Nature and Extent of Gender-Based Violence and its Negative Reproductive Health Consequences amongst Women in Nepal

BACKGROUND

Gender-based violence (GBV) is both a public health problem and a violation of human rights. It has a profound short term and long term emotional, psychological, social, physical and maternal health consequences both immediately and many years after the assaults. The reproductive health of women around the world is affected by violence, often perpetrated by intimate partners or used as a strategy of social control or tactic of intimidation during war. As in many societies, it is believed that GBV exists in Nepal since centuries, but no detail studies were carried out so far. There are various reasons to believe in this hypothesis. *First,* Nepal is being a patriarchal society where women have relatively less or no power decide to whom and when to marry, whether or not to have sexual relations, and when and how many children to bear. Inter-spousal communication on matters related to sexuality is rare in Nepal. Contraceptive and family size decisions were mainly taken by the husband alone or in conjunction with elder members of his family. All these factors may be perpetuating gender-based violence including unwanted pregnancy, abortion or unwanted birth in this country, which has direct implications on ill reproductive and sexual health of women.

Second, Nepalese women are culturally not expected to say 'no' to sexual propositions even if they are not willing to and men generally see no problem in exercising some force for sexual act. This attitude may facilitate GBV including sexual coercion of women regardless of their marital status and age. Therefore, the dividing line between agreeing and refusing sexual propositions is often unclear which makes female both more vulnerable to coerced sex. Third, sex education in the school and counselling services related sex and sexuality are still the matter of taboo and debatable issue, thus far from reaching the needy people. Low awareness on sexual rights and sexual health may also propagate GBV including sexual coercion. Fourth, Nepal has long history of girls trafficking for commercial sex especially to India. It is reported that about 5,000 to 7,000 Nepali girls trafficked to India every year. Ongoing conflicts and political unrest in the country is also a reason for escalating the incidence of GBV.

Despite established negative consequences of gender-based violence on reproductive and sexual health, it has received little attention from researchers, policy makers and programme designers in Nepal. This paper aims to review and analyse the information related to the prevalence of GBV, its nature and factors associated with it and impacts of reproductive and sexual health based on the preliminary results from an ongoing study in Nepal.

DATA SOURCES AND METHODS

Information for this paper are drawn from the published and unpublished reports on any forms of GBV in Nepal for the last three years (2001-2003): leading four national daily and three weekly newspapers. This also uses the data of Nepal Demographic

Health Survey 2001 (DHS). Descriptive statistics is the main output produced from the data. However, binary logistic regression was used to identify the correlates of one form of GBV from DHS 2001 data.

FINDINGS

Prevalence of GBV

Review of the existing studies and newspapers suggest that the prevalence of gender-based violence ranges from 40 to 88 percent in Nepal. For example, a study conducted by SAATHI (a non-governmental organisation) amongst 1250 respondents in five district of Nepal (both urban and rural) documented that 88 per cent of the respondents reported occasional GBV. According to a main hospital in the capital, 165 rape cases were registered over the period of 32 months. Another study conducted by Puri et al (2002) amongst the young factory workers showed that over one-quarter of the girls (28%) reported that their friends had experienced of sexual harassment. One in every nine girls reported that their friends had been victims of rape. One in ten girls (11%) reported personal experience of sexual harassment. Twelve out of 550 young females interviewed (2.2%) said that they had been raped at least once. Another study found that about one in five women reported hitting, slapping or kicking at least once since marriage. The prevalence varies by demographic and socio-economic status of the respondents. Women residing in the *terai* (plain) area were more likely than the hill and mountain women to suffer from domestic violence resulted from the practice of dowry system. The *terai* originated ethnicities such as *Yadav, Rajbansi, Shah, Mandal and Chaudhari* were more likely to experience GBV compared with hill and mountain origin ethnicity. Whereas, girls trafficking for forced prostitution was more prevalent among hill origin ethnicities such as *Tamang* and scheduled castes. GBV were more likely to occur in younger age group (age 10-25 years) than over 50 years of age. Other socio-economic status was negatively correlated to the occurrence of gender based violence. According to the Nepal DHS data, about 10 per cent of the men feel that a husband is justified in beating his wife if she refuses to have sex with him. Men are three times more likely than women to report that a man is justified in beating his wife if she refuses to have sex with him. The results from logistics regression suggest that low socio-economic status elevated the likelihood of experiencing GBV.

