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Counseling Centre

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Report

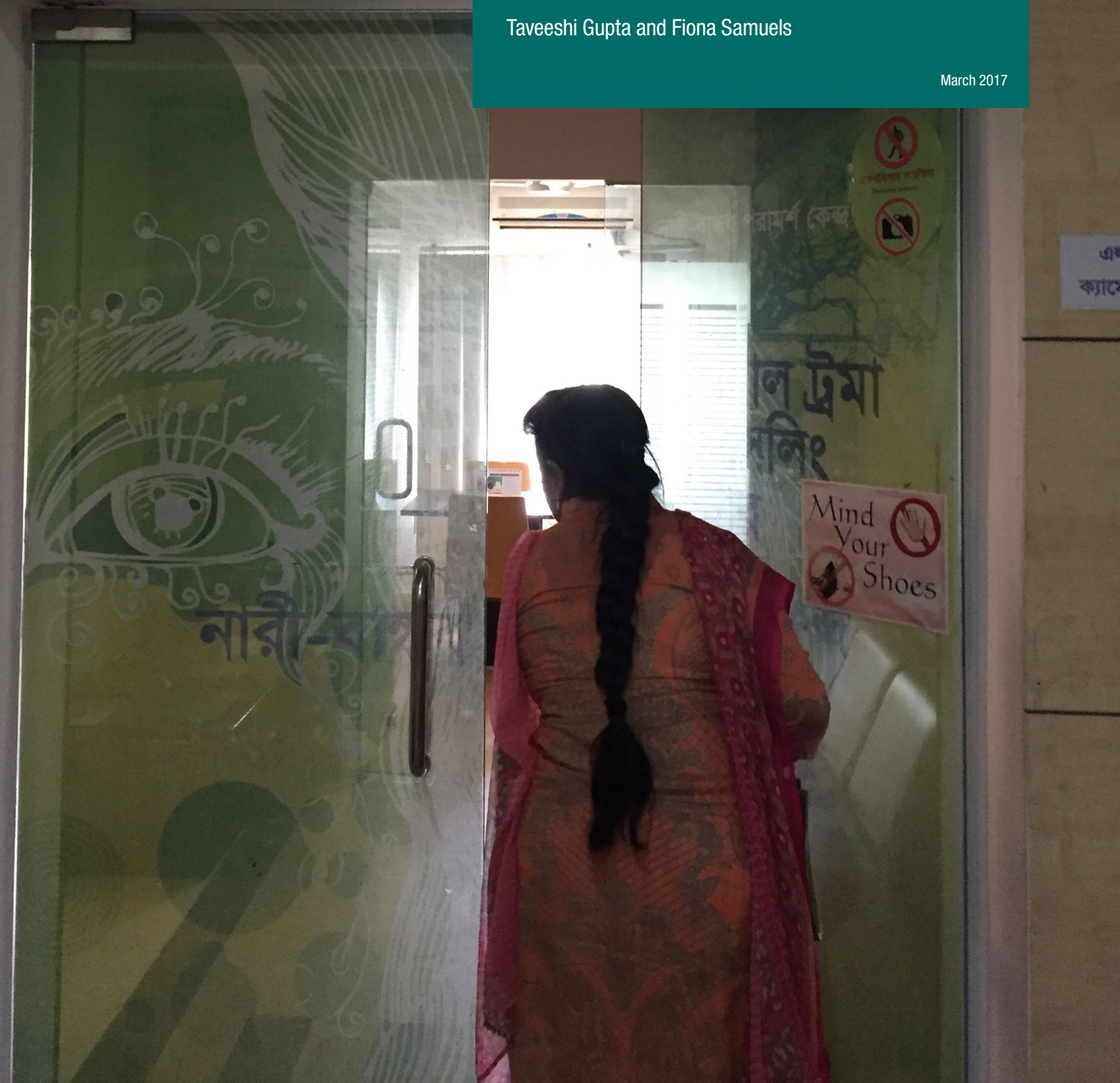
Literature review of male perpetrators of intimate partner violence in South Asia

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Abbreviations

CBBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic Health Survey
BNWLA	Bangladesh National Women’s Lawyers Association
BUHS	Bangladesh Urban Household Survey
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
FGD	Focus group discussions
GBV	Gender-based violence
HIC	High income countries
HIV/AIDS	Human Immunodeficiency Virus/ Acquired immunodeficiency syndrome
HRCP	Human Rights Commission of Pakistan
ICRW	International Center for Research on Women
IGWG	Interagency Gender Working Group
IMAGES	International Men and Gender Equality Survey
INFHS	Indian National Family Health Survey
INSEC	Informal Sector Service Centre
IPV	Intimate partner violence
IRC	International Rescue Committee
LMIC	Low and middle income countries
LSHTM	London School of Hygiene & Tropical Medicine
NDHS	Nepal Demographic Health Survey
NGO	Non-governmental organisations
NIPORT	National Institute of Population Research and Training
NPR	Nepal Rupee
P4P	Partners for Prevention
PDHS	Pakistan Demographic Health Survey
SANAM	South Asian Network to Address Masculinity
SRQ	Self-Reporting Questionnaire
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children’s Emergency Fund
USA	United States of America
VAWG	Violence against women and girls
UNDP	United Nations Development Programme
UNIFEM	United Nations Development Fund for Women
UNV	United Nations Volunteers
WBGSN	World Bank Survey on Gender
WHO	World Health Organisation
WOREC	Women’s Rehabilitation Centre

1. Introduction

As a key component of a broader study exploring intimate partner violence (IPV) in three focal countries, Bangladesh, Pakistan and Nepal (Samuels, Jones, and Gupta, 2017), a literature review on male perpetrators of IPV based on systematic principles was conducted between 2015-2016. In this literature review, we attempt to review and summarise the available evidence for Intimate Partner Violence by male perpetrators, with a specific focus on the South Asia region (i.e., Bangladesh, Pakistan, and Nepal). However, as Johnston & Naved (2008) suggest, given that there are “different definitions of physical violence; different reference periods; differences in perpetrators; cultural and geographic variations; socioeconomic variations; and differences in primary focus of data collection” (Johnston & Naved, 2008, p.367), estimates of prevalence as well as associations found vary from study to study (also see Ali et al., 2015; NIPORT et al., 2008). Moreover, methodological issues create difficulty in obtaining reliable data. For instance, in Bangladesh, Das et al., (2008) notes the 2004 Bangladesh Demographic Health Survey (BDHS) had men’s report of violence to be higher than any other previous survey in the country while, on the other hand, the World Bank Survey on Gender (WBGSN) 2006 found reporting by men to be almost twice as high as that by women, but not as high as the BDHS 2004. Given that both surveys were conducted by the same agency around the same time, the discrepancy in men’s responses suggests that the setting, question format, and a host of environmental factors can influence responses. Thus, comparing the nature of IPV across

settings must be done with caution. Nonetheless, we attempt to contextualize our findings in both the regional and global context as it is important to understand the degree and underlying factors of IPV comprehensively for change to be effective.

This literature review is divided into 7 sections. First, we outline the methodology used to collect resources for the review. Next, we delve into the findings and begin by describing the nature of IPV beginning with how IPV has been conceptualised in the literature using the human rights approach, the public health discourse, and the gender perspective. We focus on both the global conceptualisation and the regional South Asian conceptualisation. We then define IPV and the types of behaviours that fall under its definition. We also discuss global prevalence rates of IPV (both women and men reported estimates), followed by focal country estimates. Section 4 explores the negative consequences of IPV for both victims as well as perpetrators in terms of physical, mental, and sexual and reproductive health, economic impacts at national and household level, and consequences on children at both global and country-level. In Section 5 we focus solely on male perpetrators of IPV, identifying the risk factors that increase the likelihood of boys and men committing IPV at both global and country-level. In section 6, we describe the global legal efforts to reduce IPV. Next, we describe the programming efforts involving boys and men globally and in South Asia more generally. Finally, section 8 concludes and summarises the main points of this review.

2. Methodology

Marcus and Page (2013) note that while systematic reviews are most appropriate for projects assessing effectiveness of interventions, it is possible to incorporate systematic principles when conducting a literature review for other types of studies as well. Thus, building on techniques utilised in systematic reviews, we ensured a comprehensive and step-by-step approach in conducting this literature review. Our first step was to develop a clear search protocol (Annex A). In this search protocol, we identified specific research questions, inclusion/exclusion criteria, databases from which to search in, combinations of search strings to retrieve articles, and a key informant interview protocol. We also drafted a combination of key words on topics related to our review that were used in different combinations of AND/OR/NOT in the database search function (Annex B). Specific objectives guiding this review, and which were also derived from the original proposal, are outlined below:

1. How is IPV understood globally and in South Asia?
2. What factors drive male perpetration of IPV at individual, household, and community level, globally and in South Asia?
3. What does research indicate about adolescent male IPV specifically, globally and in South Asia?
4. What programmes exist that are focussed on prevention of men's perpetration of IPV globally and in South Asia?

Once the search protocol and search strings were peer-reviewed and finalised, we conducted database searches using the search strings. Parallel literature searches were conducted on the following databases, selected for their quality and depth of coverage of the social science literature: British Library of Development Studies, Econ Lit, Google, Google Scholar (used 'cited by' function), IBSS, PubMed, Scopus and, SocInfo.

Sources for reviews included peer reviewed journal articles and books, policy documentation from government and international agencies, and grey literature (including NGO reports and evaluations). For peer-reviewed journal articles, we also conducted a search in journals that were identified by experts in the field to be most relevant to the topic. In addition, a search for articles was conducted on relevant websites known to work in the field of violence against women (see table 1).

Finally, we interviewed (through skype or email), 10 experts in the field, to seek their opinion on seminal resources on IPV (annex A). The interview protocol

Table 1. List of websites and institutions we consulted

3ie	Liverpool School of Tropical Medicine
ActionAid	MenEngage
Adolescent Girls Initiative	Oxfam
African Gender Institute	Partners for Prevention
AWID	Plan
Better evaluation network	Population Council
Camfed	Poverty Action Lab
CARE	Promundo
Care Evaluation Database	RECOUP
Coalition for Adolescent Girls	Restless Development
CREATE	Save
DFID	Sonke Gender Justice
Eldis	STRIVE
FAWE	The Communication Initiative
FORWARD	UCL Institute of Global health
GSDRC	UN Women (Virtual Knowledge Centre to End VAWG)
ICRW	UNAIDS
IDS	UNFPA
IRC	UNICEF
JPAL	UNRISD

London School of Hygiene and Tropical Medicine

is provided in Annex A. Using the above outlined combination of systematic principles, a total of 110 articles, reports, and working papers were reviewed at the global level, and 74 in Bangladesh, 28 in Pakistan, and 41 in Nepal at country level for this review.

Our efforts to be systematic in collecting resources, notwithstanding, it is important to note several caveats. Firstly, due to the large scope of this review, we were unable to review all articles on the current topic and

as a result, the search is not exhaustive at the global level. At the country level, the search is more thorough and our attempt to include all resources is more robust. Additionally, while we tried to ensure that our inclusion/exclusion criterion is neither too broad nor too rigid, we may have missed some grey literatures that could add nuance to global and country trends that we discuss below. We were also unable to access articles/books in local languages that could have added further nuance to our findings. Nevertheless, the review provides a solid overview of key issues concerning male perpetrators of Intimate Partner Violence at a global level.

2.1 Availability of research in focal countries

Bangladesh. The research on IPV, especially physical abuse, in Bangladesh is relatively well documented in comparison to the other two focal countries in this study (Pakistan and Nepal). There have been several reviews of the literature (for e.g., Johnston & Naved, 2008; Wahed & Bhuiya, 2007) and a few scholars have documented trends and prevalence rates of IPV (e.g., Das et al., 2008; Bates et al., 2004), detrimental effects of IPV on women (e.g., Azzizbaumgartner et al., 2014; Naved & Akhtar, 2008; Naved & Persson, 2008) and their children (e.g., Silverman et al., 2009; Asling-Monemi et al., 2009a, 2009b), and the risk factors underlying IPV for women, with some recent work examining risk factors of IPV for male perpetrators (e.g., Koenig et al., 2003; Naved & Persson, 2010; Siddique, 2011; Vanderende et al., 2015). There have also been efforts to disentangle rural vs. urban patterns (e.g., NIPORT et al., 2008; Naved et al., 2011). While several researchers have analysed either the BDHS (e.g., Das et al., 2008) or the Bangladesh Urban Household Survey (BUHS; e.g., NIPORT et al., 2008), many others have also reported on non-nationally representative samples. Data is mostly available on women's report of IPV (e.g., Bates et al., 2004; Garcia-Moreno et al., 2006; NIPORT et al., 2008; Naved & Persson, 2008) though men's report is increasing (e.g., Naved et al., 2011). For instance, Bangladesh was one of the seven countries chosen to be a part of The Change Project initiated by Partners for Prevention, working to prevent gender-based violence, partnering with UNDP, UNFPA, UN Women and UNV regional programme for Asia and the Pacific as the largest ever multi-country study

on gender-based violence and masculinities interviewing men (Naved et al., 2011).

Pakistan. The research in Pakistan on IPV is scarce and limited. There are limited population based-surveys (the exception are: Ali et al., 2013; Andersson et al., 2009; Karmaliani et al., 2008) and only cross-sectional data based, with the majority based on convenience samples (for exception see Qayyum et al., 2012). Most the research focuses on women as participants, though a few also include male perpetrators as participants (e.g., Shaikh, 2000). Scholars also attempt to identify risk factors for IPV for women (e.g., Shaheen, 2014), especially during pregnancy (e.g., Fikree & Bhatti, 1999; Farid et al., 2008). There are limited studies attempting to disentangle risk factors for men and risk factors for women for IPV (for exception see P4P, Rozan and ICRW, n.d.) and very few studies that attempt to understand attitudes of male perpetrators towards IPV (with an exception being Zakar et al., 2013). There is only one systematic review so far, which included 23 studies in its final sample; this review finds that majority of the studies on IPV in Pakistan are in urban settings, in hospital settings, quantitative, and with women (Ali et al., 2011).

Nepal. The state of research in Nepal suggests that intimate partner violence is an upcoming field though quality and quantity of research is still limited. One of the initial ground-breaking studies took place in 1997 by an NGO SAATHI that conducted a situation analysis on the topic in the country. There are no population based surveys though several studies conduct secondary data analysis on the NDHS modules from 2007 and 2011 (e.g., Atteraya et al., 2015; Dalal et al., 2014, Tuladhar et al., 2013). Additionally, there are only two studies that solely examine determinants of male perpetrators of IPV (see Bhatta, 2014) though several assess alcohol consumption as a risk factor (e.g., Adhikari & Tamang, 2010). Other studies combined both female and male factors in the same analysis suggesting that the role of masculinity in perpetuating IPV is still understudied (for global study exception see Fulu et al., 2013). There is also a focus on sexual violence over and above any other forms of violence, with studying sexual violence during pregnancy a well-studied area (e.g. Deuba et al., 2016; Puri et al., 2011). Our search for resources found no systematic reviews studying IPV in Nepal yet.

3. Literature review on Intimate Partner Violence

3.1 Conceptualising Intimate Partner Violence

Various overlapping and complementary approaches have been utilised to conceptualise IPV (WHO & LSHTM, 2010). The first and obvious approach is that of the human rights discourse. It is generally thought that the notion of ‘domestic violence’ does not fall under the international rights framework since international law does not apply to private harm. While this was true in previous times, more current conceptualisations pay attention to the ways in which IPV occurs through relationships of power and control over another. In its current form, the human rights approach understands IPV as a violation of various human rights such as: violations of right to life, liberty, autonomy, and security of person; violation to equality and non-discrimination; and violations to, right to be free from torture and cruel, inhuman, and degrading treatment or punishment (WHO and LSHTM, 2010).

Situated in international and regional treaties, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), this approach requires states to be accountable to violations of such rights. For instance, countries that have signed and agreed to the International Covenant on Civil and Political Rights are required to report on laws that address violence against women and specific prevention and response measures. Most of the countries in South Asia have signed the Convention on the Elimination of All Forms of Discrimination Against Women (with reservations in some countries as shown in table 2 below). However, the CEDAW articulates that states are not only obligated to refrain from committing violations themselves, but are also responsible for otherwise what was earlier understood as ‘private’ acts. This responsibility is also reflected in the Declaration on the Elimination of Violence against Women and the Vienna Declaration and Programme of Action from the 1993 World Conference on Human Rights. Additionally, the Inter-American Convention on Prevention, Punishment, and Eradication of Violence against Women (Convention of Belem do Para, 1994) focuses on violence against women more specifically. An example at the regional level is the Protocol to the African Charter on the Rights of Women in Africa that commits States Parties to implementing “appropriate measures to

ensure the protection of every woman’s right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence” and measures to combat all other behaviour, attitudes, or practices that negatively affect the fundamental rights of women and girls” (Articles 3 and 5).

The second widely used method approach to understanding IPV is the public health perspective. According to Krug et al., (2002) and WHO and LSHTM (2010), “the public health approach is a science-driven, population-based, interdisciplinary, inter-sectoral approach based on the ecological model which emphasizes primary prevention” (WHO, LSHTM, 2010: 6). This tradition attempts to focus on entire populations rather than individuals. Building on various disciplines, the public health approach proposes a multi-sectoral response to IPV. As per the public health perspective, prevention to IPV is categorised in three ways (Dahlberg & Krug, 2002; WHO & LSHTM, 2010:7):

- Primary prevention – approaches that aim to prevent violence before it occurs.
- Secondary prevention – approaches that focus on responses to violence after it occurs, such as pre-hospital care, emergency services or treatment for sexually transmitted infections following a rape.
- Tertiary prevention – approaches that focus on long-term care, such as rehabilitation and reintegration, and attempt to lessen trauma or reduce long-term disability associated with violence.

The third approach to conceptualise IPV applies/adopts a gender perspective and encompasses both the human rights and public health discourse and is rooted in the notions of power derived from the patriarchy (Abrahams et al., 2006; Amirthalingam, 2005; Fleming et al., 2013; Heise, 2011). The gender approach pays attention to the ways in which the patriarchal social and power structures in a society give men power over women. As a result, male superiority is manifested in lower value and respect for women (Jewkes, 2002).

IPV, using this perspective is understood as to be a consequence of such structural inequalities. These structural inequalities lead to a man’s masculine identity

Table 2: Status of country-specific information on the ratification status, reservations, and declarations pertaining to the CEDAW Convention by the South Asian countries (2010)

State	Date of Signature	Date of Ratification. Accession(a)	Reservations and Declarations	Withdrawal of Reservation and Declaration
Afghanistan	14/08/1980	02/03/2003		
Bangladesh		6/11/1984(a)	Reservation to Articles 2 , 13(1)(a), 16(1)(c)(f)	Withdrawal of reservation 13 (a) and 16(1)(f):On 23 July 1997, the Government of Bangladesh notified the Secretary-General that it had decided to withdraw the reservation relating to Articles 13(a) and 16(1) (f) made upon accession.
Bhutan	17/07/1980	31/08/1981	None	
India	30/07/1980	09/07/1993	Reservation to Article – 29(1); Declaration Art 5(a) &16(1),(2),	
Maldives		01/07/1993(a)	Reservation to Articles – Art 7(a) & 16.	Withdrawal of Reservation 7(a) –On 31 March 2010, the Government of the Republic of Maldives notified the Secretary-General of its decision to withdraw its reservation regarding Article 7(a). The reservation read as follows: " ... The Government of the Republic of Maldives expresses its reservation to Article 7(a) of the Convention, to the extent that the provision contained in the said paragraph conflicts with the provision of Article 34 of the Constitution of the Republic of Maldives ..."
Nepal	05/02/1991	05/02/1991		
Pakistan			Reservation to Article – 29(1); general declaration on accession subject to Constitutional provisions	
Sri Lanka	17/07/1990	05/10/1981		

Source: <http://cedawsouthasia.org/regional-overview/ratification-status-in-south-asia>

being defined by more power and feelings of power and dominance over a woman. When threats are perceived to one's masculine identity, violence is used as an expression of power. According to Amirthalingam, (2005:684), "the key to understanding domestic violence from a gender perspective is to appreciate that the root cause of violence lies in an unequal power relationship between men and women that is compounded in male dominated societies".

In other words, gender inequality also stems from norms and beliefs at the societal level wherein men are justified in exerting power and violence over women. Similarly, the UN special report (1996) on Violence against Women has defined domestic violence in gender terms as "violence perpetrated in the domestic sphere which targets women because of their role within that sphere or as violence which is intended to impact, directly and negatively, on

women within the domestic sphere”. As a result, the gender approach is often used as a theoretical basis for programming efforts aimed to change social norms.

3.2 Defining IPV

IPV refers to any behaviours within an intimate relationship (i.e., husband, boyfriend, romantic partner) that causes physical, psychological, or sexual harm to those in the relationship (Heise & Garcia-Moreno, 2002). According to WHO (2012), the following behaviours fall under IPV:

- Physical aggression (slapping, hitting, kicking, and beating)
- Psychological abuse (insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children).
- Sexual violence (forced sexual intercourse and other forms of sexual coercion), and
- Other controlling behaviours (isolating a person from family and friends; monitoring or restricting their movements; and restricting access to financial resources, employment, education, or medical care).

Another form of IPV that is not included in WHO’s conceptualisation is that of economic violence. According to various authors (e.g. Adams et al., 2008; Yount et al., 2015), economic violence, which includes controlling the victim’s ability to acquire, use, and maintain economic resources, was until relatively recently an understudied form of IPV). In the South Asian context, where unequal power relations between men and women and continue to be reinforced by the entrenched patriarchal values system, economic violence is especially important to study. Recently have researchers begun to study the consequences and factors driving economic violence in neighbouring regions such as Yount et al., (2015) in Vietnam, with others suggesting that there is an urgent need to document trends and consequences of economic violence in South Asia more specifically (Solotaroff & Pande, 2014).

Given that intimate partner violence by definition involves a romantic/intimate relationship, sexual violence in particular is a cause for concern. Nearly one in four women worldwide report IPV in the form of sexual violence (Jewkes, Sen, & Garcia-Moreno, 2002). Studies find that sexual violence may occur by itself, without physical violence. Sexual violence encompasses behaviours such as rape within marriage or relationships, customary forms of sexual violence such as forced marriage or cohabitation including early marriage, denial of right to use contraception, forced abortion, and performing checks for virginity (*ibid.*).

Other research suggests that different types of violence often coexist (e.g., Xiangxian et al., 2013). For instance, physical IPV is often accompanied by sexual IPV and emotional violence. The WHO multi country study in

Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania reports that 23-56 percent of women who experience physical IPV also experience sexual IPV (Garcia-Moreno et al., 2006). Other studies have also found that psychological abuse tends to be associated with physical abuse. For example, Capaldi and Crosby (1997) found that at age 18 years, there were significant correlations between the perpetrations of the two types of abuse.

However, the UN multi country states that, “not all perpetrators use all types of violence, and although some overlap exists between physical and sexual partner violence, this is not always the case” (Fulu et al., 2013: e204). Their findings point to regional variations; for instance, in South Asia, sexual violence often occurs on its own (Fulu & Heise, 2014). Additionally, multiple studies have found that while physical and sexual violence often have shared correlates, they also have unique associations. For instance, studies find that physical violence often stems from low levels of education, experiences of physical and emotional victimisation in childhood, gender-inequitable attitudes, conflict within the relationship, depression, and alcohol misuse (Barker et al., 2011; Fulu et al, 2013; Jewkes et al., 2002a). Sexual violence, on the other hand, often stems from experiences of childhood sexual and emotional abuse, having multiple sexual partners, and engaging in transactional sex (Fulu et al., 2013). Fulu et al., (2013) suggest that given factors associated with sexual violence and physical violence may not be the same and factors with sexual violence are more similar to those associated with non-partner violence, interventions must be tailored to address different types of violence (even when committed by the same individual) in order to be most effective.

3.2.1 Nature of IPV in South Asia

The research on IPV in South Asia suggests that IPV is frequent and acute. Adolescents in the South Asian region are particularly vulnerable given that much of the research suggests that IPV is highest in the earliest years of marriage (e.g., Mensch et al., 2005; Jejeebhoy et al., 2013) and since early marriage is common in South Asia, it is likely that married adolescents face high rates of IPV (more below). The historical context of the South Asian geography can shed light onto the high rates of IPV (see next section), with scholars suggesting that the post-colonial aftermath led to a rise of structural hierarchies and breakdown of the culture. Given that civilization in this region has existed since 2500 BC with various groups invading the area, the role of the historical context is too vast to be covered by this review. However, the role of the historical context is widely documented elsewhere with scholars suggesting, amongst other things, that 500 years of Mughal rule and more than 200 years of British rule have led to a sharp drop in women’s’ freedom and literacy rates (from 90 percent in 1847 to 12 percent in 1947) (Ahmad, 2009;

Niaz, 2003). Over time, gender norms that devalue womanhood, have become entrenched in the region. Thus, for instance a women's status is only elevated after becoming a wife and attaining motherhood. Moreover, domestic life and domestic violence in South Asia is considered a private, family issue rather than as a public and social problem (e.g., Surtees, 2003, P4P et al., n.d.; SAHAVAGI et al., 2015). IPV is rarely considered a crime, unless it leads to murder (Ali & Gavino, 2008). Religion also plays a complex role in validating and keeping patriarchal structures intact. Combined, these factors help explain the high rates of IPV in the region¹. Given the focus of this study on men's perpetration of IPV, section 4 outlines the risk factors underlying men's perpetration of IPV specifically.

