analysis through Individual, Empowerment, Family and Societal Level Factors.* JRHS, 14(4), 251-257.

Das, S., Bapat, U., Shah More, N., Alcock, G., Joshi, W., Pantvaidya, S., & Osrin, D. (2013). Intimate partner violence against women during and after pregnancy: a cross-sectional study in Mumbai slums. *BMC Public Health*, *13*, 817.

Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2014). Prevention of violence against women and girls: what does the evidence say? *Lancet*.

Ghimire, A., & Samuels, F. (2017). *Understanding intimate partner violence in Nepal: prevalence, drivers and challenges*. Retrieved from London: https://www.odi.org/publications/10754-understanding-intimate-partner-violence-pakistan-through-male-lens

Ghimire, D. J., Axinn, W. G., & Smith-Greenaway, E. (2015). Impact of the spread of mass education on married women's experience with domestic violence. *Social Science Research, 54*, 319-331.

Gill, A. (2004). Voicing the silent fear: South Asian women's experiences of domestic violence. *The Howard Journal, 43*(5), 465-483.

Gill, A. (2004). Voicing the silent fear: South Asian women's experiences of domestic violence. *The Howard Journal*, 43(5), 465-483.

Guruge, S. (2012). Intimate partner violence: a global health perspective. *Can J Nurs Res*, 44(4), 36-54.

Hawkes, S., & Puri, M. (2014). *Towards Addressing Violence Against Women in Nepal*.

Heise, L. (2011). *What works to prevent partner violence: an evidence overview*.

Heise, L. L., & Kotsadam, A. (2015). Cross-national and multilevel correlates of partner violence: an analysis of data from population-based surveys. *Lancet Glob Health, 3*(6), e332-340.

Joshi, SK. (2009). Violence Against Women (VAW) in Nepal: Role of Health Care Workers. *Kathmandu University Medical Journal*, 7(2), 89-91.

Lamichhane, P., Puri, M., Tamang, J., & Dulal, B. (2011). Women's status and violence against young married women in rural Nepal. *BMC Womens Health, 11*, 19.

Luitel, S. (2001). The social world of Nepalese women*. Occasional Papers in Sociology and Anthropology,* 7, 101-114.

Mahapatro, M., Gupta, R. N., Gupta, V., & Kundu, A. S. (2011). Domestic violence during pregnancy in India*. Journal of Interpersonal Violence, 2*6(15), 2973-2990.

Ministry of Health, New ERA, & ICF. (2017). *Nepal Demographic and Health Survey 2016*.

Ministry of Health and Population (MOHP) [Nepal], New Era, & ICF International Inc. (2012). *Nepal Demographic and Health Survey 2011*.

Ministry of Health and Population, New ERA, & ICF Macro. (2011). *Nepal demographic and health surve*y *preliminary report*. Calverton, Maryland: USAID, New ERA, Government of Nepal.

Naved, R. T. (2003). *A Situational Analysis of Violence against Women in South Asia. Violence against Women in South Asia: A Regional Analysis*.

Paudel, G. S. (2007). Domestic violence against women in Nepal. *Gender, Technology and Development, 1*1(2), 199-233.

Pulerwitz, J., & Barker, G. (2008). Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM Scale. *Men and Masculinities, 10*, 322—338.

Pun, P. (2013). Empowerment of women through education to reduce domestic violence: A case study from Itahara village Nepal. *Master thesis*. Norwegian University of Life Sciences.

Puri, M., Shah, I., & Tamang, J. (2010). Exploring the nature and reasons for sexual violence within marriage among young women in Nepal. *Journal of Interpersonal Violence, 2*5(10), 1873-1892.

Puri, M., Tamang, J., & Shah, I. (2011). Suffering in silence: Consequences of sexual violence within marriage among young women in Nepal. *BMC Public Health, 1*1(29), 1471-2458.