Forms of violence

Table 1 summarizes the forms of GBV amongst Nepalese women. Nepalese girls/women have to face different kinds of violence right from the infancy stage to old age. Violence ranges from female infanticides and abandonment in infancy stage to force sexual relationship, and trafficked to work as commercial sex workers in young age. In addition, forced abortions, marital rape and dowry related abuse and sexual harassment are more common in the prenatal and reproductive phase of women. The frequency and types of violence varies according to the place of region, ethnicities and other socio-economic status.

Table 1 Forms of violence in different life stages amongst Nepalese women

Phase	Type of violence
Infancy	Female infanticide, abandonment, emotional and physical abuse, differential access to food and medical care
Childhood	Incest and sexual abuse; differential access to food, medical care, and education; child prostitution
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Old age	Abuse of widows, elder abuse
Prenatal	Forced abortions, battering during pregnancy, coerced pregnancy
Reproductive	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape

Adopted from Heise, L. 1994. Violence against Women: The Hidden Health Burden.

Perpetrators

In most occasions the perpetrators of the GBV were family members including husbands. Perpetrators vary according to the types of violence, age and marital status of women. In most cases, husbands (50 %), son and grandson (25%), step father or mother (20%) and landlord or school teachers (5%) were main perpetrators. In forced trafficking for commercial sex, pimps and close relatives were the major perpetrators, whereas for sexual violence, strange person were the main perpetrators followed by known person including husbands and close relatives.

Health consequences

Violence against women considerably increased women's risk of poor heath. The World Bank (1993) estimates that rape and domestic violence account for 5 per cent of the healthy years of life lost to women aged 15-44 years in developing countries. The global health burden from violence against women in the reproductive age group is about 9.5 million disability-adjusted life years (DALYs), comparable to risk factors such as tuberculosis (10.9 million DALYs), HIV (10.0 million DALYs), and sepsis during childbirth (10.0 million DALYs) . There is no figure of DALYs was found for Nepal but considering wide prevalence of GBV, there are no reasons for not to believe that the figure is high in Nepal. Our reviews suggested that women frequently mentioned mental tension, depression, unwanted sex, abortion, STIs and HIV/AIDS resulting from GBV. A 2002 study on the relationship between trafficking and HIV in Nepal indicates that HIV infections were many times higher among Nepali women and girls, trafficked to India than for urban sex workers in Nepal (72 % as against 17 %).

CONCLUSIONS

GBV is one of the most widespread human rights abuses and public health problems in the world today, affecting as many as one out of every three women. It is also an extreme manifestation of gender inequity, targeting women and girls because of their subordinate social status in the family and society. The consequences of GBV are often serious and long-term, affecting women's and girls' physical health and mental well-being. At the same time, its ripple effects compromise the social development of other children in the household, the family as a unit, the communities where the individuals live, and society as a whole. We reviewed evidences of GBV that were published and unpublished reports, journal articles, four national daily and three weekly newspapers in last three years. We also analysed 2001 DHS data. The study revealed that GBV is widespread in Nepal, but the extent varies according to the types of violence. Ecological region, ethnicity and other socio-cultural and economic factors are strongly associated with GBV. The perpetrators vary by the types of violence. The findings also indicated the major impacts on women's health. The reproductive and sexual health problems such as unintended pregnancy, mental tension, depression, abortion, marital rapes, STIs and HIV/AIDS were some of the major outcomes of GBV in Nepal.

Findings suggest the need of culturally acceptable intervention programme in a different level including modification in the existing legal provisions on GBV. Very few programmes in private sector currently focus on preventing GBV in Nepal. In addition, their geographical coverage is also low. One of the reasons may be due to the fact that there is no systematic documentation on this issue in the country. Therefore, this study is an 'eye opening' for the policy makers and programme planners and will create some public and government attention in this 'over shadowed' public health problem. There is a need to develop a strategy to address this complex problem. A concrete approaches for implementing it, not only for those on the front lines attending to the women who live with violence, but also for the decision-makers, who may incorporate the lessons in the development of policies and resources are required.