In this review, though the focus is on intimate partner violence defined as physical, psychological, sexual and economic violence between romantic partners, it is important to note that in the South-Asian subcontinent, i.e., Pakistan, India, Bangladesh, Nepal, Sri Lanka, Afghanistan, and Bhutan, gender-based violence is also culture-specific, where types of violence include those found globally, such as domestic violence, spousal murder, rape, marital rape, polygamy, sexual harassment, incest, and trafficking but also include honour killings, acid attacks, public mutilation, stove-burnings, and fatwa violence which are more regionally specific (e.g., Ali & Gavino, 2008; Niaz, 2003; Solotaroff & Pande, 2014, BRAC & UNDP, 2013). Honour killings usually perpetrated by a male family member occur when women are considered to have transgressed from the norms and sanctions placed on them by the society, and have behaved in a such a way that is said to have damaged a man's honour (Dawood, 1999; Johnson & Johnson, 2001; Niaz, 2003). In Pakistan, the Aurat Foundation estimates that more than 3,000 have been killed for "honour" since 2008 in Pakistan (HRCP report, 2013). Ali & Gavino (2008) state that "official figures show that more than 4000 people including 2800 women have died during 1998 to 2004" as a result of honour killings in Pakistan alone.

Another form of violence is also prevalent in South Asia and is known as family violence. In Jejeebhoy et al.'s, (2013) study of women and men's reports of IPV in Bihar India, it was found that family violence is a common occurrence. Family violence can be understood as other members of the marital family, such as the father-, mother-, brother- or sister-in-law, perpetrating violence against women. Jejeebhoy et al. (2013) found that while both men and women in all the FGDs acknowledged the existence of family violence, women were more likely to

perceive it as being common than men and considered it as a form of emotional violence. Stove burning is yet another culturally specific form of violence, and is an extreme form of domestic violence carried out by husbands and in-laws, in most cases due to dissatisfaction with the victim's dowry (Niaz, 2003; Prasad, 1999). Ali & Gavino (2008) state that in a study by HRCP (2000), on 1000 women in Punjab, on an average, at least two women were burned every day in domestic violence incidents while in 1998, 282 burn cases of women were reported in only one province of the country (65 percent of whom died of their injuries). Finally, acid throwing includes throwing sulphuric, hydrochloric, or nitric acid to cause severe burns to the victim's face as retaliation for rejecting sexual advances and marriage proposal (Khan, 2005). Considered as public violence, these are the worst forms of gender-based violence, and if victims survive these attacks, they are scarred both physically and psychologically for life. Since we are focused on violence in romantic relationships, we do not cover family or public violence in this review.

3.3 Magnitude of IPV

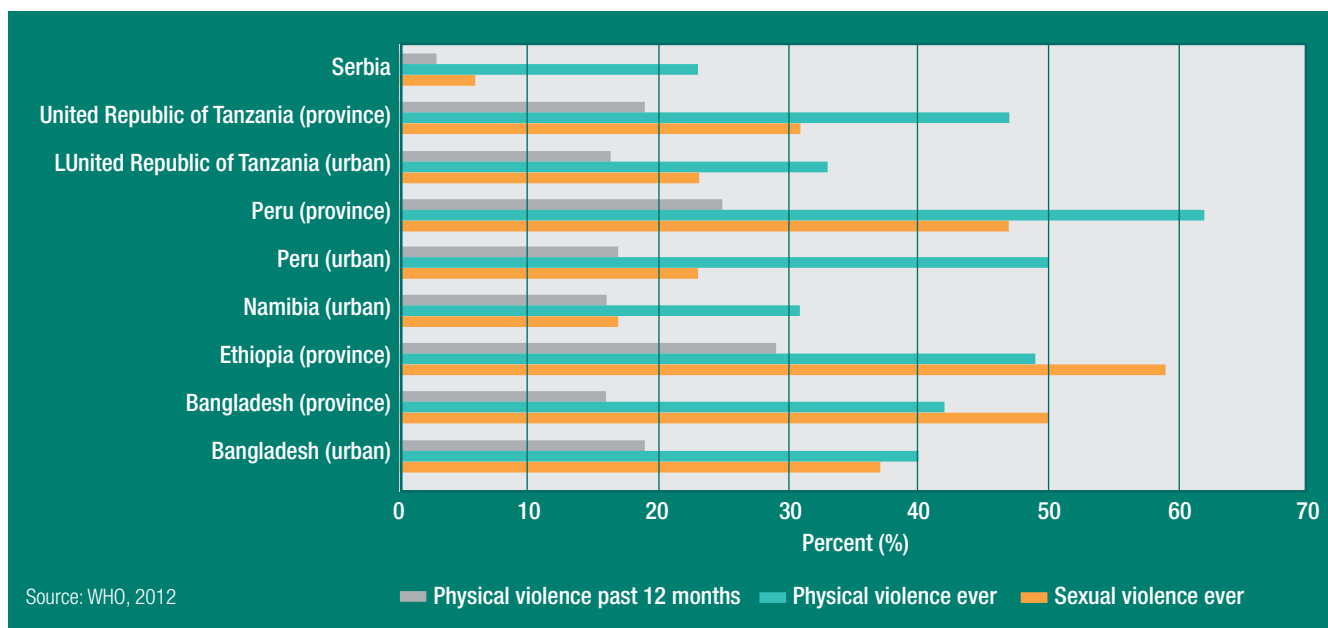
3.3.1 Global Prevalence of IPV

Both physical and sexual violence are considered "universal" types of violence affecting women and are more prevalent than any other type of violence globally. A review of studies prior to 1999 indicates that globally, between 10-52 percent of women reported having experienced physical violence and 10-30 percent reported experiencing sexual violence by an intimate partner (Krug et al., 2002). In 1997, WHO initiated the Multi-Country Study on Women's Health and Domestic Violence against Women, and found that across the globe, 15-71 percent of women experience physical and/or sexual violence at some point in their lives, with variation between and within countries (Garcia-Moreno et al., 2006; see Figure 1). Prevalence was found to be highest in the WHO African, Eastern Mediterranean and South-East Asia Regions, where approximately 37 percent of ever-partnered women reported having experienced physical and/or sexual IPV at some point in their lives (WHO, 2013). The global lifetime prevalence² of IPV has been calculated at 30 percent by WHO's research team (WHO, 2013). Similarly, Devries et al, (2011), analysed data from 81 countries (using meta-regression analysis of 141 studies) and found that 30 percent of women over the age of 15 have experienced physical or sexual violence by an intimate partner during their lifetime.

1 Note that this is not an exhaustive list of factors driving IPV in the region given variability within and across countries.

2 Prevalence of IPV across age groups in a women's lifetime. It is defined as "the proportion of ever-partnered women who reported having experienced one or more acts of physical or sexual violence, or both, by a current or former intimate partner at any point in their lives (WHO, 2013:10).

Figure 1. Percentage of ever-partnered women reporting physical and/or sexual IPV by type and when the violence took place, WHO multi-country study



For adolescents, studies of forced sexual initiation, have found that globally, between 7 percent and 48 percent of adolescent girls and between 0.2 percent and 32 percent of adolescent boys' report that their first experience of sexual intercourse was forced (Jewkes et al., 2002b). Reviews of studies, particularly in North America, find that violence in dating relationships varies from 9 percent to 49 percent (Glass et al., 2013). Since international population-based studies on dating violence are limited, there is no global estimate on adolescent dating violence. However, for country level estimates, studies in countries including South Africa and Ethiopia find the estimates to be around 42 percent and 16 percent respectively (Swart, 2002; Philpart et al., 2009). Interestingly, there are vast differences in the rates of IPV in Ethiopia with adult women (i.e., approximately 60 percent as per the WHO multi country study as shown in Figure 1) and the rates of adolescent dating violence (i.e., approximately 16 percent as found by Philpart et al., 2009). It is important thus, to examine the nature of IPV during adolescence and intervene at this stage in order to prevent or reduce the probability of committing IPV later in their lifetime.

The rates of incidence from the studies cited above are self-reported figures from women who have been victims of IPV. In the past decade, however, there has been a shift to examine male perpetrators' reports of the incidence of violence as well. The two main global studies that describe trends in male reported prevalence of violence are the IMAGES study (implemented by Instituto Promundo and International Center for Research on

Women between 2009-2010), and the UN multi-country study on men and violence (implemented by Partners for Prevention on behalf of UNDP, UNFPA, UN Women and UNV between 2010-2013). The IMAGES project interviewed and surveyed more than 8,000 men and was conducted in 6 countries (Brazil, Chile, Croatia, India, Mexico & Rwanda). Findings of this study suggest that men's report of perpetration of IPV ranged from 6-29 percent, the majority of this against a stable female partner in the cases of India and Mexico (Barker et al., 2011). The percentages of men who reported that they have ever used sexual violence (against a partner or against any woman) vary from 2 percent (in Brazil) to 25 percent (in India).

Similarly, the UN Multi country study on men and violence in the Asia-Pacific with over 10,000 men finds that the proportion of ever-partnered men who report being perpetrators of IPV ranges from 25 percent to 80 percent (Fulu et al, 2013). The prevalence of physical or sexual IPV perpetration, or both, varied by site, between 25 percent (rural Indonesia) and 80 percent (Bougainville, Papua New Guinea). When emotional or economic abuse were included, the prevalence of IPV perpetration ranged from 39 percent (Sri Lanka) to 87 percent (Bougainville, Papua New Guinea). It is important to note that studies that consider both men and women's reports of IPV find higher levels of IPV than studies that only look at women's reports of IPV. Perhaps as noted in the caveats of the WHO multi-country study, this could be attributed to the fact that women may be more hesitant to report acts of violence in surveys.

3.3.2 Prevalence of IPV: South Asia

According to NIPORT et al., (2008), “South Asia is known as the region where gender imbalance is most prominent in the world” (p. 287). Several studies suggest that rates of IPV in the region are particularly high, with NIPORT et al., (2008) citing Campbell (1999) and stating that in a categorisation of 15 regions across the world, domestic violence in South Asia falls in the ‘high’ category. More recently, Solotaroff and Pande (2014) examined rates of IPV in South Asia and found that while it is challenging to make global comparisons, South Asia (using DHS data from India, Bangladesh, and Sri Lanka) had the highest regional prevalence of IPV, compared to all other global regions:

Table 3: Regional prevalence of IPV globally

Region	Prevalence
South Asia	43 percent
Middle East and North Africa	40 percent
Sub-Saharan Africa	40 percent
Latin America and Caribbean	33 percent
East Asia and Pacific	30 percent
Europe and Central Asia	29 percent
Australia and New Zealand	28 percent
North America	21 percent

Source: Solotaroff & Pande 2014

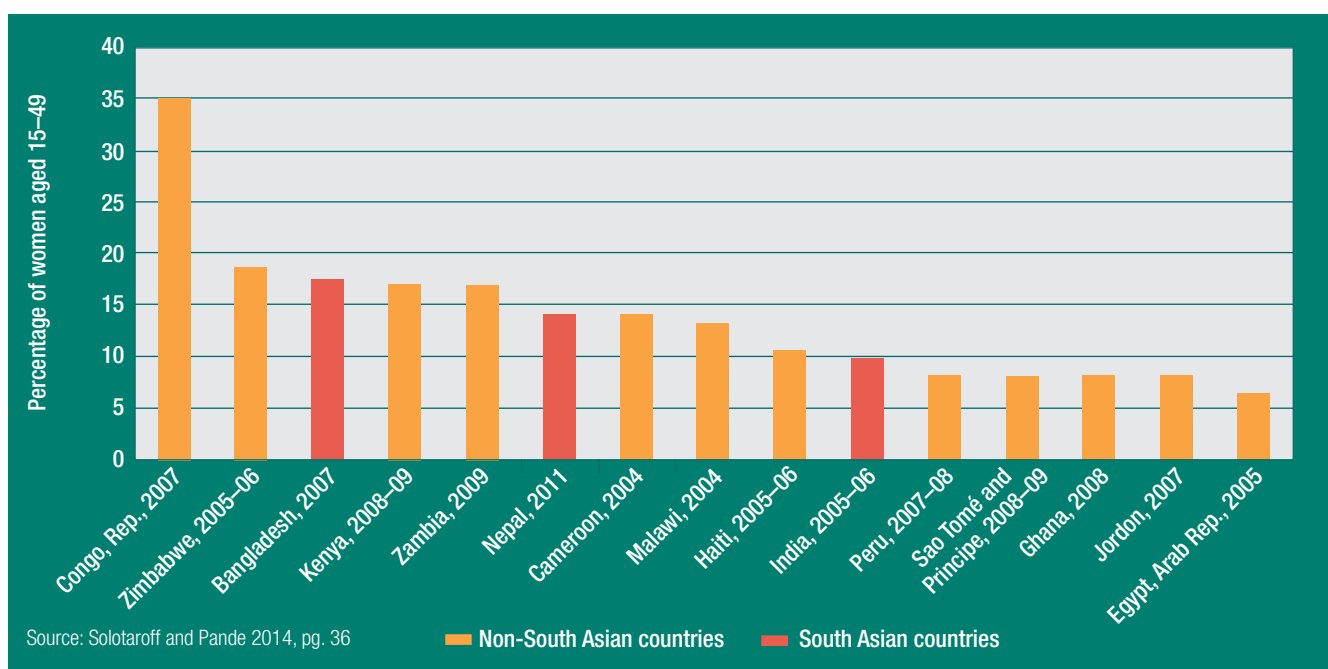
There are several reasons why the above estimates should be taken with caution: First, regional estimates are often misleading (Solotaroff & Pande 2014), definition of intimate partner violence, survey area, and measurement tools may vary from study to study (Johnston & Naved, 2008; Solotaroff & Pande, 2014), and finally given that Solotaroff & Pande only used three countries’ DHS data to represent the South Asia region due to ease of availability of the DHS data, they state that the macro-level regional groupings may hide important sub-regional variations (WHO et al. 2013, 47 cited in Solotaroff & Pande, 2014, p. 34). Moreover, while DHS across countries use the same wording, the meaning of what constitutes violence may vary across contexts; similarly, willingness to share experiences of violence are also likely to vary widely (Jejeebhoy and Bott 2003; Santhya et al. 2007). Indeed, in Bangladesh, Yount et al., (2012) find that women victims of IPV give contradictory responses in their interviews and suggest that new methodological tools are needed to capture IPV in context.

However, methodological considerations notwithstanding, some trends can be drawn across countries. For example, Solotaroff & Pande (2014) find that while there are other countries with higher rates of physical (figure 2) and sexual violence (figure 3), than the three countries in South Asia for which DHS data was available, the rates of IPV in Bangladesh and India are particularly high. In fact, Solotaroff and Pande (2014) state that “Bangladesh has the highest prevalence of intimate partner sexual and physical violence among South Asian countries for which a DHS violence module is available. Among the 15 countries with the highest global prevalence of physical intimate partner violence, Bangladesh ranks

Figure 2: 15 countries with highest prevalence of intimate partner physical violence



Figure 3: 15 countries with highest prevalence of intimate partner sexual violence



second only to the Republic of Congo. India is seventh on this list, with Pakistan and Nepal 11th and 14th, respectively” (p.35).

Other non-DHS samples in the region find similar or higher estimates, with data being most widely available for India. For instance, more than 60 percent of Indian women reported three or more episodes of physical or psychological violence by their partner in their lifetime (ICRW 2000). In yet another study in India, 40 percent of women have reported being physically abused by their husbands during their adult lives (Kumar et al., 2005). Jejeebhoy et al., (2013) report that nationally, one in three (35 percent) women in India aged 15–49 has experienced physical or sexual violence by their partner, with certain states in the country having an even higher than national average (e.g., 56 percent in Bihar) (International Institute for Population Sciences and Macro International, 2007) cited in Jejeebhoy et al., 2013, p. 1). Prevalence estimates reported by other studies in India that used population-based data range from 12 percent to 32 percent, and 9 percent to 75 percent, in the case of studies that used community- or clinic-based data (Babu & Kar, 2009; Duvvury et al., 2002; Martin et al., 1999; Santhya et al., 2007; Solomon et al., 2009). Nanda et al., (2015) examined women’s report of IPV with over 3,158 women in seven states in India and found that more than half of the women (52 percent) reported experiencing any form of violence during their lifetime, with a higher proportion of women reported experiencing physical violence (38 percent) followed by emotional violence (35 percent) as compared to other forms like sexual violence (17 percent) and economic (16 percent). Unlike these high estimates,

Ackerson and Subramanian (2008) examined the 1998 to 1999 Indian National Family Health Survey (INFHS), a nationally representative cross-sectional study of 92,447 households and found that only 16 percent and 9.3 percent of women reported lifetime IPV and recent IPV, which do not provide an accurate picture of the rate of IPV since the estimates between various age groups, socioeconomic groups, and cities, the estimates go up to 27 percent for lifetime prevalence and 17 percent for recent IPV, suggesting the importance of identifying factors that place women at risk for IPV. In other South Asian countries for instance, in Sri Lanka, 34 percent of surveyed women reported severe abuse (being choked, burned, or hit with a weapon) (Jayasuriya et al., 2011).

The past two decades has seen an increase in studies attempting to understand the nature of IPV from men’s reports of perpetration. This is an important and necessary shift in the field if men are to be included as agents of change. While global estimates for men’s report of perpetration range from 6 percent-29 percent (Barker et al., 2011) and 25 percent to 80 percent (Fulu et al, 2013), in South Asia (specifically Bangladesh, India, and Sri Lanka), the prevalence rates range from 8 percent to 80 percent (Jayasuriya et al., 2011; Solotaroff & Pande, 2014).

In a study undertaken by CARE, in a sample of 1132 men in Sri Lanka, 24 percent of ever-partnered men aged 18–49 years admitted to perpetrating physical IPV in their lifetime of which pushing and shoving (perpetrated by 19 percent of males) and slapping (perpetrated by 13 percent of men) were the most commonly reported (de Mel et al., 2013). In the past 12 months, approximately 5 percent of the men reported they had used physical violence in their

relationship. de Mel et al., (2013) also found that men are more likely to perpetrate physical violence on its own, rather than sexual violence alone, though 22 percent of the sample used both physical and sexual violence against their partner. Additionally, 18 percent of men reported economic violence (including preventing their partners from going out for employment, taking the partner's earnings and spending money on alcohol or tobacco on themselves even when there were insufficient funds to run the household) (ibid.). Finally, their study found that men are more likely to commit sexual violence against an intimate partner than a non-partner.

In India, studies have found that 39 percent of men report perpetrating IPV (Koenig et al., 2004). In the IMAGES study of over 9,000 men in India, every three in five men (or 60 percent) reported perpetrating any form of intimate partner violence against their wife/partner ever (Nanda et al., 2015). Among the various forms of violence, emotional violence was most prevalent, with 41 percent of men reporting using it and 35 percent women reporting experiencing it. Following emotional violence was physical violence, with 38 percent of the women reporting experiencing it and 33 percent men reporting perpetrating such violence. According to Nanda et al., (2015), men's report of violence was higher than women's report – except for emotional and economic violence. This is not surprising since physical and sexual violence are the most common forms of overt violence. On the other hand, emotional and economic violence are more implicit and in some ways more deeply intertwined into gender norms making it harder to quantify and report on such forms by the perpetrator.

3.3.2.1 IPV with female adolescents in South Asia

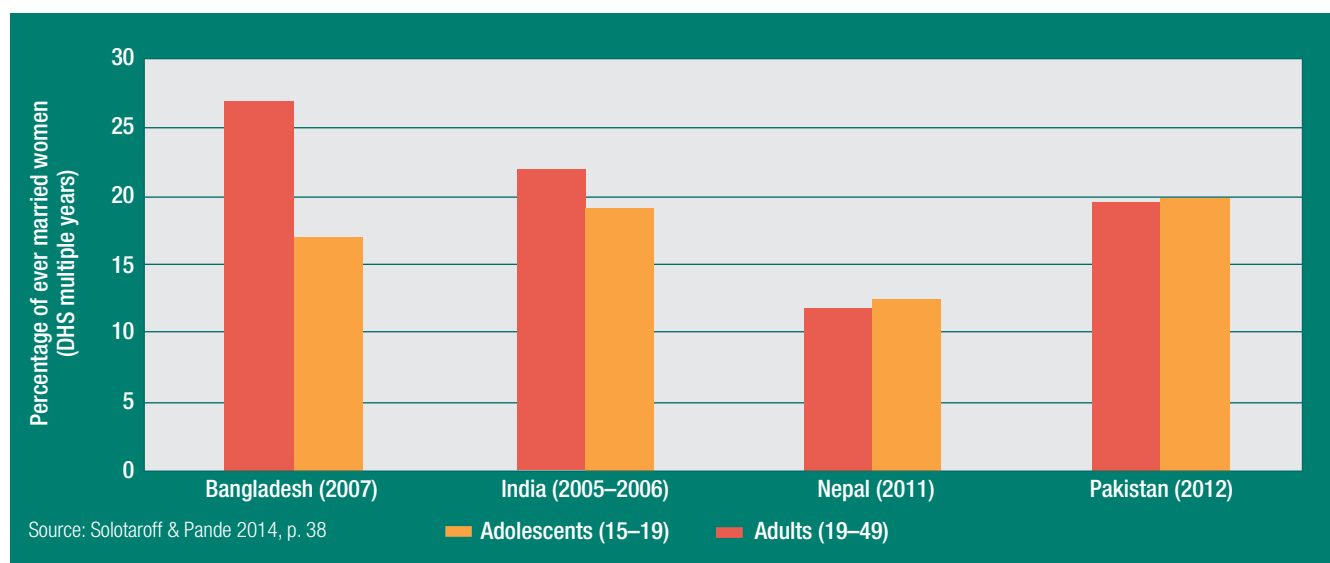
Though intimate partner violence evokes an assumption that it would be most relevant for adults, many experts

in the field suggest that adolescents are particularly vulnerable to IPV in the South Asian region. Solotaroff & Pande (2014) for instance in their review found that a higher percent of married adolescents report greater levels of recent physical spousal violence than married adults in Bangladesh and India (figure 4), and though about the same in Nepal and Pakistan. In terms of sexual violence from married partners, adolescents in India and Nepal have a higher rate of sexual violence than adults: 11 percent of married adolescents in India compared to 6 percent of adults and 12 percent of married adolescents in Nepal compared to 9 percent of adult women.

With early marriage being a common occurrence in the region, adolescent girls remain highly vulnerable to IPV. Jejeebhoy et al., 2013 found for instance that 62 percent of married women who experience IPV did so in the first two years of their marriage. Solotaroff & Pande (2014) provide estimates from other studies where married adolescents had statistically significantly higher risks of physical and sexual intimate partner violence than women who were not adolescent brides – for example in India (Raj et al., 2010; ICRW et al., 2012), Bangladesh (Hindin et al., 2008), and Nepal (Pradhan et al., 2011).

Even when adolescent girls are unmarried, they are at risk of IPV at the hands of their boyfriends – an increasingly common phenomenon in this region. For instance, Jejeebhoy et al., (2013) conducted discussions with unmarried adolescents in rural Bihar in India and found that a girlfriend is understood to be “the possession of her boyfriend and deserving of violence perpetrated by the boyfriend if she misbehaves in his opinion” (p.23). According to Jejeebhoy et al (2013), examples of the violence faced by unmarried adolescent girls are when boyfriends make false promises about marriage to lure/

Figure 4. Reported physical IPV in the past 12 months



force the girl into premarital sex or when they are hit and sometimes even murdered for refusing sex. However, on discussing this with unmarried girls, the girls believed that only those who are considered ‘bad girls’ are the ones who experience violence at the hands of their boyfriends and who, according to Jejeebhoy et al., must have defied community norms and have no family support. Perhaps this is because girls who suffer violence are assumed to have had a physical relationship with their boyfriend – a taboo in the South Asian culture. In fact, for unmarried adolescents who engage in premarital sex, violence also occurs when they are blackmailed by their boyfriends who threaten to tell others about the relationship.

3.3.2.2 Prevalence of IPV in Bangladesh

Our review found that in Bangladesh, the range of IPV from both rural and urban surveys as well as from men and women’s report estimate that lifetime prevalence of IPV are from 28 percent to 74 percent while past-year physical prevalence are 4 percent to 34 percent. The recent Bangladesh Bureau of Statistics of married Bangladeshi women found that 28.7 percent reported psychological violence, 27.2 percent sexual violence, and 49.6 percent physical violence (BBS, 2016). According to Sambisa et al., (2010), these estimates are similar to other countries in the region for both lifetime and past year IPV prevalence (Fikree et al. 2005; Panda and Agarwal 2005; UNIFEM 2006l Cited in Sambisa et al., 2010, p.166). Given the challenges with comparing studies as noted in the

methodology section, it is not meaningful to report on range of prevalence rates, however examining the estimates in general show that men and women’s report of IPV is very different from each other, with women generally reporting lower estimates than men. This is interesting given that for severe violence, men generally report lower estimates than women (see below) suggesting that perhaps collapsing various forms of violence does not form an accurate picture of the actual prevalence.