Reese, S, L, M, Asa, P, C & Parker, E. (2016). Associations of financial stressors and physical intimate partner violence perpetration. *Springer Open-Injury Epidemiology,* 3 (1), 6-23.

Rijal, Arjun. (2017). *Marriages System in Nepal*. Retrieved form : https://www.outfitternepal.com/blog/marriages-system-in-nepal.html

Samuels, F., Jones, N., & Gupta, T. (2017). *Tackling intimate partner violence in South Asia: why working with men and boys matters for women*. Retrieved from London: https://www.odi.org/sites/odi.org.uk/files/resource-documents/11342.pdf

Silwal, P. (2012). Violence during Pregnancy among Young Married Women in Nepal. *Master's Theses*, 264. http://digitalcommons.uconn.edu/gs_theses/264.

UNIFEM (2004). *Say No to Gender-Based Violence: Responses from South Asia*, New Delhi.

World Bank, & Department for International Development. (2006). *Unequal citizens: gender, caste and ethnic exclusion in Nepal summary*.

World Health Organization (2002). *World Report on Violence and Health. World Health Organization*, Geneva.

World Health Organization. (2005). *WHO multi-country study on women's health and domestic violence against women: summary report of initial results onprevalence, health outcomes and women's responses*.

World Health Organization (2012). *Understanding and addressing violence against women: Intimate partner violence*. Retrieved from http://www.who.int/reproductivehealth/publications/violence/en/

World Health Organization. (2013). *Global and regional estimaets of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*.

World Health Organization. (2011). *Intimate Partner Violence During Pregnancy Information Sheet.*

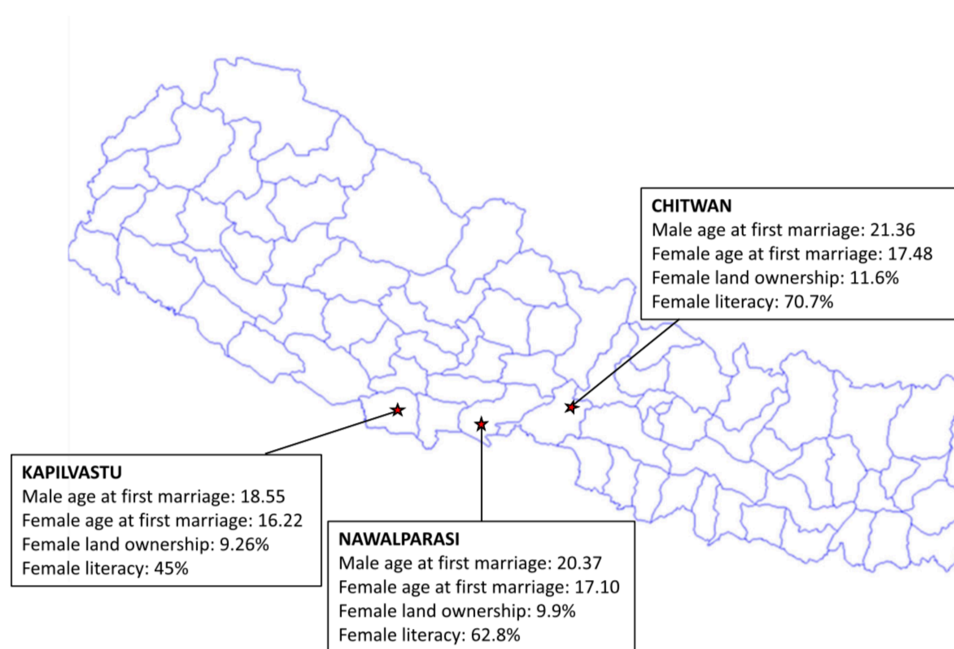
World Health Organization, United Nations Office on Drugs and Crime, & United Nations Development Program. (2014). *Global Status Report on Violence 2014*.

Yoshikawa, K., Shakya, T. M., Poudel, K. C., & Jimba, M. (2014). Acceptance of wife beating and its association with physical violence towards women in Nepal: a cross-sectional study using couple's data. *PLoS One, 9*(4), e95829.