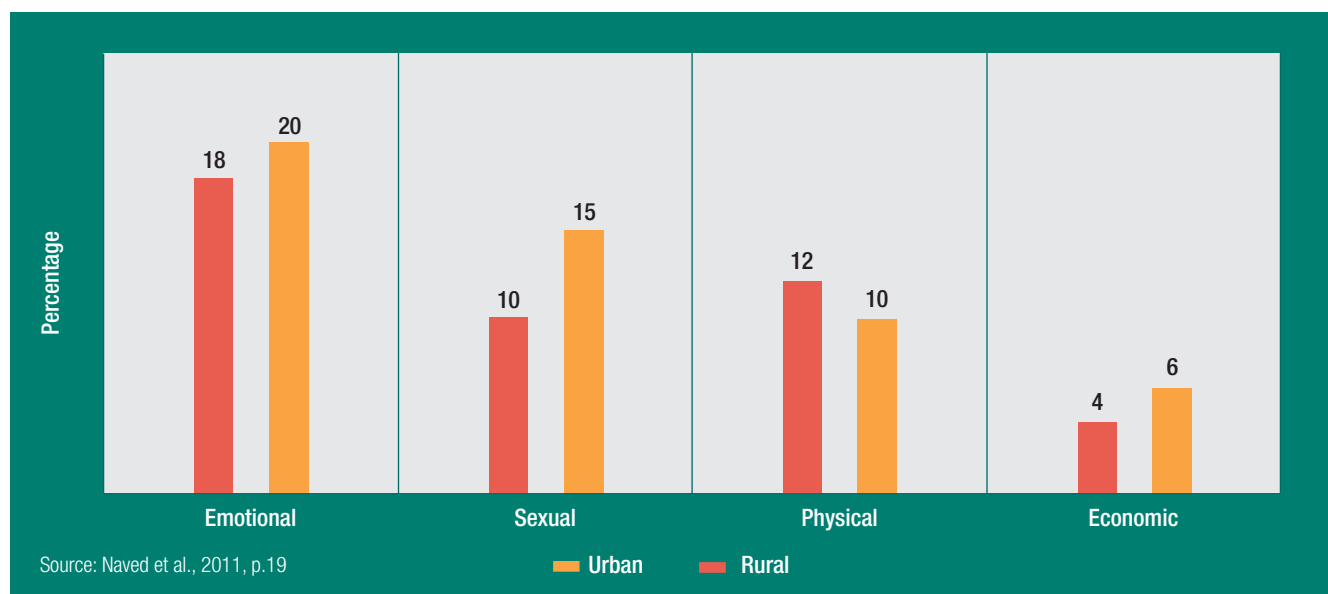
Prevalence by types of violence in Bangladesh

Below we describe prevalence rates by types of violence as defined by WHO’s definition: physical, sexual, emotional, and economic violence (see above in section 2). As can be seen in figure 5 below, the most recent UN multi-country study³ on men and violence shows that emotional violence is most common – with over 20 percent of men in urban areas and 18 percent of men in rural areas – reporting that they commit emotional violence. Sexual violence is more prevalent than physical violence for rural men only and economic violence is least reported on by men (details discussed below; Naved et al., 2011).

Physical violence

Physical violence can be categorised into severe and non-severe acts. Severe acts, according to the literature include punching, dragging, kicking, attempted strangulation, burning or murder; non-severe acts include slapping, pushing, shaking, shoving, and arm-twisting.

Figure 5. Prevalence of rural and urban men’s perpetration of different form of violence in the past 12 months



3 Sample of 1000, 18 to 49-year old men from one urban and one rural site in Bangladesh.

Men's report of violence in the 2004 BDHS analysed by Johnson & Das (2009) found that severe physical violence was reported by men who reported punching their wives (15 percent), kicking or dragging their wives (11 percent), and strangling or burning their wives (2 percent). The BDHS 2007 shows lower estimates with 6 percent reporting kicking and dragging and 1 percent report choking. As noted below, men are more likely to report higher prevalence of IPV, but less likely to report that they commit severe forms of IPV than women (NIPORT et al., 2009). The UN Multi country study on men and violence found similar trends (Naved et al., 2011): 17 percent of urban and 18 percent of rural men reported hitting their wives/partners with their fists, followed by 8 percent of urban and 7 percent of rural men kicking, dragging, or beating their wives/partners, and finally 2 percent of urban and 1 percent of rural men threatening or using a weapon. Urban men are more likely to kick, drag, beat, or use a weapon to threaten their wives/partners than rural men.

In terms of non-severe physical violence, in Johnson & Das's study, 41 percent of the men report ever pushing or shaking, whereas 13 percent report doing so in the past year, and 62 percent report ever slapping their wives or twisting their wives' arms, whereas 23 percent report doing so in the past year. The 2007 BDHS found lower prevalence rates: 55 percent report slapping their wives (15 percent in the past year), 28 percent report pushing or shaking or throwing something (7 percent in the past year), and 9 percent report punching (NIPORT et al., 2009). With respect to non-severe acts, the UN multi country study found similar trends in Bangladesh with 52 percent of men reporting engaging in physical violence, with 48 percent of rural and urban men slapping their wives/partners, followed by 38 percent of rural and urban men pushing or shoving their wives (Naved et al., 2011).

In terms of women's report, both severe and non-severe physical acts are reported with the most common types being slapping, pushing, or shaking, arm-twisting, punching, kicking, dragging, strangling, burning, and threatening with a knife or gun. For instance, in terms of severe physical violence, NIPORT et al., (2008) found that 32 percent of women from the slums reported being punched and 25 percent reported being kicked and dragged. A much higher percentage of women reported attempt by the husband to strangle or burn or kill them (9 percent vs 2.1 percent) than men do in Johnson and Das's study. Similarly, in NIPORT's analysis, men in slums were less likely to report severe violence such as attempted strangulation, burning or murder than what women reported (8.7 percent vs. 1.9 percent). Women's reports from the BDHS 2007 also indicated high levels of severe physical violence: 30 percent reported having something thrown at them (11 percent in the past 12 months), 17 percent reported that their husbands have punched them with their fist or with something that could hurt them (7 percent in the past 12 months), 15 percent reported being

kicked, dragged, or beaten, having their arms twisted or their hair pulled (6 percent in the past 12 months, 5 percent being choked or burned (3 percent in the past 12 months), and 2 percent being threatened with a knife, gun or weapon (1 percent in the past 12 months) (NIPORT et al., 2009).

In terms of non-severe physical violence, women from the slums reported that 59 percent of women have been slapped or have had their arms twisted (NIPORT et al., 2008), 42 percent of women from slums reported being pushed, shaken, or having things thrown at them, 32 percent. Moreover, NIPORT et al., (2008) note that women in non-slum areas are much more likely to report less severe abuse than those in the slum areas – though this does not hold true for kicking. The BDHS 2007 found that 46 percent of ever married women report ever being slapped (17 percent in the past 12 months). Like NIPORT's analysis (2008), rural women are slightly more likely to report both physical and sexual violence than urban women. Moreover, similar to NIPORT's analysis, although men are more likely than women to report physical acts of violence that are less severe (e.g. slapping), they are much less likely than women to report more severe acts of physical violence, such as punching, kicking, choking, burning, or use of a weapon.

In his study of 483 households in Dinajpur, Sunamganj and Tangail, Siddique (2011) found that the most prevalent form of violence was both severe and non-severe physical violence, especially slapping, kicking, punching, hair pulling, beating/hitting with hands/feet (89.5 percent) and with an object (81.8 percent). In this study, Siddique also found other controlling behaviors such deprivation of food (67.8 percent), deprivation of maintenance (62.4 percent), insults (59.3 percent) and threats (49.6 percent). However, there was little to no incidences of acid throwing, trafficking, denial of earned income, sexual violence, and the use of a weapon.

Of note is that vulnerable populations such as migrant women or displaced women are shown to be at even further risk for IPV. Azziz-Baumgartner et al., (2014) report that out of 205 low-income, ethnic, and/or displaced mothers who experienced IPV, 53 percent reported ever being hit with a fist or some other object, 44 percent were kicked, dragged, or beaten, a high number were choked or burnt (24 percent), 13 percent were injured with a knife or gun. Post-birth of their child was a greater risk factor for these women since out of 133 mothers who reported that their husband hit them with a fist or some other object, 89 percent experienced this violence before the birth of the child and 74 percent after.

Sexual violence

Johnston and Naved (2008) summarised available research on sexual violence in Bangladesh and found that while physical violence has received attention, sexual violence has received relatively little. In terms of men's reports, Johnson & Das (2009) find that 27 percent of men reported that they had ever physically forced their wives to have sex even when their wives did not want to and 17 percent of men reporting

that they have done so in the past year. The BDHS 2007 showed that 9 percent of men forced their wives to have sex, 4 percent in the past year (NIPORT et al., 2009). Unlike physical violence, men in the BDHS were half as likely to report sexual violence than women. The BUHS 2006 & BUHS 2008 found that prevalence estimates of forced sex based on men's reports were 19 percent (slums), 15 percent (non-slum) and 24 percent (district municipality) (see NIPORT et al., 2008). Naved et al., (2011) in the UN multi country study found that approximately 10 percent of the urban sample and 14 percent of the rural sample reported ever perpetrating sexual violence against any woman (partner or non-partner).

With respect to women's reports, analysis of the BUHS 2006 and 2008 by NIPORT et al., (2008) found that 23 percent of the women in slums, 16 percent in non-slum areas and 17 percent District Municipalities reported being forced to have sex by their husband. In the slums, women report highest levels of forced sex, but men from District Municipalities reported the highest levels across all three regions. As per the BDHS, 8 percent of currently married women report they were forced to have sex sometimes in the past 12 months, compared with 3 percent who said they were forced to do so often. Johnston & Naved, (2008) report on the findings of the WHO multi-country study and state that 37 percent of urban women and 50 percent of rural women report lifetime prevalence of sexual violence while 20 percent of urban and 24 percent of rural women report being sexually violated by their husbands in the past one year. The study also found that those who suffer physical violence also tend to experience sexual violence: 48 percent of rural women and 41 percent of urban women reported having experienced both. Naved (2012) further analysed this data and found that physically forced sex was most common (34 percent in the urban area; 46 percent in the rural area), followed by sex out of fear (21 percent in the urban area; 32 percent in the rural area). A small number of women reported having to engage in something that was degrading / humiliating to them (3-4 percent). Women reported that they were abused more than once and reported experiencing multiple types of violence (83 percent in urban area and 69 percent in rural area). Though overlap between sexual and emotional violence was greatest (20 percent), almost 50 percent of the women experienced all three forms of violence (sexual, physical, and emotional).

In the study by Azziz-Baumgartner et al. (2014) of displaced women, of the 250 mothers in the sample, 75 percent reported sexual abuse, and 61 percent were forced into sexual intercourse by their husband, and 65 percent were threatened or coerced into sex by their husbands.

Psychological/Emotional violence

Johnston & Naved (2008) note that even though physical and sexual violence are "more readily quantifiable than emotional abuse", emotional abuse may be more "devastating than physically-abusive acts" (p.368). Male

reported emotional violence in the UN multi-country study (Naved et al., 2011) indicated that 52 percent of urban men and 46 percent of rural men reported lifetime prevalence of emotional violence, with the most common acts being intimidating, followed by threatening harm, and finally insulting their intimate partner. Naved et al., 2011 note that urban men reported higher rates of emotional violence than rural men.

For women's report, Johnston & Naved (2008) report on data from WHO's multi-country study's results, one of the few estimates of emotional violence in the country. In this study, 44 percent and 31 percent of urban and rural women respectively experienced emotional violence in their lifetime and 29 percent and 20 percent of urban and rural women experienced emotional violence in the past 12 months (*ibid.*).

In Azziz-Baumgartner et al.'s (2014) work, 89 percent of displaced mothers reported emotional violence, i.e., they were insulted or made to feel bad about themselves, 80 percent were scared or intimidated, 55 percent were belittled or humiliated in front of other people, 32 percent were threatened with injury, and 42 percent were threatened with harm to someone close to them. In their work with 3132 rural mothers, Asling-Monemi et al., (2009a) found that 28 percent of mothers experienced emotional violence (include insults, humiliation, intimidation or scaring on purpose) from the family in their lifetime.

Economic violence

As mentioned earlier, there are almost no studies on economic violence in Bangladesh. However, the UN multi-country study examined economic violence and found that 16 percent of urban men and 18 percent of rural men reported lifetime prevalence of economic violence (Naved et al., 2011). For past year prevalence, the estimates were 4 percent and 6 percent respectively. Types of economic violence included prohibiting their partners from work (10 percent) and taking partners' earnings against their will (13 percent).

3.3.2.3 Prevalence of IPV in Pakistan

According to the statistics from Aurat Foundation (2012), there has been a rise in the number of cases of domestic violence – though this is most likely a rise in the number of reported cases and as such shows an increase in women's decision to seek help. In 2008 the number of cases were 281, in 2010 the number of cases of domestic violence were 486, and in 2010 the number of cases were 989 (cited in Ali et al., 2015, p. 300). The range of prevalence of IPV in Pakistan from both rural and urban surveys find that the estimates are from men and women's report of IPV range from 12 percent to 100 percent, with differences in the types of IPV.

Prevalence of violence in Pakistan

The evidence from Pakistan indicates that similar to other countries in the region, violence against women, especially IPV is widespread. For instance, the PDHS 2012 (National Institute of Population Studies and ICF International, 2013)

reported that the lifetime prevalence for women aged 15-49 for physical violence was 26.8 percent, for psychological violence was 32.2 percent, and at least 3 types of controlling behaviours was 8 percent. These high numbers were validated by HRCP (2000), who found that in Punjab, more than 35 percent of women in hospitals admitted to being beaten by husbands. Ali et al., (2011) found that in their sample of 759 women, a large number reported physical, sexual, and psychological violence, i.e., 43.9 percent in their lifetime and 87.1 percent reported any kind of violence exposure. Shaikh (2003) found that psychological violence, i.e., being shouted or yelled at was the most frequent, while physical violence, i.e., use of a weapon e.g. gun or knife, was the least common type of violence reported.

Physical violence

Since physical violence is most easily quantified, several studies have reported on prevalence rates of physical IPV in Pakistan; this was also corroborated by the systematic review conducted by Ali and colleagues. Ali et al., (2015) note that the prevalence for physical violence is 16 percent to 76 percent. Women's reports of prevalence of physical IPV show that the lifetime prevalence of physical IPV is 34 percent to 57.6 percent (Zakar et al., 2012). Similarly, in their analysis of PDHS data 2012, Zakar et al., 2016 found that prevalence of physical IPV among 3,315 women is 26.1 percent - which is in the range that both Ali et al., (2015) and Zakar et al., (2012) report. Individual studies find that prevalence of physical IPV in Karachi was 34 percent (Fikree & Bhatti, 1999), which was similar to the estimates of Zakar et al., 2012: of the 373 women interviewed, 31.9 percent reported lifetime physical violence. On the other hand, Ali et al., (2011) studied 759 married women aged 25-60 years, living in two of the towns in Karachi, and found a 57.6 percent reported a lifetime experience of physical violence and, of these, 54.2 percent reported severe incidents of physical violence and 56.3 percent reported past-year exposure to physical violence. Pushing/shoving were most common (50.6 percent), followed by kicking/dragging and beating (43.5 percent), followed by hitting with a fist (40.3 percent), slapping/throwing something (29.9 percent), and choking/burning (24.1 percent). The PDHS 2012 found similar estimates, though they found that slapping was the most common form of spousal violence reported (25.2 percent), followed by pushing/shaking/ throwing something (16 percent), twisting the wife's arms or pulling her hair (10.9 percent), punching with fist or something that could hurt her (8.7 percent), and kicking her /dragging/beating her up (5.3 percent). Severe acts of violence such as trying to choke on purpose, threatening to attach with a knife or gun were less than 5 percent (NIPS & ICF International, 2013). Similarly, Zareen et al., (2009) found that the most frequent type of violence was slapping, 24 percent, and less frequently, kicks and punches in abdomen (6 percent), use of sticks (6 percent), legs (6 percent) and knife to

cause harm in the abdomen (1 percent). Studies report that physical violence during pregnancy is common – (see next section) – and Shaikh et al., (2008) found that the face is the most common body part to be hit during pregnancy.

Men's reports show that 33 percent of 70 men interviewed reported "ever slapping" their wives (Shaikh, 2000). Fikree et al., (2005) who also studied 183 men's reports found that the lifetime prevalence of marital physical abuse was 49.4 percent; slapping, hitting or punching being most often reported (47.7 percent).

Sexual Violence

Zakar et al., (2012) note that for clinical samples of women recruited from hospitals, prevalence of sexual violence is 21 percent to 54.5 percent and their found that in their sample of 383 women, 34.6 percent reported sexual violence. Ali et al., (2011) found that in their sample, out of the 759 women, lifetime and past-year prevalence of sexual violence from their spouse were 54.5 percent and 53.4 percent respectively. In Kapadia et al.'s sample (2010), 21 percent (103 out of 500 women) reported sexual violence in terms of being forced to have sex with their partner, 36 percent of these women (37/104) were forced to do a sexual act which they considered as degrading and humiliating, while 19 percent (20/104) submitted to the husband's demand because of the unknown fear of reaction by the husband in case of refusal. Sexual violence occurred alongside emotional and physical abuse. Shaikh (2003) found that non-consensual sex was reported by 98 (46.9 percent) of the women interviewed. The HRCP (2013) found estimates that are much higher than those reported in individual studies. In a survey in six districts in the central region of Pakistan, 66 percent of women reported facing sexual violence and 93 percent reported marital rape. On the other hand, two studies found lower estimates of sexual abuse, i.e. Rabbani et al., (2008) and Qayyum et al., (2012) found estimates to be 12 percent and 11 percent respectively. These vastly differing estimates raise questions around culturally acceptable responses around this topic in Pakistan (see Ali et al., 2015 for discussion).

In terms of men's reports, the estimates are higher than those in general of women's reports. Shaikh (2000) found that 77.1 percent of men admitted to ever engaging in a non-consensual sex with their wives, while 58.7 percent respondents said that any confirmation of their suspicion that their wives was having illicit relations would prompt them to kill her.

Psychological/emotional violence

Zakar et al., (2012) report that in clinical samples, the prevalence of psychological violence is high: 43 percent to 97 percent. Rabbani et al., (2008) found instance found when 100 percent of women in their sample reported verbal abuse while 58 percent reported other forms of psychological abuse such as suspected or actual infidelity by the husband, emotional blackmail by the male

perpetrator (most likely spouse), character assassination, social isolation or perceived neglect of basic needs by the husband. In their sample, Zakar et al., (2012) found that psychological violence occurred with 282 women (75.9 percent of the sample). This high estimate was also corroborated by the study by Ali et al., (2011) who found that for psychological violence, the prevalence for lifetime was 83.6 percent and past year was 81.8 percent, both much higher than physical and sexual violence. In fact, psychological violence (19.1 percent) was the most commonly occurring violence by itself. They found that being insulted or made to feel bad about oneself was the most common act (77.2 percent), followed by being threatened to become hurt or having a loved one get hurt (76.2 percent), followed by being humiliated in front of others (74.7 percent), and being intimidated (74 percent). Moreover, the DHS 2012 data indicated that 19.8 percent of women had experienced both physical and psychological violence.

In terms of men's reports, Fikree et al., (2005) find that of the 183 men sampled for their study, nearly all men reported verbal abuse (94.9 percent) in their marital relationship. Fikree et al., (2005) also found that out of Pathans, Punjabis, Mohajir, and Sindhis, Pathans were four times more likely to report physically abusing their wives.

Economic violence

Only one study examined economic violence. Rabbani et al., (2008) studied 108 participants in Karachi and found that 39 percent women suffered some form of economic control which included withholding money from the victim or refusal to meet household expenses, control of the woman's wages or assets and stealing valuable assets such as personal jewelry or land. Economic abuse also always occurred in combination with other forms of violence.

3.3.2.4 Prevalence of IPV in Nepal

SAATHI's situation analysis in 1997 that 93 percent of women had been exposed to mental and emotional torture, 82 percent were beaten, and, 64 percent reported polygamy (SAATHI & TAF, 1997). In 2000, SAATHI found that 66 percent of the women in the country endure verbal abuse, 33 percent emotional abuse, and 77 percent of the time, the perpetrators were family members (including husband and in-laws; SAATHI, 2009). Lammichhane et al., (2011) conducted a cross-sectional study in 2009 among 1,296 young married women aged 15-24 years in four major ethnic groups and found that more than half of young married women (51.9 percent) reported having ever experienced some type of violence from their husbands. Using the NDHS 2011, Dalal et al., (2014) report the

overall prevalence of IPV to be 32.4 percent at the national level, though both Atteraya et al., (2015) and Tuladhar et al., (2013) conducted analysis on the NDHS 2011 and found the lifetime prevalence to be 28 percent. Recently a study conducted by the Office of the Prime Minister and Council of Ministers in 2012 of rural districts found that the prevalence estimates of IPV ranged from 30 percent to 81 percent depending on the district and type of IPV assessed (Office of the Prime Minister and Council of Ministers, 2012). A community-based cross-sectional study of 905 participants among urban poor (225 participants) and general population (680 participants) revealed a lifetime prevalence rate of 33.8 percent among urban poor in Kathmandu and 19.9 percent among the general population in Nepal (Oshiro et al., 2011). In the only study that estimated prevalence of IPV as reported by men, Bhatta (2014) found that in a sample of almost 2,500 men in Kathmandu, almost 63 percent reported IPV and 31 percent reported extra-marital sex.

In terms of NGO's recording cases of IPV, the Informal Sector Service Centre (INSEC)⁴ recorded a total of 447 cases of IPV, with the majority in the mid-Western region of the country (INSEC, 2012). They also recorded 147 cases of polygamy, with the majority in the mid-region of Nepal (ibid.). The National Women's Commission in the same year reported 272 cases of IPV and WOREC⁵ in the same year reported 1019 cases of IPV (data cited in Hawkes et al., 2013, p. 21). The large discrepancy between figures in the same year (i.e., 2012) indicates that barriers to reporting IPV persist, making it difficult to understand the true magnitude of IPV in Nepal. Similarly, SAAVHAGI et al., (2015) in its analysis of secondary data from different sources found that a total of 1800 cases of domestic violence were reported to Nepal police, 1040 to WOREC, 1569 to INSEC in the year 2012-13; additionally, 350 cases of polygamy were reported to the Nepal Police, 283 to INSEC, and 4 to the Women's Commission.

3.3.2.5 Prevalence of violence in Nepal Physical violence

The prevalence rates of physical abuse in the articles we found ranged from 23.4 percent (MoHP, New Era and ICF International 2012; Dalal et al., 2014) to 43.9 percent of 360 women (Khatri, n.d). In their sample of over 1,200 women in four districts (Dolkha, Sindhupalchok, Dang, and Kapilbastu), Lammichhane et al., (2011) found that more than one in ten women reported that the husband had kicked, dragged or beaten them. Past 12-month prevalence of physical abuse was 17.4 percent. More than one in ten (11.4 percent) reported that the husband pushed or shoved them or pulled their hair in the past 12 months.

4 INSEC is a non-government organisation working for the protection and promotion of human rights in Nepal.

5 WOREC works towards anti-trafficking, advocacy, women's health, child's rights and community development programs in various districts in Nepal.

Similarly, in their sample of 905 ever-married women in Kathmandu aged 15 to 49 years of which 680 were randomly selected from general population and 225 were recruited from urban poor population, who lived in purposively selected two communities, Oshrio et al., (2011) found prevalence of physical IPV was 33.8 percent among the urban poor population and 19.9 percent among the general population.

The NDHS 2011 shows that women age 15-49 years reported experiencing physical violence at some point since the age of 15 years; among whom 9 percent were physically assaulted in the last year, either regularly (2 percent) or infrequently (7 percent; MoHP, New Era and ICF International 2012). Similarly, SAHAVAGI et al., (2015) conducted a secondary analysis of the NDHS 2011 data and found that women employed for cash were more likely (28.3 percent) and to face physical violence than those who are unemployed or not employed for cash. They also found that older women, i.e., among 40-49 years were the most likely to face physical violence.

Sexual Violence

Sexual violence is common and frequently studied in the country. Sexual violence in Nepal ranges from 12 percent to 58 percent (Adhikari & Tamang, 2010; Dalal et al., 2014; SAATHI, 1997; Shakya, n.d.; Puri et al., 2010; Puri et al., 2012). A small study conducted by Women's Rehabilitation Centre (WOREC) with 60 women in the Udayapur and Kathmandu districts of Nepal, showed that 50 percent of women reported having experienced non-consensual sex in marriage from the first day of marriage (WOREC, 2003). Lifetime prevalence of sexual abuse was found to be 46.2 percent in a sample of over 1200 women (Lamichhane et al., 2011). Nearly one in five (19.6 percent) women reported ever experiencing both sexual and physical violence. Physically forcing her to have sexual intercourse when

she did not want to was the most commonly reported act (44.9 percent). About one-fourth (24.8 percent) of women reported ever experiencing forced sexual intercourse when they were afraid to say 'no'. Past 12 month prevalence was 31.3 percent in this sample, with the most common violent act being forced sexual intercourse with more than one-fourth (29.7 percent) of women reporting this. In their work with 1,500 women, Adhikari & Tamang (2010) found that 58 percent of women reported that their husbands had physically forced them to have sexual intercourse while 45 percent reported having experienced at least two forms of sexual violence, such as unwanted physical intercourse or being forced to do something sexual that they found degrading or humiliating. Similarly, more than two in five (45 percent) mentioned that they had experienced unwanted sexual intercourse because they were afraid of what their husbands might do if they refused. A few women (3 percent) reported that their husband forced them to do something sexual that they found degrading or humiliating. Puri et al., (2012) found that amongst over 1,200 women aged 15-24 using cluster sampling in 2009, 46 percent experienced lifetime sexual violence while 31 percent had experienced it in the past 12 months. Similarly, men's report of sexual violence is also high – 46.2 percent (Bhatta, 2014).

Studies also suggest that there are differences in prevalence of sexual violence by social class. For instance, in their findings with over 50 interviews in Kathmandu, Hawkes et al., (2013) found that sexual violence was far more prevalent in the working class of both the Kathmandu Valley and the Terai than middle or upper class. Similarly, SAAVHAGI et. al (2015) in their analysis of NDHS 2011 data found that women from rural areas (12/9 percent), women from Terai (15.2 percent), those employed for cash (18.4 percent) and having no education (17.1 percent) are more likely to face sexual violence.

4. Outcomes of IPV

Our review indicated that the majority of research has focused predominantly on the outcomes of IPV on the victims of the violence, with women being the more likely victims. Nevertheless, research with boys and men finds that IPV has negative impacts on the perpetrators as well, though this evidence is still relatively new and sparse. While there are clearly larger broader social consequences of IPV, since this review is focused on both victims and perpetrators of IPV, we only discuss those below

4.1 Impact on health, including mental health

In addition to IPV being a concern in its own right, it is associated with a range of adverse physical, mental, and sexual and reproductive problems for its victims (Abramsky et al., 2011; WHO, 2013). Evidence across multiple studies finds that those experiencing IPV are significantly more likely to experience serious health problems than those who have not experienced such violence (Heise & Garcia-Moreno, 2002; WHO, 2013). In fact, one study in Australia found that among women aged 18-44, IPV was associated with 7 percent burden of overall disease, placing it at a higher risk for health outcomes than risk factors like smoking tobacco, raised blood pressure and body weight (Vos et al., 2006).

Several studies have shown that IPV is a leading cause of morbidity and mortality for women (Coker 2007; Boy & Salihu 2004; Garcia-Moreno et al., 2006; Hatcher et al., 2013). There are both direct and indirect pathways through which IPV has damaging impacts on the victim as depicted in figure 6 (WHO, 2013). Physical trauma is considered a direct pathway to severe outcomes such as disability and death. Psychological trauma can have indirect effects on mental health and substance abuse issues that may have an effect on physical ailments that lead to disability or death. Similarly, a recent body of research has shown that controlling behaviours often co-occur with sexual and physical violence and in turn lead to poor reproductive health that can interact with mental health and lead to debilitating outcomes (WHO, 2013). As the figure indicates, the relationship between IPV and health outcomes is complex and suggests that there can be various mediated pathways that increase the likelihood of an adverse outcome. However, with mostly cross-sectional data available on the health outcomes of IPV (except in the case of HIV-related outcomes), it is important to be cautious when drawing casual inferences.

4.1.1 Physical injury, including death

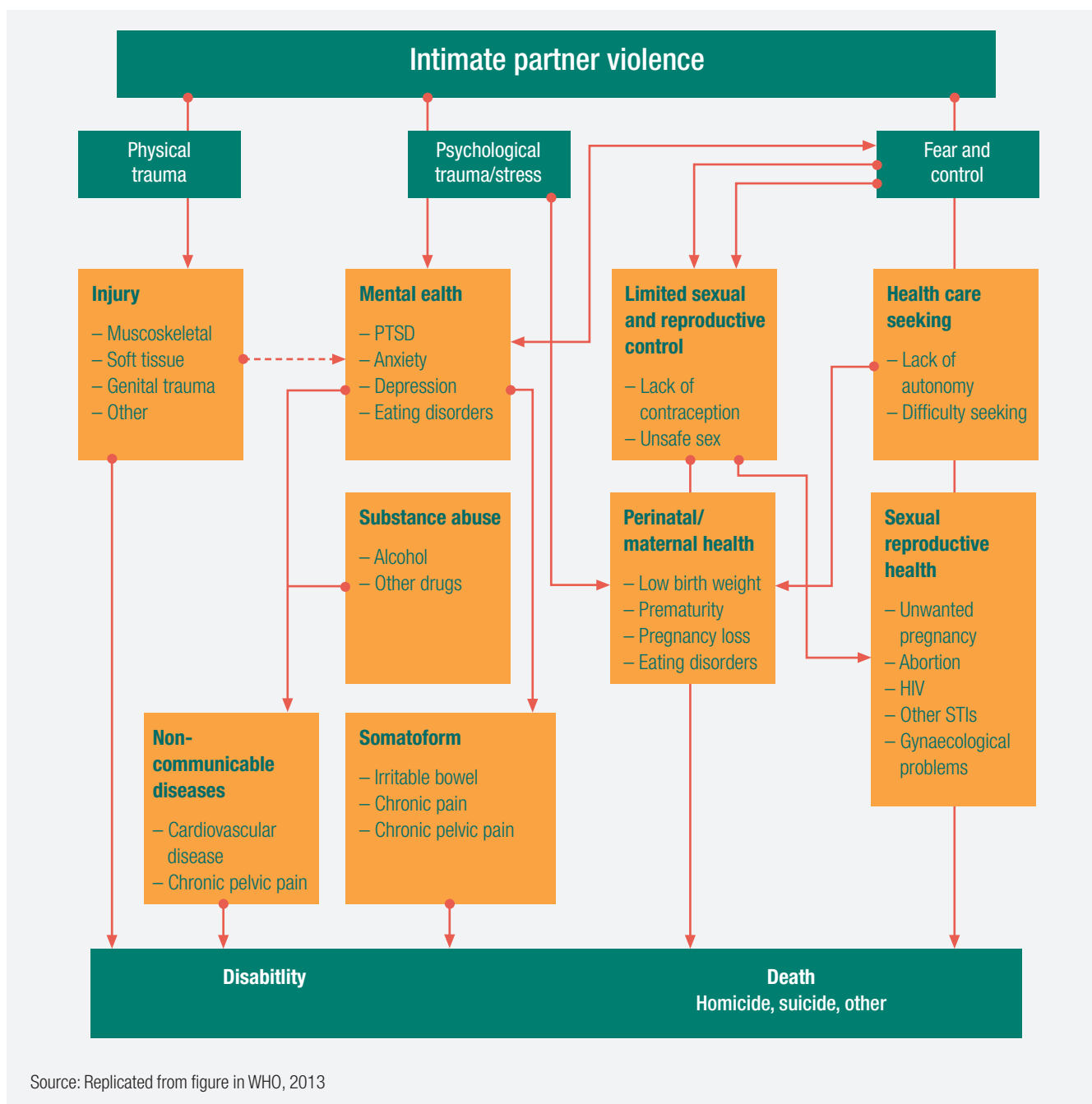
The WHO multi-country study reports that physical injury ranged from 19 percent in Ethiopia to 55 percent in Peru for those who experienced IPV. The physical damage resulting from IPV can include “bruises and welts, lacerations and abrasions, abdominal or thoracic injuries, fractures and broken bones or teeth, sight and hearing damage, head injury, attempted strangulation, and back and neck injury” (WHO, 2012: 5). Heise & Garcia-Moreno, (2002) report that there are also numerous other side effects of physical injury that have no identifiable medical cause, or are difficult to diagnose. Known as ‘functional disorders’ or ‘stress-related conditions’, these include irritable bowel syndrome/ gastrointestinal symptoms, fibromyalgia, various chronic pain syndromes and exacerbation of asthma (WHO, 2012). Moreover, non-fatal injuries such as chronic neck and back pain, abdominal pain, arthritis, coronary heart disease have been widely reported globally (Campbell, 2002; Ellsberg et al., 2008).

In addition to physical injury, Heise and Garcia-Moreno (2002) find that 40-70 percent of female murder victims were killed by their intimate partner in an abusive relationship. Stöckl et al., (2013) conducted a systematic review and found that in 66 countries, 13.5 percent of homicides were a result of IPV. Additionally, their review indicated that female homicides due to male perpetration of IPV was six times higher than male homicides due to female perpetration of IPV. Similar estimates were found by WHO (2013) analysis.

IPV’s detrimental effects on physical health are reported for male perpetrators as well. According to the findings from the IMAGES study, at the individual level, men who perpetrate violence against women are more likely to suffer a variety of mental and physical health ailments (Barker et al. 2011). Fleming et al, (2013) suggest that even though patriarchal society gives men more power over women, men are bound by rigid definitions of masculinity that restrict men’s agency and place tremendous pressure on men to be ‘manly’. This has resulted in higher burden of disease and higher rates of behavioural risk factors for diseases (Wang et al. 2012). Some of these risk factors include men’s higher rates of smoking tobacco, drinking alcohol, illicit drug use, and lower rates of health-seeking behaviours (Hawkes & Buse 2013).

At country level, findings from the review indicate similar trends:

Figure 6: Direct and indirect pathways from IPV to health



Bangladesh

In Bangladesh, multiple studies document the associations between physical injuries and intimate partner violence. The WHO multi-country study found that in Bangladesh, 26.7 per cent in the urban and 24.8 per cent in the rural area reported that they had been injured as a consequence of an assault by an intimate partner. Other studies show higher estimates. For instance, Siddique (2011) finds that in his sample of 483 women, almost all of the women surveyed experienced a physical injury as a result of the abuse (81.2 percent) and many required hospitalization

(78.7 percent). Johnston & Naved (2008) state that the frequency of physical abuse indicates a pattern of lifelong abuse with high severity of the abuse: 35 percent of urban women report being unconscious for less than hour (15 percent more than hour) and 29 percent of rural women report being unconscious for less than hour (29 percent more than hour). They also find that 69 percent of urban women and 80 percent of rural women needed healthcare for their injuries. Moreover, those who experience a lifetime of physical and sexual violence are more likely to report poor health and report problems with walking or

carrying out daily activities, pain, memory loss, dizziness, and vaginal discharge. In their work with 496 urban slums in metropolitan cities in Bangladesh, Salam et al., (2006) found that of the women who suffered from sexual violence 80 percent complained of pelvic pain, more than 50 percent reported reproductive tract infections, and more than 50 percent reported symptoms of irritable bowel syndrome. Abused women suffered from gynaecological problems at the time of pregnancy significantly more than non-abused women and abused women suffered from reproductive tract infections significantly more than non-abused women.

Often, physical injuries are more severe than the ones listed above, resulting in death. In Bangladesh, Salam et al., (2006) for example find that violence accounted for 31 percent of all death among women aged 15–19 years and 18 percent of all deaths among women aged 15–44 years (Fauveau & Blanchet (1989) cited in Salam et al., 2006) p.84). Khan (2005) reports that as per the records of the Bangladesh National Women’s Lawyers Association (BNWLA), 94 of the 249 murder cases in the year 2000 were a result of domestic violence. Johnston & Naved (2008) suggest due to the stigma associated with homicide and due to the harsh penalties associated with murders, the number of death attributed to IPV are most likely underestimated.

Pakistan

According to Rabbani et al., (2008), physical abuse was reported by over two thirds of the women in their sample with the most common site of injuries was head, neck, face and arms. Bruises, aches, pains and local swelling were commonly reported, and victims resorted to home remedies and self-treatment. Women reported that fractures and cuts were less common. On the other hand, Fikree et al., (2005) found that men reported that bruises (23.9 percent) and fractures (8 percent) were most common physical injuries due to abuse. The PDHS 2012 found similar findings: 29 percent reported that they suffered cuts, bruises, or aches; 10 percent had eye injuries, sprains, dislocations, or burns; and 6 percent had deep wounds, broken bones, broken teeth, or other serious injuries.

Shaikh et al., (2008) found that among pregnant women, 13.6 percent reported being physically abused during the current pregnancy; with 31.3 percent being slapped/pushed with no injuries or lasting pain, 4.5 percent being punched/kicked with bruises, cuts and continuing pain, 7.5 percent having concussions, burns or broken bones, and 3 percent reported permanent and internal injury. One hundred and twenty-one (24.5 percent) respondents replied affirmatively to the question of ever being physically hurt by the husband that resulted in the use of a self-prescribed medication/ointment; while an additional 42 (8.5 percent) respondents stated that the physical abuse necessitated consulting a physician or visit to a hospital for treatment.

Nepal

Only INSEC reported on physical consequences of IPV for the victims. They found that the total number of deaths in 2012 as a result of domestic violence were 112 (INSEC, 2012). They also found that 5 deaths were reported as a result of dowry related conflicts. However, Sanjel (2013) in a review of the literature on GBV in Nepal reported that as a result of IPV, women experience different types of health problem due to domestic violence for example chronic conditions like irritable bowel syndrome and chronic pain syndrome (Sharma, 2007 | cited in Sanjel, 2013 p. 180).

4.1.2 Mental health outcomes

Mental health problems such as post-traumatic stress disorder, and depression and suicidal ideation for the victims of IPV have been widely reported (Anda et al., 2001; Devries et al., 2011; Dunkle et al., 2004; Heise & Garcia-Moreno, 2002; Jewkes, Sen, & Garcia-Moreno, 2002; WHO, 2013). IPV has also been linked with alcohol and drug use, eating and sleep disorders, physical inactivity, smoking, and self-harm by the victims (WHO, 2012). Some studies suggest that the relationship between psychological problems for victims of IPV and the incidence of violence is bidirectional – women with severe mental health difficulties are more likely to experience violent victimization (Khalifeh & Dean, 2010). Similarly, a review of studies on alcohol use and IPV suggest that the relationship between alcohol use and violence is bidirectional. There is a positive association between women’s experience of IPV and subsequent alcohol use, as well as an association between alcohol use and subsequent IPV (Campbell et al., 2002; WHO, 2013).

Similar to physical health problems, studies have found that the emotional and mental burden to adhere to norms of masculinity are linked to more psychological problems such as depression for male perpetrators (Barker et al., 2011; Gupta et al., 2013). Theoretical foundations for this link can be found in the Gender Strain Theory (Pleck, 1995). According to Pleck (1995), the poor outcomes for boys and men are due to the fact that masculine ideals (e.g., men are strong, men are responsible for their families) are often impossible for boys and men to attain or maintain. Thus, boys and men who believe in them are likely to perceive their failure to attain these ideals as a personal failure (Pleck, 1995). It is the rigidity of these norms that are more likely to lead to psychological problems. In the IMAGES study, despite men reporting high self-esteem, the rates of experiencing depression at least once in the last month ranged from 9 percent in Brazil to 33 percent in Croatia. Similarly, the percentages of male respondents who reported having suicidal thoughts “sometimes or often” in the last month ranged from 1 percent in Brazil and Mexico to 5 percent in Croatia (Barker et al., 2011). In fragile states, masculinity is further threatened as noted in the work by Petesch (2013) in the West Bank and Gaza, where lack of economic options left

men feeling emasculated (more discussion on this in the section on risk factors).

In South Asia, studies show that IPV is linked to poor mental health as well. For instance, in India, Burton et al., (2000) examined women's health using two indicators – a self-assessment of overall health status and the SRQ-20, a Self-Reporting Questionnaire developed by WHO to assess emotional distress and a widely used as a screening instrument. The authors found that women who are more likely to report both physical and psychological violence are also more likely to report poor health or have a positive screening test on the SRQ, indicting poor mental health.

Bangladesh

In 2016, Ziaei et al., conducted an observational study as part of a larger randomised control trial with 3,504 pregnant women and used the SRQ-20 as well as levels of morning salivary cortisol to assess whether IPV was associated with poor mental health. They found that all forms of IPV (i.e., physical, sexual, controlling behaviours, and psychological) was associated with higher emotional distress and those women who experienced all forms of violence were most distressed. Similarly, Wahed and Bhuiya (2007) review the WHO multi-country study's findings that used the SRQ-20, women in both urban and rural areas had higher mean scores if they had experienced IPV than those who had not experienced violence (7.9 mean score of abused in urban areas vs. 5.4 mean score of non-abused in the urban areas and 7.4 mean score of abused in rural areas vs. 5.2 mean score of non-abused in rural areas). Similarly, Azziz-baumgartner et al., (2014) finds that in the sample of displaced mothers, those who experienced IPV felt inconsolable and depressed, and indicated they had a poor appetite during 2 days the week after the incidence of IPV, crying 1 day (1-2 days), and fearing that something bad was going to happen to them after the incidence of IPV. On the other hand, before the incidence of IPV, mothers reported enjoying themselves, feeling happy, and feeling hopeful about the future. Similarly, Johnston & Naved, (2008) find that suicidal ideation is more prevalent among women who have been through IPV than those who have not, i.e. such women are (3.5-4 times more likely to have thoughts about suicide, and 6 times more likely to attempt suicide. They find that while physical and psychological violence is associated with suicide ideation, sexual violence is not. Naved & Akhtar (2008) suggest that this may be due to the fact that sexual violence in a marriage is "widely accepted in Bangladesh" and cite WHO's country study's results where sexual violence is more accepted than physical violence.

Pakistan

Several studies in Pakistan indicate a link between IPV and poor mental health such as depression and anxiety (Ayub et al., 2009; Fikree & Bhatti, 1999; Haqqi and Faizi, 2010; Karmaliani et al., 2008; Niaz et al., 2002), and suicide ideation (e.g., Ali et al., 2013; Ayub et al., 2009; Rabbani

et al., 2008). For instance, Fikree & Bhatti (1999) find that 72 percent of physically abused women were anxious/depressed. Niaz et al., (2002) also found that 60 percent of the victims had depression and 67 percent of the victims had anxiety. Similarly, Ali et al., (2013) report that suicidal thoughts were reported by as many as 74.1 percent, 75.8 percent and 65.3 percent of the women subjected to physical, sexual and psychological violence respectively. Moreover, feeling worthless was reported by almost half the sample who experienced physical IPV, sexual IPV and psychological IPV. Physical and sexual violence increased suicidal thoughts by almost 4 times. Rabbani et al., (2008) found that in their sample, 9 women had attempted suicide and 3 reported suicidal thoughts. Moreover, women reported despair and hopelessness for their future.

Nepal

Puri et al., (2011) found that many women (11 out of 15) reported that they had experienced psychological trauma after they were coerced into having sex. Women reported being very depressed and stressed after coercive sexual experiences with their husbands. In their sample of 72 women, Budhakothi et al., (2013) did not find any significant relationships between violence and postpartum depression, though they found the poor marital communication was linked to post-partum depression.

4.1.3 Sexual and reproductive health problems

IPV is associated with a range of sexual and reproductive health problems such as unwanted pregnancy and/or abortion, gynaecological complications, and sexually transmitted infections including HIV/AIDS (Dunkle et al., 2004).

IPV has been found to be highly prevalent during pregnancy around the world; ranging from 1 percent in Japan to 28 percent in provincial Peru, with prevalence in most sites in the WHO multi-country study being around 4-12 percent (Garia-Moreno et al., 2005). Similarly, a review of studies from 19 countries found prevalence rates ranging from 2 percent in settings such as Australia, Denmark and Cambodia, to 13.5 percent in Uganda, with the majority ranging between 4 percent and 9 percent (Devries et al., 2011). Violence in pregnancy can lead to miscarriage, late entry into prenatal care, stillbirth, premature labour and birth, foetal injury (WHO, 2012). Women who experience IPV during pregnancy are 16 percent more likely to have a baby with low birth weight and gestational age (WHO, 2013).

Additionally, for over two decades, studies have found a strong association between gender-based violence and HIV risk (Fonck et al. 2005; Hatcher et al., 2013; Jewkes et al., 2010; WHO, 2013). However, the number of longitudinal studies depicting the link are limited (Jewkes et al., 2010). Nevertheless, studies, particularly in Sub-Saharan Africa and South Asia show that HIV-positive women more likely to have experienced lifetime violence than HIV-negative

counterparts (Decker et al., 2009; Jewkes et al., 2009). In Rwanda, interviews with women in stable relationships showed that HIV-positive women were more likely to report a history of physical violence and sexual coercion by their male partners than were HIV-negative women (Jewkes et al., 2009). In Tanzania, a study of 245 women attending a voluntary HIV counselling and testing centre found that in women younger than 30 years, HIV-positive women were more likely to report at least one event of physical or sexual violence from their current partner than were HIV-negative women. Similarly, in a study with 1366 women in South Africa, IPV and high levels of male control in a woman's current relationship were associated with higher HIV seropositivity (i.e., having HIV antibodies in the blood indicating the person is HIV positive) (ibid.). In the South Asia region, Chibber et al., (2012) state that evidence shows that exposure to sexual violence may be independently associated with a range of women's reproductive health outcomes, including sexually transmitted infections (STIs) such as HIV/AIDS (Ghosh et al., 2011; Jain et al., 1994; Newmann et al., 2000; Stephenson et al., 2006; Sudha & Morrison, 2011; Swain et al., 2011 cited in Chibber et al., 2012, p. 3).

Bangladesh

In section 2.3.2 we discussed prevalence of IPV in Bangladesh. An important finding from the review suggested that a sub-set of women who are vulnerable to IPV are those who are pregnant. Ziaei et al., (2016), found that among 3,504 pregnant women, more than 57 percent of women experienced any form of IPV in their lifetime, with the most common form being controlling behaviours (36.8 percent), followed by emotional violence (27.5 percent). Similarly, Naved & Persson (2008) note that 1 in 10 women their sample were abused during pregnancy – often a continued pattern of abuse from before the pregnancy. Asling-Monemi, et al., (2008) examined rural pregnant women and found that 14 percent of mothers experienced moderate physical violence (including slapping, throwing things, pushing, and shoving), 8 percent experienced severe physical violence (including hitting, kicking, dragging, beating, choking, strangling, burning, and threatening to use a weapon) and 8 percent experienced physical violence during pregnancy. In NIPORT et al.'s (2008) analysis, 37 percent in Dhaka and 28 percent in Matlab were punched or kicked in the abdomen. In fact, family violence is a common occurrence during pregnancy in Bangladesh and if one's mother or mother-in-law had experienced physical abuse, then that increased the woman's chances of being abused during pregnancy as well by 2-3 times. In some cases, sexual violence is associated with unintended pregnancy, as noted in Pallito et al., (2013) analysis of the WHO multi-country study data. The authors find that in Bangladesh, 43 percent of urban women and 36 percent of rural women reported having an unwanted/

mistimed pregnancy in their experience of IPV. Abuse during pregnancy is also related to maternal death, as found in NIPORT et al.'s (2008) analysis where 13.8 per cent of maternal deaths in pregnancy were reported as resulting from injury/violence. Women who are pregnant are certainly vulnerable, but women who are childless are also vulnerable, with Nahar (2001) finding that in her sample, childless women were highly stigmatized by the society because of their inability to produce child. Moreover, they suffer from emotional abuse as continuously receive threat to be abandoned, with husbands who would then go for a second marriage.

Pakistan

The majority of the research in Pakistan is focused on the link between IPV and its consequences on women's pregnancy. As a result, samples are predominantly drawn from hospital settings. For instance, Fikree & Bhatti (1999) found that among 150 women from health facilities, 15 percent reported being physically abused while pregnant and Shaikh (2003) found that 25 percent reported that violence increased during pregnancy. Farid et al., (2008) found that among 500 women, 44 percent of women reported abuse during pregnancy. Karmalaini et al., (2008) found that on a population based survey of more than 3000 pregnant women, 6 months prior to and/or during pregnancy, 51 percent reported experiencing verbal, physical or sexual abuse of which 20 percent experienced physical or sexual abuse alone. Of these 16 percent reported suicidal thoughts as a result of the abuse.

Men also report that they are violent towards their wives during pregnancy – Shaikh (2002) found out of 70 men, 32.8 percent slapped their wives and 1.4 percent admitted to doing so when their wife was pregnant, 18.6 percent kicked their wives and 5.7 percent admitted to doing so when she was pregnant. As a result of these kicks three out of 70 sustained bruises, while two suffered internal injuries and received medical treatment. Kapadia et al., (2009) found that sexual violence was responsible for unintended pregnancy among 14 percent of the women in their sample. Zakar et al., (2016) found similar results in their analysis of the PDHS 2012 data: pregnancy loss had been experienced by 1282 (36.4 percent) participants and unintended pregnancy was reported by 391 (19.5 percent) women.

Other types of poor sexual and reproductive health were studied by Zakar et al., (2012) who found that the women who experienced any type of IPV had more complaints of foul smelling vaginal discharge, loss of libido, difficult urination, and pain in the abdomen and/or vagina during intercourse than the women who did not experience IPV. Moreover, those women who suffered from severe physical and sexual IPV were more likely to have husbands who refused to use contraceptives, less likely to have prenatal care, more likely to have more unplanned pregnancies.