Yount, K. M., James-Hawkins, L., Cheong, Y. F., & Naved, R. T. (2016). Men's perpetration of partner violence in Bangladesh: community-gender norms and violence in childhood. *Psychology of Men & Masculinity, September 19, 2016*, No pagination specified.

Tables and Figures

Figure 1. Basic Characteristics of Women in Study Districts



Source: Public Domain, https://commons.wikimedia.org/w/index.php?curid=1411003

Figure 2. Research Design of the *Change* Program

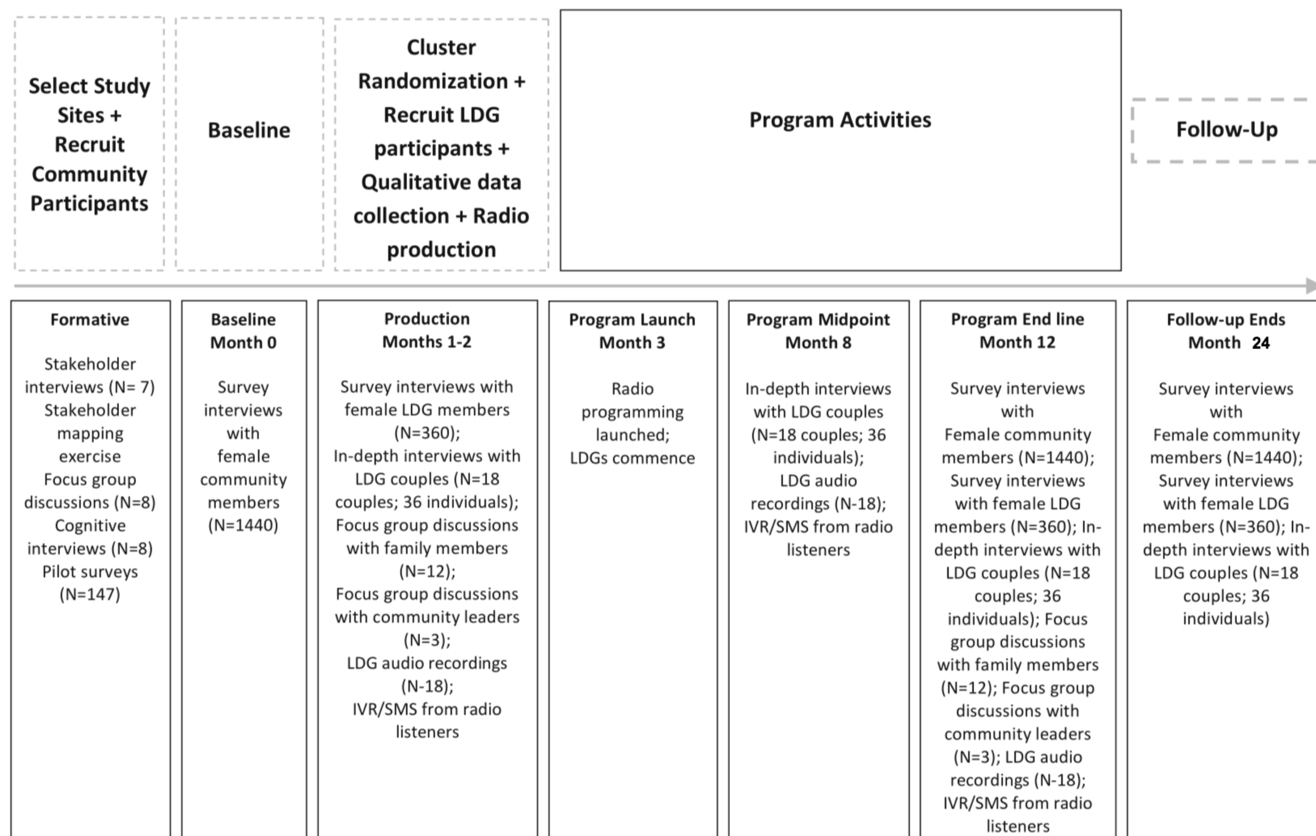


Table 1. Prevalence of Physical and / or Sexual Intimate Partner Violence

	Total (n=1800) No.(%)
Physical Violence	282 (15.67)
Sexual Violence	325 (18.07)
Physical and/or Sexual Violence	455 (25.28)