Nepal

The greater proportion of research in Nepal is focused on the incidence of violence during pregnancy and sexual violence and its consequences on women's SRH health. Deuba and Rana (2006) found that in a sample of 300 mothers, 42 percent reported forced sex during pregnancy. Recently, in a study by Deuba et al., (2016) with 20 pregnant women in urban slums in Kathmandu it was found that pregnant women were found to be at risk for IPV if they refused sex during pregnancy. Women also faced severe physical violence during pregnancy such as having their hair pulled, being slapped, battered, pushed to the floor, pushed down stairs, and kicked in the abdomen. Psychological violence was also common during pregnancy with women reporting that they were scolded, abused, called a sex worker, and accused of infidelity. Sexual violence was also found to occur during pregnancy since a commonly held belief in Nepal is that having sex during pregnancy increases the chance of having a son (as noted in Deuba et al., 2016 and Puri et al., 2011). While these are common types of violence, Pun et al., (2016) found that other forms of violence during pregnancy take the form of forcing pregnant women to do heavy lifting and hard physical work, and denying them food. In extreme cases, some women experience severe physical violence such as being beaten with an iron rod, pushed down the stairs and kicked in the abdomen during pregnancy (Puri et al., 2011).

Studies have found that the consequences of IPV during pregnancy are: high maternal death, preterm birth, high prenatal mortality, abortion, miscarriage, and an impact on the long-term health of women (Deuba & Rana, 2006). IPV during pregnancy also affects low birth weight of the neonate, preterm delivery, small size for gestational age in foetus, mental health problems, kidney infections, less weight gain during pregnancy and more likely to undergo operative delivery in pregnant women (UNCT-Nepal 2009, cited in Sanjel 2013, p. 181). Physical problems range from backache, body ache, headache, and lower abdominal pain, white discharge, vaginal itching, and dark blood flow (Puri et al., 2011). Shakya et al., (2014) found that in their sample of 362 women, 48.5 percent of women suffered from gynecological problems with those who suffered from sexual violence having 2.32 times more likelihood of having a gynecological problem than those who did not.

Other consequences of violence on victim's sexual and reproductive health is that men report that they are unwilling to use condoms during extra martial affairs (82 percent of 2,500 men; Bhatta 2014). Among the 1710 respondents, men said that the reasons for not to use any family planning methods were that the belief that it is a woman's duty to think about family planning (15.81 percent), it reduced sexual power (23.20 percent), it reduced working power (32.12 percent), had cultural and religious barriers (15.31 percent), and had other causes (13.71 percent) (*ibid.*).

4.2 Economic Impact

IPV has an economic impact both at the individual as well as at the national level. Over 30 studies, mostly from developed countries have quantified costs of violence against women and found economic impacts as a result of the costs of service utilization, losses due to decreased productivity and lower earnings (Duvvury & Carney, 2012). One of the most comprehensive studies showed that IPV had a £22.9 billion annual cost to the economy in England and Wales alone (Walby, 2004). In developing nations, a few studies in the Global South have estimated the economic impact of IPV. For instance, in Brazil, direct medical costs due to any violence was found to be 0.4 percent of the total health budget (WHO and CDC, 2007) and in Colombia, roughly 0.6 percent of the total national budget was spent in 2003 to prevent and detect incidences of IPV and offer services to survivors (Friedemann-Sánchez & Lovatón, 2012).

At the individual and household level, studies have found that when women are unable to work due to incidents of violence (both employed work and household work) there will be an economic impact for the household. In Vietnam, both men and women in a partnership missed days of work when a man abused his partner (Duvvury & Carney 2012). Reasons for men missing work include being incarcerated following an IPV complaint by the woman (*ibid.*). According to Heise and Garcia-Moreno (2002), IPV was found to affect a women's ability to retain her job and earn more. For instance, in a study in Nicaragua, women victims of IPV earned 46 percent less than other women, even after controlling for other confounding factors (Morrison & Orlando, 1999).

In South Asia, we only found a handful of studies examining the economic impact of IPV. In Nagpur, India, for example, 13 percent of IPV victims had to forgo paid work because of abuse, missing an average of 7 workdays per incident and 11 percent had been unable to perform household chores because of an incident of violence (Heise & Garcia-Moreno, 2002).

Bangladesh

IPV has an economic impact and in Bangladesh, this has been studied at the household level though only by one study commissioned by CARE Bangladesh and US AID. In this study, it was found that in a sample of 483 families in the year 2010, the total cost associated with IPV was Taka 57.8 lac, an average cost of Taka 11,976 per family per year (Siddique, 2011). The main expense was related to medical costs (average of Taka 2,968/victim/family). In some cases, when a relative intervened, their medical costs were also covered (average of Taka 1,051). The next set of expenses were related to accessing justice, which included cost of food and transportation to attend court (Taka 2,213 per family) since many families did not live close to the courts. Moreover, the cost of having a case heard at a family court was estimated to be Taka 831 per family per

year and district court 2,161 per family per year. Costs also occur on the perpetrators' side. Siddique (2011) reports that the total cost believed to be borne by the perpetrator's family was over 50 lac, an average of 10,384 per family per year. This includes paying a fine to the victim (7,987 per family) but in some cases, when the perpetrator chooses to run away and hide, the cost of relocation or hiding was estimated to be Taka 1,184.

Indirect costs in terms of wages lost were also found by this analysis. A total of Taka 66,72,000 in wages were lost during the year 2010 (average of 13,831 per family a year) by the victim and over Taka 11 lac was lost in income due to the perpetrator losing the ability to work (average of 2,417 per family). Moreover, if a perpetrator spent time in prison, the income lost was Taka 10,43,000. Overall, it was found that the cost of domestic violence represents about 12.5 percent of Bangladesh's national annual expenditure, or about 2.1 percent of gross domestic product (*ibid.*).

4.3 Impact on children

As discussed in section on risk factors below, witnessing abuse in childhood is a strong risk factor for future likelihood of committing IPV. In a study in Mexico, 50 percent of abused women said that their children routinely witnessed the (Grandos, 1996). Aside from predisposing children to become future victims or perpetrators of violence, studies have also indicated that children from households where there is IPV may have poor physical and mental health.

Children from households where IPV occurs are less likely to be immunized and have a greater risk of dying before age five (e.g., as found in León and Nicaragua) (Asling-Monemi et al., 2008). Similarly, in Uganda, Karamagi et al., (2006) found that infants under 6 months were more likely to have illnesses such as fever, diarrhoea, coughing and fast breathing, when they lived in a household where IPV occurred. Yount et al., (2011), propose a conceptual framework suggesting that IPV against a mother has negative impacts on a child's nutrition and growth, prenatally until the age of 3 years.

A similar pattern was also noted for mental health. Studies have shown that children from such households may exhibit increased rates of behavioural and emotional problems which are further related to difficulties with education and employment. There is evidence from the USA that children from these households are more likely to drop out of school early, experience early pregnancy (Anda et al., 2001; Dube et al., 2002). Similarly, the WHO multi-country study's findings from Brazil indicated that exposure to severe physical and/or sexual IPV was associated to school problems, behavioural dysfunctions in general and aggressive behaviours (Durand et al., 2011). Systematic review of studies in East Asia showed that experiencing IPV in the household is linked to suicide ideation (Fry et al., 2012). A meta-analysis found that

significant mean-weighted effect sizes of .48 (SE=.04) for internalizing behaviours and .47 (SE=.05) for externalizing behaviours, indicating moderate associations between exposure and both outcomes (Evans et al., 2008). Findings for gender differences have been mixed, with some meta-analyses finding that girls experience more internalizing symptoms than boys (Evans et al., 2008), and other meta-analyses (Kitzmann et al., 2003; Wolfe et al., 2003) and cross sectional studies finding no significant gender differences (Yount et al., 2014). In South Asia, several studies (mostly from India) have shown that in households where IPV occurs, there is higher likelihood of miscarriages (Jejeebhoy, 1998) and foetal or infant death (Ahmed et al., 2006; Panchanadeswaran & Koverola, 2005). Other studies in India have found that in households where domestic violence occurs, higher rates of asthma in young children were reported (Subrananian et al., 2007), as well as being under nourished than those children who are in households where IPV does not occur (Ackerson & Subramanian, 2008).

Bangladesh

In Bangladesh, several studies have provided evidence for the link between IPV and poor health outcomes for children. For instance, in a study of over 1,500 women in Bangladesh, Silverman et al., (2009) found that children whose mothers experienced IPV were more likely to report recent acute respiratory tract infections (ARI) and diarrhoea. Similarly, Rahman & Mostafa (2011) analysed the BDHS data and found that maternal experience of any physical or sexual IPV was associated with increased risk of diarrhoea, ARI, fever, and any illness in children aged younger than five years. Asling-Monemi, et al. (2009a) studied over 4000 mothers and found that infants of mothers exposed to different forms of family violence had 26 percent to 37 percent higher incidence of diarrhoea, especially daughters or children younger than 5 years of age of severely abused mothers. Moreover, given that family violence and IPV are linked to poor mental health for the victims, Asling-Monemi et al., (2009a,b) speculate that infant mortality may result from maternal depression in a context of violence. Women who have more than 2 years of education and a female child were more likely to have infant mortality (Asling-Monemi et al., 2008).

Another outcome for children of abused mothers is the impact on children's nutrition. In one study, authors examined birth weight and nutrition deficiencies among children from homes where domestic violence takes place and found that exposure to violence was related to low birth weight and height, as well as poor weight gain and length at 2 years of age (Asling-Monemi et al., 2009b). An analysis of the BDHS by Ziaei et al., (2012) found that women were more likely to have a stunted child if they had lifetime experience of physical IPV or had been exposed to sexual IPV in their lifetime. Johnston & Naved (2008) in their review of studies find that when women are victims

of violence, they are unable to take care of their children – even during pregnancy. For instance, consumption of food supplements provided by the National Nutrition Programme was less for pregnant women who experienced physical violence during pregnancy (Naved & Persson, 2005). In another study, Johnston & NIPORT et al., (2008) report that mother-feed interaction is diminished for mothers who are victims of abuse (Frith et al., 2003| cited in Johnston & Naved, 2008, p.369).

Nepal

Using the NDHS (2011), Tuladhar et al., (2013) report that children of mothers who did not experience physical or sexual spousal violence were fully immunized more

than children whose mothers experienced spousal violence (96 percent versus 84 percent). Additionally, they also found that the prevalence of any form of anaemia (mild, moderate, or severe) was greater for children whose mothers had ever experienced physical or spousal violence than for children whose mothers had not experienced such violence.

“Men are the gatekeepers of current gender orders and are potential resistors of change. If we do not effectively reach men and boys, many of our efforts will be either thwarted or simply ignored.”

Kaufman | cited in Ruxton, 2004:20

5. Risk factors underlying male perpetrators of IPV

At this point in our review, it is important to note that men can be victims of violence from their intimate partners as well (Fleming et al., 2013). Some statistics show that men are just as likely to be victims of intimate partner physical violence as women (Black et al. 2011; Swart et al., 2002), but are much less likely to be physically harmed by violence perpetrated by women (Fulu & Heise, 2014). Instead, they are likely to be harmed as a result of self-defence by women (Williams et al., 2008), and are less likely to report fearing their partner (WHO & LSHTM, 2010; Williams et al., 2008). Moreover, the statistics on mutual incidences of violence reflect incidence high income countries since in low and middle-income countries (LMICs), the majority of partner violence is perpetrated by men against women (Fulu & Heise, 2014). Indeed, in LMICs, the overwhelming burden of IPV and sexual violence is endured by women at the hands of male perpetrators (WHO & LSHTM, 2010). Until recently, most research has focused on assessing the prevalence and impacts of physical and/or sexual violence by men on women (Devries et al., 2011) with a recently growing focus on male perpetrators of IPV. In their review, Fulu & Heise (2014) suggest that there is a gap in the literature on men's perpetration of VAWG, with much of the focus on women as victims or survivors. For this review, given the focus of the larger project, we focus on risk factors for male perpetration of IPV only.

Risk factors driving IPV by men

In the 1970s and 1980s, understanding of intimate partner violence was informed primarily by theory and research emanating from various disciplines such as criminology, sociology, psychology, and feminist theory, all of which were isolated from each other. By the mid-1990's, many theorists began to pay attention to the complex and multi-faceted nature of IPV. Scholars argued that IPV does not stem from single factors, but instead is rooted in an interplay of factors that are nested within each other and interact with each other at different levels. This theory came to be known as the "ecological framework" (Bronfenbrenner, 1979); theory that has been used in various disciplines such as psychology, sociology etc. Fulu & Heise (2014) summarize that IPV emerges from an "interplay of multiple interacting factors at different levels of the social 'ecology'" (pg.2). According to Heise (2011),

the ecological model conceptualised the cause of violence as probabilistic, rather than deterministic which allowed for a more effective prevention approach. The ecological model proposes that violence is a result of factors operating at four levels: individual, household/relationship, community and societal. However, Fulu & Heise (2014) find that the current evidence base is highly skewed toward individual level predictors of abuse. They suggest that more evidence is needed on household/relationship and community level risk and protective factors.

Additionally, Fulu & Heise (2014) note that since some factors such as education and women's employment, appear to have a complex relationship to partner violence that varies by social context, the risk factors "cannot be understood in isolation and should be understood in a broader environment of pervasive gender inequality" (p.4) and therefore efforts should be aimed at stopping the interplay of these factors. Indeed, other theorists also note that in some cases, protective factors in one setting may be ineffective or actually increase risk in another, such as women's economic empowerment as discussed below (Abramsky et al., 2011).

5.1 Individual level risk factors

Various risk factors at individual level have been identified in the literature that place boys and men at higher risk for engaging in IPV (Stith et al., 2004). Factors such as poverty, education level, childhood exposure to violence both as a witness in the household and experiencing abuse itself, age, alcohol and drug use, and poor mental health are related to higher incidences of IPV.

5.1.1 Poverty and Education

A key factor identified as a risk factor for male perpetrated IPV is poverty. Jewkes (2002) notes that even though violence occurs across all socioeconomic groups, it is more frequent and severe in the lowest income group (Ellsberg et al., 1999). Barker et al., (2011, 2013) and other theorists suggest that this relationship can be explained based on the theoretical framework that IPV is directly related to stress. Given that those in poverty are less likely to have resources that can alleviate stress, they are also more likely to engage in violence, particularly IPV (Jewkes, 2002). Additionally,

men in poverty are severely marginalised and left out of 'traditional power structures' despite having power in their own household. As a result, theorists posit that when men experience this lack of power in the larger society, their frustration may be manifested in violent behaviours that gives them power over others (Gelles, 1974; Barker, 2005; Jewkes, 2002). In other words, violence and poverty are mediated via notions of masculine identity.

At the individual level, it is possible to postulate that educational levels and income are directly related, and findings from the review reveal that to some extent, higher levels of education are related to lower incidences of IPV. However, evidence for this varies greatly from country to country. For instance, in the IMAGES study, higher levels of education (e.g. Chile, Croatia, Mexico, Bosnia) tended to be more supportive of gender equality and women's agency, whereas countries with lower levels of education (e.g. the Democratic Republic of Congo, Rwanda) were less supportive. However, in Brazil and India, this was not the case. Almost 80 percent of Indian men in the IMAGES study had studied till at least up to secondary school but only 43.7 percent of Brazilian men had. Despite these differences in education, Brazilian men consistently had more gender equitable attitudes compared to Indian men, and Indian men were the most supportive of violence against women.

Recent arguments from experts in the field suggest that perhaps the relationship between poverty and violence is more complex than previously proposed. Although poverty and low education have been thought to be predictors of violence, several studies have also produced mixed results. Evidence from different sites has shown that income, male unemployment, women's educational attainment, men's education, educational level of the man vs. woman, financial disparity and poverty indices are not necessarily positively associated to IPV in all sites (Jewkes et al., 2002a; Kishor & Johnson, 2006; Vyas & Watts, 2008). Nevertheless, given the role income plays, experts in the field suggest that even if it is not an independent or proximate risk factor, socioeconomic status of households should be taken into account when designing and targeting IPV intervention programmes (Abramsky et al., 2011).

In South Asia, the relationship between IPV and education is equally complex. With respect to women's educational attainment, Ackerson and Subramanian (2008) found that in India women with no formal education were 4.5 times more likely to report lifetime IPV and 5.6 times more likely to report recent IPV compared with those schooled for more than 12 years. Ackerson and Subramanian (2008) also found that in India, women with higher education than their husbands were more likely to experience lifetime IPV as compared to women in marriages with no educational gap. However, in neighbouring countries such as Thailand, Hoffman et al., (1994) found that there is no relationship between educational level and men's perpetration of physical IPV.

Just as the relationship between women's educational level and IPV is complex, the same holds true for men. In India, Ackerson and Subramanian (2008) found that higher educational levels for husbands were associated with lower odds of lifetime and recent IPV. In other words, women married to husbands with no formal education were much more likely to report lifetime IPV than women married to husbands who were college educated. However, this is contradictory to the findings from the IMAGES study in India mentioned above. More recent work in India finds that men who are more educated are less likely to perpetrate violence and the difference is particularly stark with those having completed schooling (Nanda et al., 2015). In Sri Lanka's CARE study, de Mel et al., (2013) found that while there was no statistically significant variation in the rates of IPV perpetration by education level, about 35 percent of men who reported perpetration of IPV, and 9 percent of men who reported perpetration of non-partner sexual violence had completed tertiary education. Another study in Sri Lanka with 476 medical male students found that 1/3rd of the sample justified wife-beating, 2/3rd of the sample stated that women were to be blamed for IPV and about 1/4th stated that IPV must be endured to maintain marital harmony (Jayatilleke, et al., 2010, p.93). In the neighbouring South East Asian region, in Vietnam, only men with the highest level of schooling were shown to have lower odds of perpetrating violence (Fulu et al., 2013; Yount et al., 2012).

Bangladesh

In Bangladesh, education (for both men and women) has been shown to be protective against IPV (Bates et al., 2004; Koenig et al., 2003; Johnson & Das, 2009; Johnston & Naved, 2008; Naved & Persson, 2005; Sambisa et al., 2010), albeit with some caveats. For women, Bates et al., (2004) found that having at least 6 years of education is protective and Koenig et al., (2003) found that having any level of primary school attendance is protective against IPV. For men, in urban areas, being educated beyond 6th grade and for men in rural areas, being educated beyond 10th grade had a protective effect against IPV (Naved & Persson, 2005). Johnston & Naved (2008) suggest that in rural areas, education may act as a buffer against harmful gender norms in the society. The BDHS 2007 indicated that higher education was only protective against physical violence with no clear relationship between education and sexual violence.

In a study of India and Bangladesh, there is a complex relationship emerging when there is an educational gap between spouses i.e., when one spouse is more or less educated than the other. With a sample of 4,195 women from Bangladesh and 65,610 women from India, Rapp (2012) found the education was protective such that couples who were equally low-educated (primary education level or less) had the highest rates of IPV and couples who were equally highly-educated (secondary

educational level or higher) had the lowest rates of IPV. Moreover, women who had more education than their husbands were less likely to experience IPV than women who had less education than their husbands (ibid.).

Interestingly, Ackerson and Subramanian (2008) also found that over and above individual level factors, in Bangladesh average level of literacy in the neighbourhood was associated with IPV such that lower male and female literacy predicted higher IPV. In fact, the role of neighbourhood literacy was such that it modified the relation between a woman's education and IPV so that the protective effects of neighbourhood literacy were stronger for women with a middle to high level of education. Thus having social status among peers may help men cope with their frustration and anger – which would otherwise be vented in the form of violence (ibid.).

Pakistan

Ali & Khan (2007) found that both physical and sexual violence are more likely if the wife or husband have no formal education. Moreover, educational level of the husband had a statistically significant association with all three forms of violence over the lifetime, i.e., physical, sexual and psychological violence. Similarly, Fikree et al., (2005) found that wives with no formal education were nearly five times more likely to be physically abused than wives with some formal education.

Nepal

On the one hand, studies in Nepal found that lack of education is a risk factor for increased IPV (Atteraya et al., 2015; Dalal et al., 2014, Oshiro et al., 2011), even during pregnancy (Pun et al., 2016). Puri et al., (2012) suggest that the odds of a woman with a husband educated to higher secondary level or above experiencing sexual violence were about 60 percent lower than for women whose husbands were illiterate or had no formal education. Similarly, women who have had university level education were more likely to get family support in accessing justice in case of IPV than those women who were illiterate (NJA, 2016). Oshiro et al., (2011) found that those who are less educated are also more likely to have lower household SES, consume more alcohol, have a greater likelihood of an early marriage, and have a spouse with a lower educational level. Others found that women whose husbands were working in agriculture or in the daily wage/labor sector were 56 percent and 44 percent respectively, more likely to experience sexual coercion compared to those women whose husbands worked in the public/business sectors (Adhikari & Tamang, 2010). Khatri (n.d.) found that women whose husbands' occupation was driver/contractor were more likely to be physically, sexually, and psychologically abused.

On the other hand, Bhatta (2014) conducted a random sampled study among 2,466 married males in Kathmandu and found that men who had education level secondary or

higher, had an income of 5000 NPR or above per month and had formal employment were more likely to have perpetrated intimate partner violence.

5.1.2 History of violence and child abuse in childhood/family

“Children who are subject to violence come to engage in violence in their later marital relationships because they acquire certain attitudes which facilitate violence”

Markowitz, 2001: 215

Experiencing or witnessing abuse is one of the strongest drivers of IPV as found in several studies and across diverse sites such as Nicaragua, the United States, Vietnam, and all 6 countries in the IMAGES study (Fleming et al., 2015; Abrahams et al., 2006; Abramsky et al., 2011; Barker et al., 2011, 2013; Dunkle et al., 2004b; Fulu et al., 2013; Yount et al., 2014, 2015). Indeed in the IMAGES work, history of abuse was the only variable that presents a statistically significant association in all countries, both during lifetime and in the last 12 months. Similarly, in a systematic review of studies, Flood and Pease (2009) found that childhood victimization had consistent, small-to-medium effect in the findings of 8 out of 10 relevant studies. Boys can be victims of violence at the hands of their fathers, mothers, siblings, peers, or other adults in their lives. The IMAGES data from six countries found that many men reported being victims of violence in childhood. Between 20 percent and 85 percent report having experienced psychological violence before the age of 18; between 26 percent and 67 percent report having experienced physical violence before 18; between 1 percent and 21 percent of men report having experienced sexual violence before 18 (Fleming et al., 2013; Contreras et al., 2012). Cross-sectional findings have also been corroborated with longitudinal findings (e.g., Yount et al., 2015), suggesting a robust link between experiencing/witnessing abuse and later likelihood of committing IPV.

Similarly, a systematic review found that IPV by men increased 3 or 4 times when men were exposed to childhood violence (Gil-Gonzalez et al., 2008), and a meta-analysis found that exposure to any childhood sexual abuse (but not physical abuse alone) increased the likelihood of perpetration of violence by men by more than 3 times (Jespersen et al., 2009). In other studies, witnessing abuse has been found to be more important than having experienced violence in the form of beating (Abrahams et al., 2006). Several theorists turn to Social Learning Theory to explain these associations. Witnessing violence during childhood perhaps teaches men that violence is an effective tool to resolve frustrations, stress or conflict (Heise, 1998). It also teaches boys and men that violence is acceptable and appropriate to use to assert power (Contreras et al. 2012).

In South Asia, Jejeebhoy et al., (2013) find that intergenerational transmission of violence is substantial in India. Nanda et al., (2015) report that in India among men who have experienced discrimination/harassment often during their childhood, 44 percent reported perpetrating violence in the past 12 months, compared to 14 percent amongst men who did not experience any discrimination. Similarly, in Sri Lanka de Mels et al., (2013) find that childhood sexual abuse and childhood emotional abuse was significantly related to higher likelihood of perpetrating IPV in Sri Lanka with men who had experienced sexual abuse or emotional abuse as a child being twice as likely to perpetrate sexual violence later in life.

Bangladesh

In Bangladesh, Naved et al., (2011), using the UN multi country study found that a large portion of urban (70 percent) and rural men (63 percent) reported experiencing some form of emotional abuse. The types of abuse ranged from seeing their mother being beaten up, to being emotionally abused (being told they are lazy or stupid or ugly), to physical abuse during childhood. Of the men who reported family history of witnessing violence, 40 percent of urban men and 36 percent of rural men reported past year prevalence, while 57 percent of urban men and 53 percent of rural men reported lifetime prevalence (see also Stöckl et al., 2014). Similarly, the BDHS 2007 found that a family history of domestic violence is strongly associated with men's reports of violence against their wives. Three-fourths of men who reported seeing their father beat their mother have committed physical and sexual violence against their wives, compared with 49 percent of men who did not witness such violence. The relationship also holds true for sexual violence. Naved and Persson (2005) also find that the strongest risk factor that emerges is a history of abuse in their sample.

Pakistan

Two studies suggest there are links between perpetrating IPV and witnessing abuse in childhood. Farid et al., (2008) found that husband's exposure to their mother's abuse is a risk factor for perpetrating IPV in the future by almost three-fold. Moreover, Fikree et al., 2005 found that men who reported being abused as children (55 percent of the sample) were nearly five times more likely to practice physical abuse as adults. Additionally, men who witnessed violence at home (65 percent of the sample) were three times as likely to be abusers in the future – similar to Farid et al.'s findings.

5.1.3 Age

Younger age is consistently linked with higher likelihood of committing IPV in a number of studies (Abramsky et al., 2011; WHO, 2012). In the IMAGES study, Fleming et al., (2013) find that in Chile, Croatia, India, Rwanda and Mexico, the age of perpetrators is significantly lower than the age of non-perpetrators. According to Flood and Pease

(2009), the age effect is understood as a result of varied experiences as boys grow older. They speculate that older men could possibly have more informed and improved attitudes towards violence against women as a result of greater exposure to positive role models. Evidence of better attitudes among individuals over 55 (ANOP Research Services, 1995; Carlson & Worden, 2005; Nagel et al., 2005) and more inequitable attitudes among the younger age groups have been reported. Flood and Pease (2009) also review a series of international studies that indicates that boys and young men are more likely than older men to endorse rape-supportive norms and have a higher likelihood of committing rape (Aromaki et al., 2002). However, in South Africa, findings suggested that men aged 20–40 years were more likely to have raped than younger and older men (Jewkes et al., 2006), suggesting that perhaps contextual factors are important to consider when accounting for age as a variable in any analysis.

Adolescent males as perpetrators

Given that younger age is a risk-factor for higher likelihood of committing IPV, there is a strong need to study adolescent males since “styles of interaction in intimate relationships are rehearsed during adolescence, providing a strong empirical and theoretical basis for working with young men in reproductive health issues, relationship needs and gender equity” (Barker, 2005: 94). Adolescence is the time during which patterns of behaviours predicting future behaviours are formed (Samuels & Jones, 2015). For instance, studies have found that when adolescent boys view women as sexual objects, they are more likely to commit sexual violence later on (Jejeebhoy, 1999). Adolescence therefore is a crucial developmental time period for such attitudes to form since studies suggest that experiencing violence as a child is a predictor for men's future aggression against women (Jewkes et al., 2011; Knight & Sims-Knight 2003).

At country level, there were some variations from the global trends:

Bangladesh

Unlike global trends where younger age is consistently linked with higher likelihood of committing IPV in a number of studies, the BDHS 2004 and BDHS 2007 in Bangladesh finds that the proportion of men who report ever committing physical violence increases with men's age, while the proportion ever committing sexual violence decreases with age. On the other hand, Bhuiya et al., (2003) show that the odds of beating among women with husbands aged less than 30 years were six times higher than of those with husbands aged 50 years or more.

Pakistan

In Pakistan, there were no studies that examined age of men as a risk factor. However studies indicated that age of woman may be a risk factor in some cases where older

women were more at risk (Ali & Khan, 2007; Asif et al., 2009). Additionally, Asif et al., 2009 found that age of marriage is linked to likelihood of IPV: the likelihood of having high physical abuse is greater among wives who had their first marriage before attaining 20 years (23 percent) followed by wives whose age at first marriage was between 20 and 24 years (13 percent). Wives who married late, after celebrating their 25th birthday, had the least likelihood (10 percent).

Nepal

Age was a risk factor in Nepal as well. The NDHS 2011 found that women whose husbands were older than themselves by 5 years or more had a 33 percent higher chance of experiencing sexual violence compared with women whose husbands were only 1 to 5 years older (MoHP, New Era and ICF International 2012). Bhatta (2014) found that older men (above the age of 25) were more likely to perpetuate violence.

5.1.4 Alcohol and drug misuse

Another consistent risk factor for IPV found across the review is the use (misuse) of alcohol (Abramsky et al., 2011; Abrahams et al., 2006; Barker et al., 2011, 2013; Copenhagen et al., 2000; Heise, 2011). Though illicit use of drugs has also been associated with IPV, the majority of the literature has focused on alcohol use by men. A systematic review pooled the results of 11 studies and reported that harmful use of alcohol was associated with the likelihood of committing IPV by 4.6 times, compared to mild or no alcohol use (Gil-Gonzales et al., 2006).

The IMAGES study (Barker et al., 2011; Fleming et al., 2013) shows that men's rates of regular misuse of alcohol – defined as having five or more drinks in one night on a once monthly or greater basis – vary from 23 percent in India to 69 percent in Brazil. Additionally, younger men reported misusing and abusing alcohol more than older men in Chile, Croatia, and Mexico. Moreover, in these countries (Chile, Croatia, and Mexico), men holding more inequitable views about gender were by far the most regular abusers of alcohol. Similarly, Abramsky et al., (2011) conducted analysis on data from population based surveys in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Republic of Tanzania, Samoa, Serbia and Montenegro, and Thailand and found that alcohol use by the husband was consistently associated with women's risk of IPV across all countries. Other cross-sectional studies from low and middle income countries find that men who misuse alcohol are 1.6 to 4.8 times more likely to perpetrate IPV (Abrahams et al., 2004; Dalal et al., 2009). These associations have been reported mainly for misuse of alcohol and physical violence. According to the review conducted by WHO & LSHTM (2010), the association between misuse of alcohol and sexual violence is less clear since studies have found no or weak associations between the two (e.g., Abbey et al., 2004).

One reason often cited by men to justify wife-beating is the use of alcohol by women. For instance, in their study with South African men, Abrahams et al., (2006) found that 21.4 percent of men reported that it is acceptable to batter a woman if she uses alcohol. Often rooted in cultural norms that consider it unacceptable for women to drink alcohol, according to these study findings, men associate women's alcohol use with sexual infidelity (Abrahams et al., 2006; Jewkes et al., 2002b).

Though we found no studies on alcohol and drug use and IPV in Bangladesh, we did find studies in Pakistan and Nepal:

Pakistan

In Pakistan, studies indicate that using tobacco or alcohol is associated with higher likelihood of perpetrating IPV (Farid et al., 2008). For example, Zareen et al., (2009) found that the most important cause for violence in the study was addiction of husband in 39.02 percent of cases. The PDHS 2012 found that women whose husbands get drunk often are 35 percent more likely to experience both physical and emotional violence than women whose husbands do not drink.

Nepal

Several studies have examined the alcohol consumption as a risk factor for male perpetrated IPV (Deuba et al., 2016). Similar to research in other countries in South Asia as well as other regions, researchers in Nepal found that husbands who consumed alcohol were more likely to perpetrate IPV (Khatri, n.d.; Khatri & Pandey, 2012; Puri et al., 2010, 2011). For instance, Adhikari & Tamang (2010) report that in their sample of over 1,500 women, women whose husbands consumed alcohol were 27 percent more likely to report sexual violence. Similarly, Oshiro et al., (2011) found that frequency of husband's drinking was significantly associated with violence for both the general population as well as the urban poor. An analysis of the NDHS 2011 found that 37.1 of women who suffered violence came from alcoholic households (Atteraya et al., 2015). Similarly in their analysis, Dalal et al., (2014) found that emotional violence was reported by 10.5 percent (n=168) women, physical violence was reported by 13.4 percent (n=214) women, and sexual violence was reported by 9.8 percent (n=157) women whose husbands were alcoholic. In their study of 41 men and 76 women in Dhulikhel municipality, Pun et al., (2016) found that excessive consumption of alcohol during pregnancy risk factor for IPV.

5.1.5 Mental health

Men's mental health may also be related to higher incidences of violence. Garcia-Moreno et al., (2005), WHO & LSHTM (2010), suggest that a man suffering from depression may take out feelings of sadness and loneliness by using violence against a partner. Other reviews (WHO

& LSHTM, 2010) found a consistent and significant association between antisocial personality disorders and the perpetration of IPV or sexual violence.

Given that mental health is related to IPV, the IMAGES study examined men's mental health and found men tended to report high levels of psychological distress. When asked about feeling depressed men showed signs of high vulnerability and high levels of suicidal thoughts (Barker et al., 2011; Fleming et al., 2013). The rates of experiencing depression at least once in the last month ranged from 9 percent in Brazil to a high of 33 percent in Croatia. One factor that contributes to poor mental health according to Barker et al., (2011) and Fleming et al., (2013) is work-related stress. Similarly, Petesch (2013) reports that since economic factors are important determinants of men's feelings of power, the status of the economy greatly affects their agency. In the IMAGES work, Barker and colleagues found that between 34 percent and 88 percent of men in the survey sites report having experienced work-related stress. Moreover, men who reported experiencing economic or work-related stress were also more likely to report depression, suicide ideation, previous arrests, and use of violence. Their analysis revealed that men's stress of not being able to make ends meet, of not having enough income or work and of not achieving the role of provider was a key factor associated with perpetration of violence and higher rates of alcohol abuse (another risk factor for perpetration of IPV).

We found no studies examining the risk of men's mental health as an underlying factor driving IPV in our focal countries.

5.2 Household/relationship level risk factors

At the household/relationship level, there were only a few risk factors that were identified in LMICs consistently across seminal studies⁶: women's household economic power, quality of marital relationship between husband and wife, the number of partners a man or woman has, and the number of children in the household.

5.2.1 Women's economic decision making power

The relationship between women's economic empowerment and IPV is complex. A systematic review of studies conducted between 1992 and 2005 found that women's working status is protective in some settings while it makes them more vulnerable in other settings (Vyas & Watts, 2009). For instance, in India, Rao (1997) finds that even after controlling for total household income, the greater the wife's income, the lower the likelihood that she will experience IPV. In some cases,

lack of economic empowerment is related to higher incidences of IPV. Lori Heise states that "male economic and decision-making dominance in the family is one of the strongest predictors of high levels of violence against women" (Heise 1998, Heise 2006, 35). However, on the other hand, Jewkes (2002) suggests that financial independence for women may not always be a protective factor if her partner is not working. When men are unable to be the 'bread-winner', it may have the opposite effect on IPV, i.e. leading to increase in IPV (Heise, 2011). As can be expected, poverty is an additive risk factor and Kabeer (1999, p. 149) suggests that poor women are often most vulnerable to violence because "they are most exposed to the risk of violence and least able to remove themselves from violent situations".

Bangladesh

In Bangladesh, several studies have attempted to disentangle the relationship between microcredit programmes and likelihood of experiencing violence though Johnston & Naved (2008) suggest that the debate is inconclusive. For instance, Schuler et al., (2013) find that in a qualitative study in 4 villages participants were almost unanimous in stating that wife beating had recently declined in their villages, a fact that Schuler and colleagues attribute to women's increased involvement in income generation, which was mentioned in all 11 group discussions. However, other studies have found that increased economic empowerment has led to an increase in experiencing violence (Naved & Persson, 2005). For instance, Hadi (2000) finds that involvement of women in credit programs and consequentially financial contribution to families was significantly associated with sexual violence and even more severe violence if involvement in the programme exceeded 5 years. Wahed & Bhuiya (2007) in their review find that though violence increases with membership of women in micro-credit organizations initially, it tapers off as duration of involvement increased. Schuler et al., (2013) build on Jewkes (2002) argument that when women experience empowerment, men feel the need to reinforce their dominance and masculinity.

Pakistan

The PDHS 2012 found that women who are employed for cash are more likely than other women to have ever experienced either both physical or emotional violence. Of the 2,500 women who were unemployed, 30.5 percent experienced emotional violence and 25.4 percent experienced physical violence. On the other hand, of the 889 women employed for cash, 36.2 percent experienced emotional violence whereas 43 percent experienced physical violence.

6 There are a high number of studies identifying various household factors (household composition) in HIC.

5.2.2 Household SES

Studies in South Asia show that the relationship between household economic status and physical IPV against women is strong across several countries such as Cambodia (Yount & Carrera, 2006), India (Burton et al., 2000; Nanda et al., 2015), the Philippines (Hindin & Adair, 2002), and Thailand (Hoffman et al., 1994). For example, in India, Burton et al., (2000) found that women coming from homes with fewer appliances are more likely to experience physical and psychological IPV. Similarly, Nanda et al., (2015) find that men who come from lower household SES are more likely to perpetrate violence (42 percent of men belonging to poorest wealth class reported perpetrating violence in the past 12 months vs. 25 percent men amongst a higher strata of wealth). They explain this relation by the stress of financial burden, unemployment and insecurity that come with belonging to a household with a lower SES. In their analysis with men in India, 40 percent of men who had economic stress reported perpetrating any form of violence in the past 12 months compared to 27 percent amongst men who did not have any economic stress (*ibid.*). Moreover, similar to the relationship between educational gap, husbands with wives who earned more had a higher likelihood to perpetrate IPV than those with wives who earned less (*ibid.*).

Bangladesh

In Bangladesh, while many studies find that higher SES is protective (Ahmed, 2006; Bates et al 2004; Koenig et al 2003; Sambisa et al., 2010, 2011), Johnston & Naved (2008) state that this relationship is unclear (see also Naved & Persson, 2005). However, other surveys such as the BDHS 2004 indicated that women who belong to homes in the lowest wealth quintile report more physical and sexual violence than women in the highest quintile (57 percent vs. 34 percent respectively). This was found again in BDHS 2007 though there was no clear relationship between sexual violence and wealth. Similarly, in their study comparing Morocco, Uganda and Bangladesh, Duvvury et al., (2009) found that only in Bangladesh was there a uniform trend of decline in the reporting of lifetime and current intimate partner violence with increased wealth. Das et al., (2008) found that controlling for several confounding variables (such as attitudinal, regional and demographic characteristics), women from poor families were more at risk for IPV. In a multi-level contextual-effects analysis VanderEnde et al., (2015) found that for higher household incomes, women's risk of experiencing prior-year physical and/or sexual IPV was lower.

Pakistan

Ali & Khan (2007) found that for physical violence, if the husband is an unskilled worker or unemployed and consequently the household socio-economic status of the family is low, the likelihood of IPV is greater. Ali et al., (2011) found that in a study of 759 women, poor

socioeconomic life circumstances constituted the main risk factor for all forms of lifetime violence. Similarly, Fikree et al., (2005) reported that men in poverty were three times more likely to perpetrate physical abuse than those who were not poor. It can be also generalized that greater number of children may be linked to household SES. The PDHS 2012 found that the greater the number of children, the more likely that the woman will experience IPV.

Nepal

As reported above, given that education and household SES are strongly intertwined, Oshiro et al., (2011) found that for both the general population and urban poor, household SES was related to IPV, with lower household SES having more likelihood of incidences of IPV. It can be also generalized that greater number of children may be linked to household SES. Bhatta (2014) found that men who had more than three or equal children were less likely to have perpetrated domestic violence compared with those who had less than two or equal children.

5.2.3 Relationship conflict, including with multiple partners

Relationship conflict or marital discord has also been shown to be a risk factor for IPV, and in marriages/relationships, violence is often displayed as an expression of anger or frustration. In her review, Jewkes (2002) suggests that there is heightened vulnerability to IPV when a partner is considering leaving the marriage.

Relationship conflict also occurs in the case of multiple partners – both at perpetrator level and victim level. Men who have more than one partner are also more likely to perpetrate violence, while women who are perceived to have multiple partners are at risk of IPV (Abrahams et al., 2004; 2006). In the review by the WHO and LSHTM (2010) team, they found that estimates ranged from a 1.5-fold (India) to 17.1-fold (South Africa) greater risk of the perpetration of IPV and sexual violence, and a 1.5-fold (Uganda) to 2.4-fold (Viet Nam) greater risk of experiencing IPV if the woman had multiple partners (Jewkes et al., 2006; Koenig et al., 2004; Vung & Krantz, 2009). Indeed, women, when suspected of infidelity are at heightened risk for violence by their partners as found across multiple studies as per the WHO and LSHTM review.

In terms of men having multiple partners, it is plausible to speculate that when men have multiple partners, they are likely to feel more in control and superior to women who will most likely not be allowed to have multiple partners (Jewkes et al., 2006). As a result, these men will also have a higher likelihood of displaying their power through violence

Bangladesh

Another risk factor for IPV is polygamy, a phenomenon that is rooted in social norms in Bangladesh. For instance,

Khan (2005) found that desiring or having another wife are underlying causes for torture or murder of the first wife. Similarly, Siddique (2011) finds that 6.2 percent of women experienced more violence after a second wife enters the family. Das et al., (2008) also found that men who report having been unfaithful to their wives are much more likely to report recent violence. Similarly, in Bangladesh, spousal communication is a protective factor against IPV (Naved & Persson, 2005)

Nepal

Extra-marital affairs, a type of violence rooted in gender norms was also found to be a risk factor in Nepal. For instance, Puri et al., (2012) found that women whose husbands had casual sexual partners or more than one wife (as reported by women) were more than twice as likely as others to have experienced sexual violence in the last 12 months.

5.3 Community/society level factors

At the community level, risk factors that drive male perpetrators to commit IPV fall under social norms that define masculinity, norms around dowry and bride price, norms around acceptability of violence, and norms around religion that condone violence.

5.3.1 Social norms around masculinity

At the community level, social norms and beliefs have been researched and documented heavily as a risk factor for IPV (Fleming et al, 2015; Flood & Pease, 2009; Fulu et al., 2013; Heise, 1998; Santana et al., 2006). While they are located here at the community/society level, these social norms also occur at the household, relationship and individual levels. Jewkes (2002)⁷ suggests that IPV is a 'learned social behaviour' (p.1426), and is intergenerational in nature, i.e., sons who see domestic violence at home are more likely to engage in IPV in the future (see also above 5.1.2).

Rigid constructions of masculinity stemming from traditional gender ideologies have been identified as a risk factor for both physical and sexual violence (Courtenay, 2000; Jones et al., 2014; Moore & Stuart, 2005; Watson et al., 2015). Various gender theorists (e.g., Connell, 1995; Pleck, 1995; Way, 2011) suggest that men are subjected to limitations on their behaviours as a result of gender norms as much as women are. For instance, behaviours such as showing physical aggression or emotional stoicism are desired and expected in order to be considered masculine. According to Connell (1995), there is no single masculinity, instead multiple masculinities exist across time and contexts. Described as "hegemonic masculinities" theory

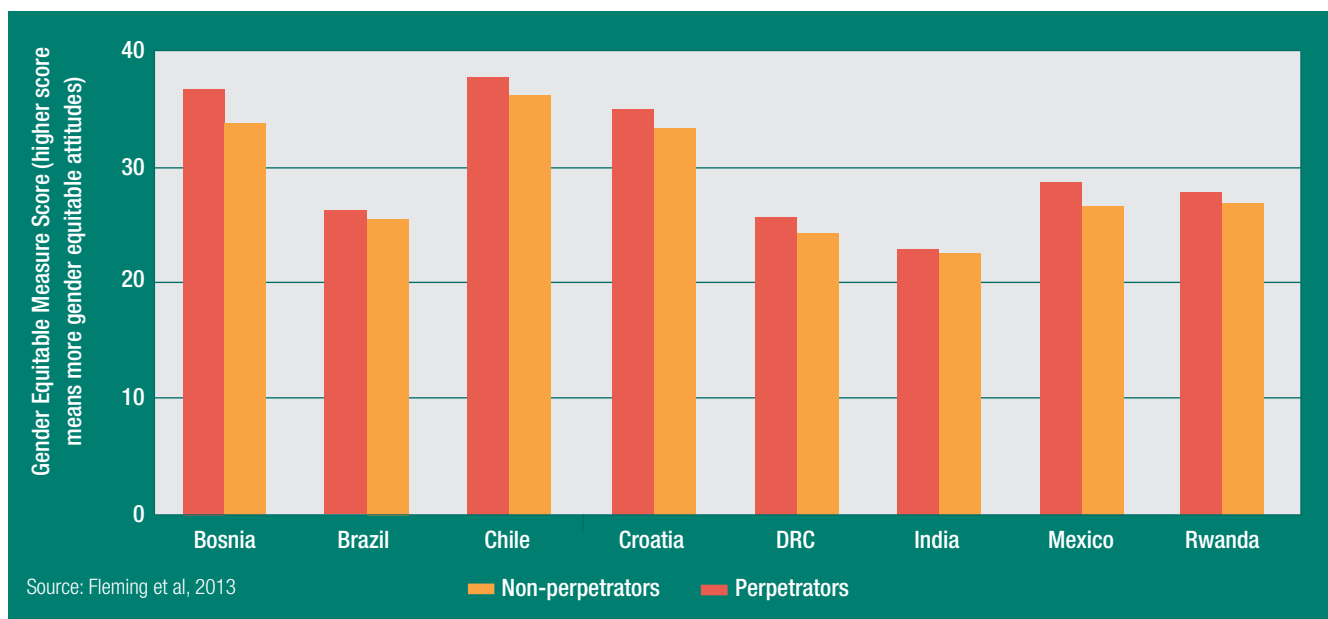
suggests that different components of masculinities are placed in a hierarchy such that hegemonic masculinity are patterns and narratives of masculinity that are perceived to be dominant, and against which other patterns of masculinity are measured. Hegemonic masculinities value certain types of men over other men and women, and help to create and maintain patriarchy (Connell, 1995). Though hegemonic masculinities are not enacted by the majority of the men, they are considered normative. Characteristics that are included into these ideals of manhood that are considered normative are violence and aggression, stoicism (emotional restraint), courage, toughness, risk-taking, adventure and thrill-seeking, competitiveness, and achievement and success. While hegemony masculinity does not mean violence, the ideals of manhood can be supported by violence (Connell & Messerschmidt, 2005).

Fleming et al.'s, (2013) review of research on the role of masculinity in partner violence indicated that different domains of masculinity and male gender norms influence perpetration of violence. In the IMAGES project (Figure 7), men were asked to report their attitudes on the Gender Equitable Measure (GEM) and Barker et al., (2011) found that adult and younger men who adhere to more rigid views about masculinity (e.g., believing that men need sex more than women, that men should dominate women, that women are "responsible" for domestic tasks, among others) are more likely to report use of violence against a partner, sexually transmitted infection, previous arrests and drug or alcohol use. Another domain of masculinity that is most commonly associated with being a masculine man is to be the provider and protector of the family (Connell, 1995). According to Barker (2005), men who are unable to provide for their family may find alternative methods to demonstrate their masculinity such as sexual coercion, capacity for drinking, or shows of force to demonstrate their masculinity for their peers (Courtenay 2000).

Masculine norms also act as risk factors for sexual violence. Studies find that sexual violence is often the result of men believing that they are justified in raping their wife, because of beliefs around male superiority in the society. Boys and young men who endorse more rape-supportive beliefs are also more likely to be sexually coercive (Anderson et al., 2004). Murnen et al (2002) in a meta-analysis found that all but one measure of masculine ideology was significantly associated with higher levels of sexual aggression – i.e., stronger beliefs around traditional masculinity is associated with higher sexual violence. The IMAGES study (Barker et al., 2011) finds that in India and Rwanda, a majority of the male participants believed that men need sex more than women do and held the most inequitable gender beliefs out of the 6 countries studied.

⁷ Jewkes (2002) is considered a seminal piece on conceptualising risk factors for male perpetration of IPV.

Figure 7: Differences between men who have ever perpetrated violence against a partner and those who have not from IMAGES study



A few studies have turned their attention to the enforcers and gatekeepers of these norms. In contexts where religion plays a strong role in everyday life, it is the religious institutions and leaders that have an impact on norms and beliefs around masculinity. Flood & Pease (2009) cite evidence of the ways in which religion can be misused to perpetuate violence against women. For example, they cite the work on Christian evangelism’s emphasis on wifely submission that encourages pastors to counsel women to stay with their abusers (Nason-Clark, 1997). They also report on work in Arab and Islamic countries, where selective excerpts from the Koran could be used to prove that men who beat their wives are following God’s commandments (Douki et al., 2003). In a qualitative study of 40 women, Shaheen (2014) finds that religious norms are deeply embedded into day-to-day actions and expectations of married couples. As a result, religious ideals such as norms around wearing the hijab, around Islamic standards of morality are accepted reasons for IPV (*ibid.*).

In South Asia, Jejeebhoy et al., (2013) find that deeply ingrained conventional beliefs about the roles of men and women drive violence in India. For instance, more violent than nonviolent husbands believed that women should not have the same rights as men.

Bangladesh

In Bangladesh, Das et al., (2008) found that egalitarian attitudes towards financial decisions, i.e., men who report equal household financial decision making are less likely to report that they have been violent toward their wives

in the past year. Similarly, in the UN multi-country study, inequitable attitudes were found in both rural and urban sites (78 percent of urban men and 92 percent rural men believed that a woman’s most important role is to take care of her home and cook for her family). The greater the inequitable attitudes, the higher the likelihood that there will be physical IPV. However, Naved et al., (2011) find that the link between sexual violence and inequitable attitudes around gender roles is not significant. In the rural site however, men who held the most gender inequitable opinions in relation to sex (e.g., men are entitled to sex) were 1.80 times more likely to perpetrate sexual violence against a woman.

Yount et al., (2016) find that men’s controlling behaviors were associated with physical IPV perpetration and negatively associated with psychological IPV perpetration, i.e. more controlling behaviors lead to more physical violence but perhaps controlling behaviours are a form of psychological violence. The authors explain this by stating that men believe that women are their property and can be controlled and violence against women is men’s prerogative, all of which are situated / framed / justified by/ in social norms around gender in the society.