Table 2. Sociodemographic Characteristics of the Sample and Bivariate and Multivariate Association with Physical and / or Sexual IPV (N=1800).

	Distribution		Bivariate		Multivariate	
	No.	%	OR	95%CI	OR	95%CI
Caste						
Uppercaste and relatively advantaged Janajatis	833	46.36	REF		REF	
Disadvantaged non-Dalit and Janajatis	812	45.19	2.02	(1.60,2.54)	1.63	(1.22,2.19)
Dalit and religious minorities	152	8.46	2.20	(1.51,3.21)	1.40	(0.88,2.22)
Age at Marriage						
<15	226	12.56	REF		REF	
15-17	646	35.89	0.74	(0.53,1.02)	0.89	(0.60,1.30)
18-20	615	34.17	0.63	(0.45,0.88)	1.00	(0.67,1.51)
21+	313	17.39	0.49	(0.33,0.72)	0.80	(0.50,1.30)
Marriage Type						
Love w/fam blessing	185	10.28	1.00	(0.70,1.44)	0.90	(0.59,1.38)
Love w/o fam blessing	297	16.50	1.10	(0.82,1.48)	0.80	(0.56,1.13)
Arranged w/consent	1148	63.78	REF		REF	
Arranged w/o consent	170	9.44	1.84	(1.31,2.59)	1.30	(0.86,1.97)
Wife Education	1.31	1.10	0.78	(0.71,0.87)	1.13	(0.97,1.33)
Husband Education	1.78	1.01	0.72	(0.65,0.80)	0.87	(0.74,1.02)
Wife Employment						
Unemployed	941	52.28	REF		REF	
Earns less than her husband	521	28.94	1.34	(1.05,1.72)	1.51	(1.14,2.01)
Earns the same amount as her husband	269	14.94	1.47	(1.09,2.00)	1.79	(1.25,2.56)
Earns more than her husband	69	3.83	1.42	(0.83,2.44)	1.46	(0.77,2.74)
Income Stress	806	44.88	2.11	(1.70,2.62)	1.57	(1.21,2.02)

Marital Communication (mean/SD)	1.89	0.85	0.67	(0.59,0.75)	0.72	(0.62,0.83)
Quarreling	1208	67.11	5.33	(3.91,7.28)	4.33	(3.10,6.04)
Husband Frequently Drunk	426	23.67	3.83	(3.03,4.84)	2.47	(1.87,3.24)
Wife Exposed to IPV As a Child	380	21.11	2.24	(1.76,2.86)	1.59	(1.19,2.12)
Husband Exposed to IPV As a Child						
No	1159	64.39	REF		REF	
Yes	273	15.17	2.46	(1.85,3.25)	1.58	(1.13,2.21)
Don't know	368	20.44	1.56	(1.20,2.04)	1.40	(1.03,1.92)
In-law Violence	184	10.26	4.30	(3.15,5.87)	3.20	(2.24,4.57)
Gender Equitable Attitudes (mean/SD)	1.10	0.49	0.71	(0.57,0.88)	0.85	(0.64,1.13)
Gender Equitable Normative Expectations (mean/SD)	1.03	0.54	0.55	(0.45,0.68)	0.68	(0.53,0.88)
District						
Nawalparasi	600	33.33	REF		REF	
Chitwan	600	33.33	0.84	(0.64,1.10)	0.67	(0.49,0.93)
Kapilvastu	600	33.33	1.29	(1.00,1.66)	0.96	(0.70,1.32)