Another risk factor is the social norm of son preference. Though in Nepal studies find that continuing women to bear children until a son is born is considered a form of violence (see below), studies in Bangladesh have not documented that as of yet. However, according to the BDHS 2004, men who have a preference for sons are more likely (than men who have no preference or who want equal numbers of sons and daughters) to report having been violent to their wives.

Pakistan

Though no studies examined gender norms and their risk to IPV, the study by P4P, Rozan and ICRW (n.d.), found that norms of masculinity are driving men's attitudes towards violence against women. For instance, men believed that men should be sexually potent and that sexual potency defines manhood. Moreover, men reported that a man needs to control his wife, look after the needs of parents more than the wife, and take major decisions within family. They stated that men and women have clearly defined roles in the household that divided housework in gendered ways. According to this study, some men stated that working within the home was shameful for men as: "real men did not do work meant for women". Religion was considered to define how men and women should behave, especially when it came to their responsibilities as a son. Other men explained that women should be distrusted and controlling women's sexual activity is one way to do that. The findings also showed that "once a woman had engaged in sexual activity, she was not to be trusted; 'whether you steal once or you steal a thousand times it is the same, whether you steal one rupee or one lakh rupee it is the same thing'" (p. 12).

Nepal

In Nepal, social norms around gender have been documented as risk factors for male perpetrators of IPV. Much like the rest of the region, women who experience more control from their husbands are more likely to report higher IPV. For instance, in their study of more than 1500 women, Adhikari & Tamang (2010) found that women who experienced higher levels of patriarchal control from their husband were almost twice as likely to face sexual violence. Puri et al., (2010) found that factors that encourage sexual violence are gender roles, which dictate that men are expected to take the initiative and be aggressive in sexual matters and women are expected to be bashful, coy, and submissive. One's manhood is rooted in one's sexual activity.

Other gender norms that have been shown to be risk factors are that of son preference (Deuba et al., 2016). For instance, Joshi & Kharel (2008) cite Adhikari & Dahal (2004) that found that in the Banke district, in a sample of 235 women and adolescent girls, verbal abuse was experienced as a result of giving birth to daughters only.

5.3.2 Social norms around dowry and bride price

A risk factor for high IPV in the South Asian region are norms around dowry which in the past used to be

Table 4. Estimates of Dowry Violence in Select South Asian Countries

Estimates of dowry violence	Year and author
Bangladesh	
25 percent–30 percent of violence against women reported to police was dowry-related	Farouk 2005
330 women in 2011 killed because of dowry, vs. 137 in 2010	Islam 2012
Violence in first 6 mo. of 2013	Islam 2013
India	
5,000 dowry deaths annually	1995; Indira Jaising 1995
12,000–20,000 dowry deaths annually	Early 1990s; Purkayastha et al 2003
25,000 dowry deaths annually	Late 1990s; Menski (1998) cited in Anderson (2007)
8,000 dowry deaths annually	2007–11; NCRB 2012
Pakistan	
50 cases of stove burning reported by news media in 2009	Perveen 2010
As of 2003, 4 women burned to death by relatives every day	Bukhari 2003
More than 6,500 women in Islamabad – Rawalpindi area burned by family members; less than 1 percent survived	1994–2003; Bukhari 2003
4,000 women burned by relatives in Islamabad	1994–2002; Terzieff 2002

Source: Solotaroff & Pande, 2014, p. 49

voluntary gift, but has now become mandatory. While “the system of dowry is not unique to South Asia, but the transformations in the meaning and forms of dowry in South Asia over the past several decades have triggered a form of violence that is unique to the region—namely, dowry-related violence that often results in a young married woman’s death” (Solotaroff & Pande, 2014, p. 47-48). As seen in Table 4, the estimates of dowry related death are high across Bangladesh, India and Pakistan (we could not find estimates in Nepal).

Dowry related deaths can occur for a host of reasons ranging from harassment by in-laws for believing that the dowry was inadequate. This is also known to drive the women to suicide in some cases as in the case of India and Nepal (Jaising 1995| cited in Solotaroff & Pande, 2014, p. 48; Rao, 1997), while to murder in other cases that is covered up by being called a ‘kitchen accident’ (Jaising 1995| cited in Solotaroff & Pande, 2014, p. 48). On the opposite end, in places where bride price is the custom (the grooms family in a sense pays for the bride), and because it can be relatively high, it can lead to some families feeling the need to marry their daughters to settle debts as is shown in Afghanistan or lead to anger on the husband’s part for having to pay the bride price (Smith, 2009). In India, Burton et al., (2000) note that Despite the Dowry Prohibition Act of 1961, research indicates there was a 169.7 percent increase in dowry-related deaths from the year 1987 to 1991 and Solotaroff & Pande (2014) find that this rate is steadily growing.

Bangladesh

In Bangladesh, traditionally, Muslims exchanged Din-Mahr (bride price) but this seems to have been replaced by Joutukh (dowry) which became illegal in 1980 (Khan, 2005). Naved and Persson (2010) find that dowry was demanded 53 percent of the times in rural Bangladesh and 14 percent of the times in urban areas. Bates et al., (2004) found similar estimates in 2004 – 46 percent of married women had dowry agreements. However, around the same time, Islam et al., (2004) found a much higher rate i.e., 72 percent of women aged 15-19 had dowry given in their marriage. The relationship between dowry and IPV is fairly strong though there is still lack of clarity around whether absence of dowry is protective or not (Das, 2008). According to Naved and Persson (2010), the patriarchal attitudes that surround dowry exchange, are the reason underlying IPV related to dowry. Dowry suggests that women are a commodity and devalues their humanity. In some cases women who bring a dowry may feel more assertive and confident – a value that is not acceptable from daughter in laws. In other cases, families that demand dowry are also likely to find violence acceptable. Bates et al., (2004) suggest that unpaid dowry may result in dowry related deaths but also find that women with a dowry payment were more likely than those without a dowry agreement to report IPV in the past year (odds ratio 1.5).

Naved and Persson (2010) find that absence of dowry demand in marriage lowered the likelihood of physical wife abuse in the rural site. On the other hand, Suran et al. (2004) found that paying dowry is linked to higher likelihood of IPV (cited in Naved & Persson, 2010, p.833). Siddique (2011) in his survey finds that dowry was the most common reason cited for violence (24.4 percent).

Pakistan

No studies have researched the link between dowry and IPV in Pakistan, though Ali & Khan (2007) suggest that it may act as a risk factor since it may be the cause of disputes between husband and wife.

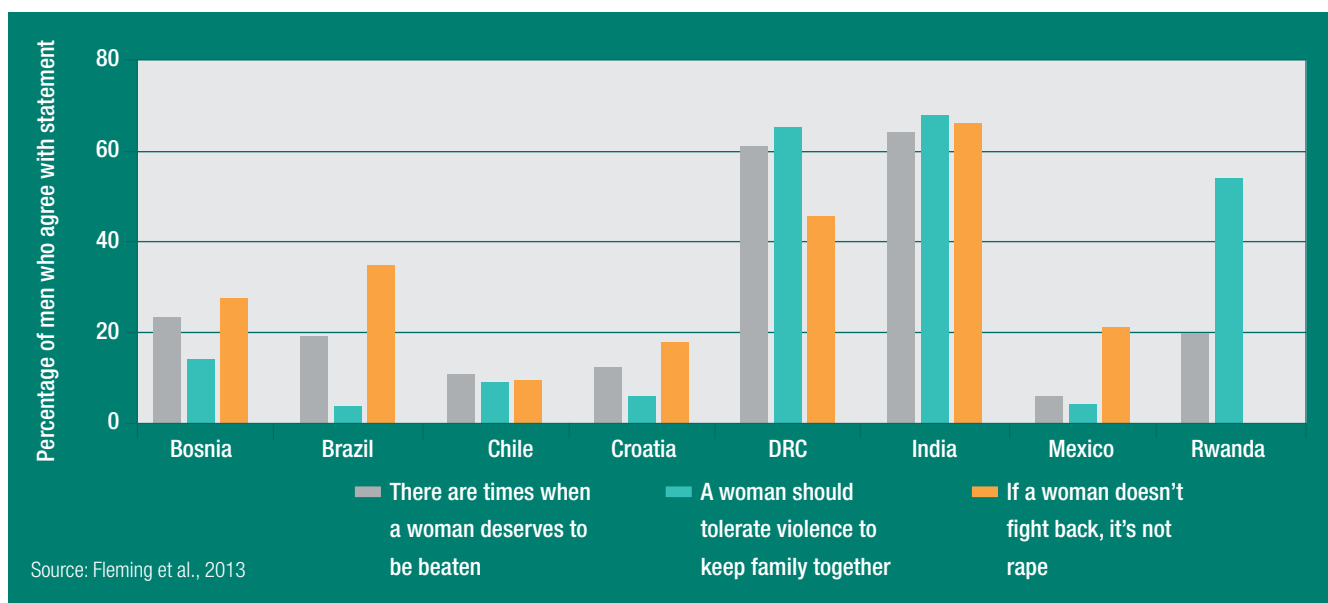
Nepal

Oshiro et al., (2011) in their sample of 900 women found that dowry was not significantly associated with violence in the general population. For urban poor on the other hand, existence of dowry was associated with higher frequency of the husband’s drinking which is a known risk factor for all types of violence in Nepal (see below). Furthermore, Hawkes et al., (2013) found that in interviews with 45 stakeholders who are involved in IPV and GBV work in Nepal and 6 women victims in Kathmandu and Terai, over 86 percent in Kathmandu and 63 percent in Terai completely agreed with the statement that “it is acceptable for a man to beat or mistreat his wife if she does not have a dowry”.

5.3.3 Norms around acceptability of violence

According to Jewkes, Sen, & Garcia-Moreno (2002), the general level of tolerance of violence against women in a community is a strong predictor of the rates of IPV in that community. Jewkes (2002) believes that gender inequitable societies are more likely to normalise violence against women. In a 2008 review of 10 recent Demographic and Health surveys (DHS), if a man agreed that wife beating was justified in one or more situations, it was a strong predictor of his wife being beaten in Bangladesh, Bolivia, Malawi, Rwanda and Zimbabwe (Hindin et al., 2008). Similarly, Abramsky et al, (2011) conducted analysis on data from population based surveys in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Republic of Tanzania, Samoa, Serbia and Montenegro, and Thailand and found that attitudes supporting wife beating increased the risk of IPV. According to Waltermaurer (2012) the link between acceptability of violence and IPV can be understood using the Social Justification model, which posits that the more a community feels that IPV is justifiable, the more the perpetrator is likely to feel that he/she is right when committing IPV. This is found to be true at household level as well. Children who witness violence between their parents learn that violence is an acceptable domestic strategy, which increases their risk of becoming abusers as adults (Black et al., 1999; Ellsberg et al., 1999) (see section 5.1.2). In the IMAGES study, men in the DRC and India

Figure 8: Men's attitudes towards physical and sexual violence against women from IMAGES study



reported highest incidences of acceptability of violence against women (Figure 8).

Studies have found that acceptability of violence is justified particularly when transgressions from gender roles occur (Heise, 1998; Hindin et al., 2008; Jewkes et al., 2002a). Others also suggest that social norms set by the society are very powerful and deviations from norms may lead to punishment through social exclusion, ostracism, and violence (Dorais & Lajeunesse 2004; Fleming et al., 2013). For instance, in Tanzania, women describe the degree to which norms around wife beating are acceptable when women digresses from what is expected of her: “It is very common if you refuse his orders you will be beaten, when he denies to start a business and you did it anyway, you will be beaten” (McCleary-Sills et al. 2013). The more gender inequitable a society, the more severe the punishment.

Often times, women themselves are enforcers of norms that perpetuate IPV. For instance, in an analysis of 52 developing countries, one in three women agreed that wife beating is justified if a woman goes out without permission (Klugman et al., 2014). Similarly, in a study of 17 Sub-Saharan African countries, wife-beating was accepted under certain conditions by both men and women, but women were more likely to justify it than men (Uthman et al., 2009). Cross-sectional studies in Vietnam (Krause et al., 2015) and rural Ethiopia (Yount & Li, 2009), and Zambia (Samuels et al., 2015) also find that women justify and find a good reason for IPV.

This is true in the South Asian region as well (Santhya et al. 2007; Hindin et al., 2008; Abramsky et al. 2011; Johnson and Das 2008) since the review finds that acceptability of wife-beating in the region is high ranging

from 29 percent in Nepal to 57 percent in India (Rani and Bonu 2009| cited in Naved et al., 2011; Jejeebhoy et al., 2013). Studies find that both men and women justify IPV with women justifying it as a coping mechanism (Santhya et al., 2007). Solotaroff & Pande (2014) use DHS from multiple countries and find that even though Bangladesh has the highest prevalence of intimate partner physical violence among married women in South Asia, ever-married women in India and Pakistan hold attitudes that most accept the violence (see table 5), with variations across countries for reasons to justify violence. In Bangladesh and Pakistan, arguing with one’s wife is considered the most acceptable reason for wife-beating. In Maldives, refusing sex is considered acceptable while in India and Nepal, neglecting children is the main reason for IPV. Similar findings have emerged from Sri Lanka (Jayasuriya et al., 2011) and Bhutan (NSB, 2011). Indeed, in Sri Lanka, de Mel et al., (2013) found that nearly 26.4 percent of men and 37.5 percent of women agreed with the statement “there are times a woman deserves to be beaten”. More than 66 percent of women and 58 percent of men agreed that “It is manly to defend the honour of your family even by violent means”. 58 percent of women vs. 40 percent of men believed that “A woman should tolerate violence in order to keep her family together”.

Though reasons for justification vary, most agree that transgressing from rules of the society are acceptable reasons to “control” and perpetrate violence against one’s wife in India (ICRW, 2000; Jejeebhoy et al., 2013; Rao, 1997), Bangladesh (Schuler et al., 1996), Pakistan (Qayyum, n.d.), Nepal (Nanda et al., 2012), Cambodia (Surtees, 2003) and Vietnam (Yount et al., 2013). However,

Table 5. Percentage of Ever-Married Women Who Think a Husband Is Justified to Beat His Wife

Reasons	Bangladesh	India	Maldives	Nepal	Pakistan
	2011	2005–06	2009	2006	2012–13
Burns the food/does not cook properly	4.2	17.8	7.1	2.9	18.4
Argues with him	22.6	27.6	18.7	7.6	33.7
Goes out without telling him	16.9	27.4	15.0	9.4	29.6
Neglect the children	18.4	35.4	20.5	21.0	31.1
Refuses to have sexual intercourse with him	8.3	12.5	22.1	2.6	30.6
She shows disrespect to/neglects in-laws	–	–	–	–	27.6
At least one specified reason	32.3	46.7	35.5	24.3	42.5
Number of ever-married women	17,796	121,853	6,845	10,767	13,558

Source: Solotaroff & Pande (2014) p. 37

Yount et al., (2013) find that women who have had more exposure to the outside world are less willing to accept the violence. Similarly, in India, Jejeebhoy et al., (2013) find that unmarried adolescents do not condone forced sex and consider it rape. However, married men and women had mixed responses on whether forced sex after marriage is acceptable, with most men stating that women do not have

a right to refuse sex unless they are unwell, pregnant, or menstruating (ibid.). Nevertheless, adolescents also tend to justify IPV, and Jejeebhoy et al., (2013) find that they do so more than adult women.

Bangladesh. The majority of the research coming from Bangladesh on acceptability of violence is secondary data analysis of population based surveys such as the BDHS or BUHS which generally find that there is a high level of acceptance of violence in the country (Bhuiya et al., 2003; Wahed & Bhuiya, 2007). The BDHS in 2004 indicated that 55 percent of men agree with wife-beating: 49 percent agree to it if the wife goes out without telling her husband, and 28 percent agree to it if a wife argues with her husband. In 2007, the BDHS found that most cited reason to justify violence (47 percent) was if the wife disobeyed the husband. Table 6 shows the degree of agreement with wife-beating by men and women's reports.

NIPORT et al.,s (2008) analysis of the BUHS 2006 and BUHS 2008 finds that about 48, 32 and 30 percent of women in the slums of the city, non-slum areas of city and District Municipalities respectively agreed with at least one reason for wife beating.

Rashid et al., (2014) examined the BDHS 2011 data and found similar findings to those in table 5. They also find that women from low- and middle-income background, with primary or no education, or women from rural households were more likely to justify wife beating than women from high-income, higher education background, and urban households. Moreover, women who are unemployed (and therefore living in low income households) are more likely to experience wife-beating with the reason cited above. They also found that women living in Chittagong, Rajshahi, and Sylhet were more likely to be beaten for the reasons cited above than women living in Rangpur, Khulna, and Dhaka.

Table 6: Reasons given for acceptability of violence BDHS 2007

Reason	Women	Men
Without any reason	31.1	7.1
Financial crisis	27.1	12.3
Wife neglected household chores	20.7	23.6
Wife disobeyed husband	15.7	46.9
Wife refused sex	15.3	2.6
Wife neglected children	14.4	8.7
Dowry issue	11.5	1.2
Envy or malice	7.4	14.0
Food crisis	5.5	2.5
Wife went out without permission	4.9	5.8
Husband unemployed	4.6	0.6
Other	11.6	10.7
Total	771	468

Table 7. Male views on domestic violence

Male views on...	percent of men who agree with statement
BA man has a right to exercise violence against his spouse	46.0
Domestic violence is tolerated by the general public	88.6
Domestic violence is a common problem in our society	74.4
Being a victim of violence in one's childhood makes one more prone to perpetrating violence	42.5
Those who grow up in households with domestic violence are more likely to be violent citizens	49.4
Need to create awareness about the existence of domestic violence	65.3
Help should be available for people who exhibit abusive behavior	56.3
Government should spend time and money to educate people	44.9

Source: Fikree et al., (2005), p. 55

In addition to national level surveys, other studies have shown much higher rates of approval of IPV. For instance, Schuler & Islam (2008) find that among 1200 women and men from 6 villages, 84 percent of women and 92 percent of men agreed with wife-beating for at least one reason. Similarly, Sayem et al., (2012) found that 84 percent of their sample of 331 women named one or more scenarios in which they said IPV was justified, with older women, less educated women and men agreeing with reasons more. Interestingly, Schuler et al., (2006) also found that women who accept violence as normal are less likely to experience it, though it is possible that those who condone violence are more likely to report it on surveys.

The reason for the vast discrepancy between acceptability rates of DHS surveys and other studies can be understood by arguments put forth by Yount et al., (2012) and Schuler et al., (2011) who suggest that there are limitations in questionnaire designed in the BDHS which may under-represent the proportions of women who justified IPV. For instance, Yount et al., note that many women tend to switch responses within the context of a single interview suggesting that one survey may not capture the full picture of IPV.

Pakistan

Data from Pakistan's DHS 2012 indicate that among men, those in Khyber Pakhtunkhwa are most likely to justify wife-beating (73.5 percent), followed by men in Balochistan (51.3 percent), followed by men in Sindh (37 percent) and Punjab (36.3 percent) (NIPS and ICF International, 2013). Two other studies examined attitudes towards IPV and the role of acceptability of violence as a risk factor. Fikree et al., (2005) studied 176 men and found that acceptability for wife-beating was high (see table 7). 46 percent of men agreed that domestic violence is a right of the husbands, and 89 percent believed that domestic

violence is tolerated by the public. The authors found that perpetrators of physical abuse were more likely to report acceptability of domestic violence – both individually and by the public - than non-perpetrators of physical abuse. They were also less likely to believe that there is a need to create awareness around domestic violence issues than non-perpetrators.

In a study by Partners for Prevention, Rozan and ICRW (n.d.), 39 interviews were conducted with 15-25 year old men and women. They found that men justified their behaviours by blaming women's attire, believing that rape cannot happen without the consent of a woman. Women's interviews also revealed a "chilling acceptance of domestic violence" (p. 16). Women reported that domestic violence occurs when women make mistakes such as disobeying their husband or doing something bad outside the house. Nevertheless, they reported that the punishment for doing such things was excessive and unfair. Others state that since a man cannot be violent with anyone outside, he is justified in beating his wife. Like men, women also believed that avoiding violence was the woman's responsibility. Moreover, sexual infidelity was considered as one reason why all women agreed that violence was justified.

Nepal

Dalal et al., (2012) found that as per the NDHS 2006, 28 percent of 939 male respondents (aged 15-19 years) had supported wife abuse. Logistic regression shows those boys who believe that a husband has a right to get angry with his wife are more likely to support wife beating compared with those who do not support this notion. Similarly, Joshi & Kharel (2008) cite studies from men advocates network and report that 11 percent of men below the age of 30 and 8 percent of men between 30-39 years justified wife-beating for refusing sex. This was also found in the recent

study by Pun et al. (2016) who in qualitative interviews found that men think that violence can be necessary and should be used if the “wife doesn’t understand”. In their own analysis, Hawkes et al., (2013) report that those who are less educated and from lower economic classes are more likely to approve of violence.

Role of religion in condoning acceptability of IPV Bangladesh

In contexts where religion plays a strong role in everyday life, it is the religious institutions and leaders that have an impact on norms and beliefs around masculinity. The role of religion in South Asia is by itself strong and the role it plays in justifying violence has been shown across several countries (e.g., Pakistan, Rabbani et al., 2008; Bangladesh, Schuler et al., 1996). In Bangladesh, Schuler et al. (1996) found that men use religious texts to justify violence as a means of control over wives, a finding that was corroborated by Johnston & Das, 2008. Using the WBSGN 2006, Das et al., (2008) found that older women are less likely to report ever experiencing violence if they practice

pardah (though this was not a robust relationship and this relationship did not hold true for younger women). Men are less likely to support violence (66 percent) and reduce their likelihood of violence by 37 percent if women practice *pardah*. The norms around *pardah* are strongly enforced. Hussain and Imam’s (2001) studied 100 male respondents aged 16-30 in Rajshahi and found 63 percent of the respondents supported *pardah*⁸ while 33 percent did not (cited in Rafi, 2003).

Pakistan

Surprisingly, there is only one study that empirically link religious beliefs with perpetration of IPV. In their study, Shaikh et al., (2008) found that 4.9 percent believed that religion allowed a husband to beat his wife, even if she has been faithful to him, while 21.3 percent believed that religion allowed a husband to forcibly have sex with his wife even if she does not want to engage in it. Similarly, P4P’ et al’s., (n.d) study found that religion was cited as the reason by men to justify their actions and their beliefs about restricting women’s freedoms.

8 A practice according to which a female does not physically come in front of men (except selected males, e.g., father, husband, brother) without covering all parts of the body accepting her face, foot, and wrist.

6. Legal landscape against IPV

There have been several strong reform measures undertaken by countries worldwide to provide support for victims of IPV. According to Heise (2011), as of 2011, 125 countries (including those in Latin America and the Caribbean) have passed legislation on domestic violence. Additionally, 18 Asian countries have introduced and passed specific laws on domestic violence – such as Malaysia. Similarly, in Sub-Saharan Africa, 21 out of 48 countries have enacted domestic violence bills by 2010 (UN women, 2010). Though there is progress, it remains insufficient. As of 2014, 20 countries had not criminalised domestic violence (Algeria, Armenia, Burkina Faso, Cameroon, Congo, Ivory Coast, Egypt, Haiti, Iran, Latvia, Kenya, Lebanon, Lesotho, Mali, Niger, Pakistan, Russia Federation, Syria, Uzbekistan and Yemen)⁹. In fact, in 2017, Russia passed a vote that decriminalized domestic violence by a 380-3 vote in favour of softening the laws on domestic violence¹⁰.

Most of the countries in South Asia have signed the Convention on the Elimination of All Forms of Discrimination Against Women (see table 2 above). According to Goonesekere and De Silva-de Alwis (2005), the standards set by the CEADAW have paved the path for other important legislation at national level in the region. Table 7 provides an overview of current legal provisions that protect women from gender-based violence for Bangladesh, Nepal and Pakistan.

As can be seen in table 7, in *Bangladesh*, there is a strong legal framework that recognises 30 different types of violence, including dowry related violence, acid attacks, and abduction--encompasses a number of conventions and laws on violence against women. For instance, notable actions have been taken by the government to protect women's legal rights and improve their social status such as the Dowry Prohibition Act, 1980, the Nari-O-Shishu Nirjatan Daman Ain, 2000 (Law on the Suppression of Violence against Women and Children, 2000) expanding the definition of rape and sexual assaults, Family Violence Prevention and Protection Act, 2010, and National Women policy, 2011 (Hossain et al., 2014). Recently, in 2014, a

Human Rights Council report of the Special Rapporteur on violence against women found that to increase women's participation in the political sphere, the Fifteenth Amendment Act of 2011 increased the number of seats reserved for women in Parliament from 45 to 50, though this only represents 20 percent of the total seats available in Parliament. In *Pakistan*, the right to live a violent free life, with dignity and equality in a just and equitable society is firmly established under the Constitution of the Islamic Republic of Pakistan and its international obligations. However, the complexity of the struggle for legal protection of women from violence is evident in the recent (early 2016) nationwide protest against the women's protection bill of Punjab by the religious parties, who call it un-Islamic, and demanded that it be withdrawn. In *Nepal*, a review of the last twenty years (1995-2015) by SAHAVAGI et al., (2015) shows that considerable number efforts have been put in place regarding gender based violence more generally: amendment of constitutional and legal framework to make it more gender friendly, increasing the number of women in institutions that give services related to GBV, and improving women's access to economic resources, land and property and microcredit. So far, 64 provisions have been amended and 19 schedules in addressing inequality issues in areas of divorce, abortion, marital rape and marriage have been enacted. Similarly, 56 gender discriminatory laws were amended following the enactment of GBV act in 2007 with an addition of 32 more in 2014 (FWLD and ICJ, 2014). Women's representation and participation in government services have also increased as a result of several steps taken by the relevant ministries (MoWCSW, 2014; NJA, 2014, 2016; SAHAVAGI et al., 2015). As a result, now women make upon 5.7 percent of the police force, 8.1 percent of the judges in the appellate courts and 1.2 percent of the judges in the district court. For more details on laws and policies in these focal countries, please see (Samuels, Jones & Gupta, 2017).

However, both in South Asia and globally, there is still a long way to do. When there are weak legal sanctions

9 http://www.huffingtonpost.com/2014/03/08/countries-no-domestic-violence-law_n_4918784.html

10 <http://www.cnn.com/2017/02/07/europe/russia-domestic-violence-bill-putin/>

Table 8: Conventions, laws, and acts on violence against women in Bangladesh, Nepal and Pakistan

Bangladesh	Nepal	Pakistan
1. Convention on the elimination of all forms of discrimination against women (1979)	1. Police act, 2012 B.S	1. Pakistan Penal Code 1860
2. The Dowry Prohibition Act (1980)	2. Libel and Slander Act, 2033	2. Family Laws Ordinance (1996)
3. The Family Courts Ordinance (1985)	3. Country Code, 2020 B.S	3. Criminal Law (Amendment) Act, 2004
4. Convention on the Rights of the Child (1989)	4. Crime and Punishment, Act, 2027 B.S	4. The Protection of Women Act (Criminal Laws Amendment) Act, 2006
5. Suppression of Violence against Women and Children Act, 2000 (the Nari O Shishu Nirjatan Daman Ain, 2000 (NSA))	5. Social practices (Reform) Act, 2033 B.S	5. Criminal Law (Second Amendment) Act, 2011
6. Domestic Violence (Prevention and Protection) Act (2010)	6. Children act, 2048 B.S	6. Dowry and Bridal Gifts (Restriction) Act, 1976
7. National Children Policy (2011)	7. Labor act, 2048 B.S	7. The Protection Against Harassment of Women at the Workplace Act, 2010
8. National Women Development Policy (2011)	8. Local Self Governance Act, 2055 B.S	8. Acid Control and Acid Crimes prevention Act 2011
9. Domestic Violence (Prevention and Protection) Rules (2013)	9. National Women Commission Act, 2063	9. Prevention of Anti-Women Practices (Criminal Law Amendment) Act 2011
10. Deoxyribonucleic Acid (DNA) Act (2014)	10. National Women commission Rules, 2063 B.S	10. Child Marriage Restraint Act 1929
11. (Draft) National Psychosocial Counselling Policy (2014)	11. Human Trafficking and Transportation (control) Act, 2064	11. Domestic Violence (Prevention and Protection) Bill, 2012
	12. Human Trafficking and Transportation (control) Regulation, 2065 B.S	12. Women's protection act (passed in Punjab) (2016)
	13. Domestic Violence (Offence and Punishment) Act, 2066	
	14. Domestic Violence (Crime and Punishment) Act, 2067	
	15. Gender Violence Elimination Fund (Operation) Rules, 2067 B.S	
	16. Gender Equality Act, 2006	

against IPV, the likelihood of committing violent acts is greater. The UN multi-country study on men and violence in the Asia-Pacific region finds that the vast majority of men who perpetuated rape (72-97 percent) did not experience any legal consequences (Fulu et al, 2013). Similarly, despite considerable reform over the past decade in the case of Singapore and Malaysia to improve the legislation and support for victims of IPV, Amirthalingam (2005) suggests that there are several defects such as failing to recognize domestic violence as a specific crime, defining domestic violence too narrowly, including unnecessary constraints on obtaining protection orders, discriminating against the victim with respect to residential rights, failing to extend protection beyond marital relationships, and failing to

recognize marital rape as an offence. Such limitations are likely to exist in many other countries, particularly LMICs. For instance, in Nepal, SAHAVAGI et al., (2015), found that inadequate enforcement of laws, lack of data and evidence base on VAWG, lack of wider implementation of affirmative actions and policies, and intersectionality of vulnerability are several weakness hindering IPV survivor's ability to access services in the country.

In addition to having laws in place to protect victims, studies have also examined whether it is important that the perpetrators know about the laws on VAWG and availability of services. In Nepal, NJA (2016) outlines that lack of knowledge about available services is a barrier to accessing services for victims of violence. Out of 1497

women who did not use any formal institutions for justice, 65.4 percent of women knew that there are legal redressal mechanisms, 25.8 percent knew that legal services are free, and only 16 percent of women (out of 282) who had reported their case in the formal institutions knew that court fees can actually be paid after the court process. Simply knowing that services exist is not enough as noted by NJA (2014) who found that though women consider financial problem as the most important barrier to seeking services, the second most cited reason is the cumbersome judicial process and difficulties in understanding the judicial language. In fact, out of the 1497 women surveyed in 2016, 78 percent felt that the courts and police offices need to be made more gender friendly, 84 percent felt that security measures for victims and witness were weak, and 21 percent said that court processes do not safeguard privacy of victims. In the IMAGES work, knowledge of laws and services produced mixed results: Only 59 percent of men in Bosnia were aware of any laws against VAWG, while 91 percent of men in Brazil and 85 percent of Indian men were aware of laws against VAWG. However, despite being aware of such laws, 26 percent of men in Bosnia, 24 percent of men in Brazil, and 37 percent of men in India reported perpetrating violence against women (Fleming et al, 2013).

Perhaps this variation can be attributed to variation across countries in their approach to legislation against violence. For example, there is tremendous variation in the legal definition of marital rape (Heise et al., 1994). In Bangladesh, marital rape is not criminalised unless the wife is younger than 13 years (Penal Code, 1860) whereas marital rape in China is not criminalized at all and in Sri Lanka marital rape is not criminalized unless husband and wife are judicially separated (*ibid.*).

Additionally, when the legal landscape of the country does not promote women's civil rights, the likelihood of IPV is higher. Several studies indicated that lack of economic rights and entitlements for women is linked to higher levels of IPV (Heise, 2011). Often times, the political economy of a country is often a driver for IPV. For instance, in Bangladesh, with economic gains in the country, there is an increasing demand for women in the labour force, which has had positive impacts on women's economic empowerment. Nazneen et al., (2011) provide evidence that IPV is declining in rural villages in the country as women's economic roles expand and they gain a stronger sense of their rights.

Moreover, fragility of the national context intersects with and influences the legal landscape that makes matters more complex. In her review of evidence, even though Heise (2011) finds that there is little empirical research available to evaluate whether rates of IPV are higher in

fragile versus well-functioning states, others argue that while the severity, frequency, and purpose of this violence increases during times of conflict or emergency, "its foundations are laid during "peacetime," as is underscored by the extreme levels of violence observed consistently across the globe" (Heilman et al., 2014: 3).

The general trend that emerged from the articles reviewed was that in conflict settings, the likelihood of men perpetrating IPV increases. For instance, Fleming et al., 2013 report that areas of conflict or post-conflict typically have much higher rates of violence against women, especially sexual violence. National level studies in the DRC for instance find that more than half of ever-partnered women (56.9 percent) reported being physically assaulted by an intimate partner and more than one third (35.4 percent) report experiencing sexual assault by an intimate partner (Ministère du Plan, Macro International, 2008). Similarly, in 2008, IRC conducted a survey in Côte d'Ivoire and results showed that 50 percent of ever-partnered women had experienced physical and/or sexual IPV in their lifetime and 84 percent of men agreed with the statement: 'a woman should obey her husband even if she disagrees' and nearly half of men (47 percent) affirmed at least one reason when it was acceptable for a man to hit his wife (Hossain et al., 2014).

According to Eckman (2007), in the context of conflict, multiple masculine identities are shaped and reconstructed resulting from the intersections of masculinity with religion, nationality and ethnicity which are themselves being redefined. Domingo et al., (2013) in their review of evidence find that during times of conflict, women experience economic empowerment while men experience the opposite. For instance, Petesch (2012) finds that in states such as Afghanistan, Liberia, West Bank and Gaza, females become empowered when they have to search for economic opportunities, while men's identity faces emasculation as a result of poor economic conditions post-conflict. Fleming et al, (2013) suggest that certain contexts can also facilitate violence against women, manifested by an increase in impunity of perpetrators as social institutions that prevent violence become unenforced or ineffective. In post-conflict settings, this is more common since many times courts and institutions responsible for preventing violence are not established or repaired (UN Women, 2013). Interestingly, in the review of evidence by Heise (2011), only one cross-sectional study from Palestine, which was robust and well-designed enough to show effects, found that rates of partner violence are 90 percent to 120 percent higher among men directly exposed to political violence compared to those who are not.

7. Programming efforts on preventing male perpetration of IPV

Given the magnitude of IPV as described above, there have been numerous programming efforts to prevent IPV in both high income (HIC) and low and middle income (LMIC) settings. However, most primary prevention programmes to prevent intimate partner and sexual violence have mainly been evaluated in HIC and little is known of their suitability or effectiveness outside such countries (Taylor & Barker, 2013). In high income countries, programmes are largely focused on i) women's economic empowerment, ii) reducing childhood exposure to violence, iii) legal and justice reform, iv) reducing alcohol use, and v) gender norm change (Heise, 2011).

The majority of the programming efforts have focused on intervening with women victims and survivors of IPV. For instance, with respect to women's empowerment, there is emerging evidence of the effectiveness in LMICs of empowerment and participatory approaches in preventing IPV through microfinance combined with gender-equality training (e.g., Gupta et al., 2013). One of the most rigorously evaluated and successful microfinance and women's empowerment programmes is the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) in South Africa. IMAGE incorporates education sessions and skills-building workshops with microfinance modalities to help change gender norms, improve communication in relationships and empower women in other ways and has been shown to be effective at reducing IPV (Kim et al., 2009). However, Heise (2011) notes that the issue of whether microfinance programmes “empower women” is of considerable debate (Kabeer, 2005). The IMAGE study is one exception which found that after two years, combined microcredit and empowerment initiative halved the rate of physical and sexual partner violence, though the positive findings of microfinance in the IMAGE work were found to be a result of the Sisters of Life community education. Similarly, in a randomised experiment in Burundi, a savings and loan association was combined with discussion for groups for couples and that resulted in increased decision-making for women, but no decrease in rates of IPV.

Recognising that to be most effective, men need to be engaged and included in programmes as much as women, a shift has occurred such that national governments and international agencies have affirmed the need to involve men in work addressing gender equality (Dunkle & Jewkes 2007; Fleming et al., 2013; Flood, 2011; Heise, 2011; Taylor & Barker, 2013). Much of the increased programming engaging men and boys was initiated by the United Nations International Conference on Population and Development in Cairo, Egypt, in 1994, and the Fourth World Conference on Women in 1995, both of which documented the need to involve men and boys in the push for more equitable gender norms (UN, 1994).

7.1 Involving boys and men in programming efforts

Historically, programming efforts to stop and reduce IPV began with creating shelters for women victims to provide them sanctuary from their abusers (Jewkes et al., 2014). Men were largely invisible from all efforts since this was a time when gender in development language (and action) implied only women. In this scenario, men were seen as the violent perpetrators and women were the victims, with programmes ignoring boys and men as active agents in primary prevention. Following this, the next era of interventions paid attention to men as being responsible and part of the problem of violence. In the 1970s, programmes for men who commit IPV emerged in the US and parts of Europe (Taylor & Barker, 2013). The programming language began to view “men as partners” and as active bystanders who could play a role in prevention. However, it was not until men began to be understood as being part of a gendered relation between individuals, that there was a focus on relationship-level and community-level changes and work with groups of women, men, boys, and girls (both separately and together) were conducted to influence dynamic processes of gender relations and norms (Jewkes et al., 2010).

Jewkes et al., (2010) propose that IPV is “characterised by an understanding of gender inequalities as systemic

and violence as an instrument of this oppressive system”. Recognising that gender inequalities are embedded in a larger system of norms and beliefs is therefore crucial. The focus on systems calls for more structural level changes in programming efforts so that all levels of the social ecology can be affected. As a result, over the past two decades, men have been targets of interventions aimed at transforming gender norms. According to Flood (2011), boys and men are now involved in multiple capacities such as participants in education programmes, as targets of social marketing campaigns, as policy makers and gatekeepers, and as activists and advocates.

The 2003 World Health Organisation Report (Rothman et al., 2003), identifies programming that involves men in almost every region of the world – though Taylor and Barker (2013) note that in the Global South and regions with limited resources, these programmes are rarely evaluated (more below). Nevertheless, programming with men have three common features (*ibid.*):

- A theoretical orientation (i.e., with the aim being to end men’s perpetration of IPV)
- A voluntary or mandatory participation of men
- A degree of coordination with related health sector services, the criminal justice system, and the community (CCR).

In their review of programmes on IPV which focus on men as equal partners in reducing IPV, Taylor and Barker (2013) find that most of the programmes use a combination of cognitive-behavioural, psychotherapeutic, and gender-based or feminist approaches. Almost all programmes are embedded in a gender based approach which questions the power dynamics between men and women. Additionally, they may also include cognitive-behavioural approaches which assume that behaviour that is learned can be unlearned. One example of a programme that combines both gender and cognitive-behavioural approach is from the USA, known as the Duluth model. In this programme, a curriculum is developed that helps men recognise the violent and non-violent behaviours they use. This model has been replicated in all 50 states in the US and in 17 countries. Psychotherapeutic approaches tend to focus on past histories of violence, such as the reflective men’s group programme in Brazil which uses mixed-sex facilitators to help men arrive at their own awareness of the harm they cause through violence. A similar psycho-educational model was supported by UN women in the Caribbean (Grenada, Trinidad and Tobago, St. Lucia, Jamaica, and

Belize) called Partnership for Peace where a 16-week court mandated programme is for men to confront their harmful notions of masculinity and women.

In South Asia, involving men and boys is recent phenomenon. Platforms such as South Asian Network to Address Masculinity (SANAM) and MenEngage that create networks of NGOs working on ending VAWG by engaging men and boys have a strong presence in South Asia (Bangladesh, Nepal, Pakistan, India, and Sri Lanka). Though documentation of programming efforts in the region is somewhat sparse, there is evidence that NGOs and governments are picking up the mantle to involve men in their efforts against VAWG. For instance, in Nepal, though involving men and boys to address IPV in Nepal is a recent phenomenon it has been actively taken up by the government as well as non-government institutions such as CARE, UNICEF, UNFPA. However, apart from the county plan and country report documents of these institutions, there are no other resources providing any more information on programming efforts. Men and boys are engaged to become messengers to stop both IPV and GBV and as beneficiary trainees to address GBV. UNICEF and UNFPA programmes have mobilised male religious leaders to sensitize community about GBV while training adolescent boys about gender perspectives in daily life. Others organisations such as CARE and PLAN have been providing gender-sensitive trainings to both unmarried adolescent boys as well as married couples as a way for addressing GBV. Using famous media personalities to raise awareness against IPV is another strategy being utilised by the Nepali government.

Table 8 below summarises global efforts that involve men and boys in programming, though by no means is this table an exhaustive list of ongoing programmes.

7.2 Types of programmes

With numerous types of prevention efforts around the world with boys and men (see Table 7¹¹), Flood (2011) suggests categorising into the “spectrum of prevention” framework. This model organises the prevention efforts into five sub-groups, as listed on page 50.

Heise (2011) notes that the most “common strategies funded to combat violence in LMICs are awareness and advocacy campaigns” (p.14). For instance, an example of engaging, strengthening and mobilising communities is the UNiTE to End Violence Campaign by UN Women and the Office of the Secretary General to raise public awareness and seeks to increase political movements and resources for preventing and responding to violence against women

11 The information in this table is based on secondary sources and information on programmes was often limited or unavailable. As a result, this table is not an exhaustive list of programmes on boys and men. It is meant to provide a glimpse into the types of global programming on boys and men that currently exist. Where information was not easily available, we have used N/A.

Table 9: Five sub groups for IPV prevention efforts with boys and men' and numbered appropriately.

Strengthening individual knowledge and skills	Enhancing an individual's capability of preventing violence and promoting safety. For example, teachers, carers, and physicians may help boys and young men to increase their safety and their equitable attitudes; health care practitioners may engage patients and parents to promote healthy relationships; and other community leaders and public figures may speak to boys and men to encourage nonviolence (Davis, Parks, and Cohen 2006).
Promoting community education	Reaching groups of people with information and resources to prevent violence and promote safety. This can be done through four streams of education: face-to-face educational groups and programmes; communication and social marketing; local educational strategies such as "social norms" and "bystander" approaches ¹² ; and other media strategies.
Educating providers	Informing providers who will transmit skills and knowledge to others and model positive norms.
Engaging, strengthening and mobilising communities	Bringing together groups and individuals for broader goals and greater impact.
Influencing policy and law	Enacting laws and policies that support healthy community norms and a violence-free society

Adapted from Flood (2011), p.361

and girls. Similarly, the 16 days of Activism against Gender Violence is an annual programme spanning across various countries (e.g., Nepal) for local groups and local media to raise awareness on this issue.

Another set of commonly used and evaluated programmes fall under promoting community education (Flood, 2011). There is emerging evidence of programming efforts reducing IPV by changing social and cultural norms through working with men and boys (e.g., Pulerwitz et al., 2015 in Ethiopia). These are generally aimed at changing social norms around masculinity, power, gender and violence by increasing an individual's knowledge and awareness and their changing attitudes towards gender norms and violence. Such programmes usually involve small-group education sessions where men question their gender roles, behaviours, and treatment of women. Other programmes aim to develop the capacity and confidence of boys and young men to resist social dictates and intervene against violence, with the goal of changing the social climate in which it occurs. Noteworthy examples of such programmes are Programme H, one of the most well documented programmes in Brazil and Mexico. This programme has been expanded to India, Tanzania, Croatia, Vietnam, and countries in Central America. In Pakistan, one noteworthy example of such a programme is Rozan's Men's Program Humqadam which ran from 2009-2011. Humqadam attempted to uncover notion of masculinity through a mixed-method approach, developed a 'series of group education sessions' for young boys with an aim to mobilize youth at the community level, and trained

community based organizations and NGOs for capacity development.

There have also been several school-based interventions that use the school curriculum to teach about gender related topics; examples include the Gender Equality Movement in Schools intervention in India (Ahchyut et al., 2011). Other programmes using these strategies include the International Center for Research on Women's Parivartan (Das et al., 2012), a school-based intervention in India where trained coaches promote violence prevention. This is done by engaging coaches as positive role models and training them to deliver messages to their male athletes about the importance of respecting women and understanding the negative effects of violence. The programme also teaches skills to speak up and intervene when witnessing harmful and disrespectful behaviours.

An interesting approach has been to mainstream gender into existing research work such as the work done by AMAL in Islamabad, Pakistan. AMAL primarily works with marginalized youth and has three major work streams i.e. HIV and AIDS, Youth Empowerment, and Gender Rights using advocacy, training and capacity development as key strategies. AMAL integrates men's involvement in their work streams through different projects and research studies instead of a single programme. For instance, their recent work was a project on mainstreaming gender into HIV and AIDS to challenge masculinities in a gender-based violence program that ran from 2013-2014. Similarly, they initiated a project called 'Breaking the Male Code'. This project focused on transforming customary practices

12 A bystander approach attempts to instill "a sense of responsibility and empowerment for ending sexual violence on the shoulders of all community members" (Flood, 2011: 367).

of forced marriages like Vanni and Swara in Punjab and Sindh by engaging men. Key strategies included engaging male celebrities, organized dialogues in university, and recitals as strategy for countering forced marriages.

7.3 Evaluating effectiveness of IPV programmes involving boys and men in South Asia

All reviews of current evidence find that an overwhelming number of evaluation studies of programmes that involve boys and men come from high income countries (Ellsberg et al., 2015; Taylor & Barker, 2013; Solotaroff & Pande, 2014; WHO & LSHTM, 2010). Nevertheless, despite lack of evidence in South Asia, WHO and LSHTM (2010:34) state that “generating of evidence and the incorporation of well-designed outcome evaluation procedures into primary prevention programmes are top priorities everywhere”.

There have been several evidence reviews from experts in the field on the effectiveness of programmes tackling IPV, with a few focused on LMICs (e.g., Bourey, 2015; Ellsberg et al., 2015; Heise, 2011), even fewer focused on programmes with boys and men specifically (e.g., Barker, 2007; Taylor & Barker, 2013), and just one focused on South Asia (Solotaroff & Pande, 2014). In 2007, Barker et al., reviewed 58 programmes working with boys and men, of which a large number 41 percent ($n = 24$) were from North America, while the rest were distributed between Europe, Sub-Saharan Africa, North Africa, Middle East, Latin America, and Asia. In terms of primary prevention programmes, out of 13 programmes, only five were implemented in LMIC. Their results indicated that four of these 13 programmes were judged to be “effective” (e.g., the Nicaraguan programme judged to be effective was called ‘Violence against women: a disaster we can prevent as men’); six “promising”; and three “unclear”. Their evidence review suggested that men and boys, as a result of relatively short-term programmes, show changed attitudes and behaviour related to: sexual and reproductive behaviour; maternal, newborn and child health; their interaction with their children; their use of violence against women; questioning violence with other men; and their health-seeking behaviour. Most interventions did not go beyond the pilot stage and as a result, impacts were measured either immediately after the intervention or only a few months post intervention. Additionally, if a programme’s description clearly discussed gender norms and the social construction of masculinity and made efforts to critically discuss, question and/or transform such norms in the programme, then the programme showed strong evidence of achieving behavioural change among men. Most importantly, a holistic approach, i.e., integrated programmes and, specifically, programmes that combined group education with community outreach, mobilization and mass-media campaigns, was more effective in changing

behaviour than group education alone. Known as ‘gender transformative approach’, strategies that “challenged rigid gender roles and included critically questioning both the influence of social-cultural, community, and institutional factors as well as individual beliefs and attitudes” were found to be most effective (Carlson et al., 2015, p.1409).

“Gender transformative approaches encourage critical awareness among men and women of gender roles and norms, promote the position of women, challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers or traditional leaders”.

Our review found that evaluation evidence from South Asia is limited and uneven in coverage, with most of the evaluated programmes having been implemented in India. In their evaluation of interventions addressing violence against women and girls, Solotaroff & Pande (2014) found only 14 (out of 101) on-going programmes that involved boys and men. Of these 14, most were aimed at reducing and preventing intimate partner violence. In our review of studies in Nepal, for instance, we found that except for an ODI study (Ghimire and Samuels, forthcoming), there are no studies that have documented the impact of engaging men and boys in addressing IPV.

Those programming efforts reviewed indicated that with respect to individual programmes, evaluation studies of educational programmes that include face-to-face interaction, particularly focused on changing social norms and behaviours for boys and men find had been effective. Most existing intervention research finds that when men reflect critically about the assumptions underlying masculine ideology and gender inequity in the society, men are likely to become less complicit in maintaining those power imbalances themselves (Barker et al. 2010; Jewkes et al., 2006). For instance, discussion groups are used to help men question gender roles and other forms of gender inequality, including the construction of masculinity in India (Verma et al., 2008). Evidence from Programme H showed that after weekly educational workshops and a social marketing campaign, men reported more gender equitable beliefs and improved attitudes towards IPV (Pulerwitz et al., 2010). Specifically, those who participated in activities from Programme H reported more acceptance of domestic work as men’s responsibility, improved condom use and improved quality of relationship with spouse (Verma et al., 2008). This has been replicated in India where a more than two-fold decline in occurrence was found between intervention and follow up in men’s support for gender-inequitable norms and in self-reported violence against a partner relative to a comparison group (ibid.). In India, the Stepping Stones evaluation study found that while diffusion of the information into the community

was limited, participants remembered the information from the training, even though it had occurred 2-3 years earlier (Bradley et al., 2011).

Educational programmes like Programme H have also utilised creative social marketing modalities such as developing postcards, banners, comics, and a film, which drew on mass media and youth culture to promote gender-equitable attitudes among young men and women. For instance, in India, the NGO Breakthrough's programme, *Bell Bajao*, used series of television, radio and print ads and recruited male celebrities to help raise awareness around violence against women among the youth. Evaluation of the programme suggested that the campaign changed attitudes around domestic violence (from 53 percent at baseline to 61 percent at endline surveys) and reached more than 130 million people in 2008 through its media, print and TV strategy (Silliman et al., 2011).

With respect to programmes on reducing alcohol use, Heise (2011) cites a systematic review published in the *Lancet* that indicates that with respect to brief interventions, there is evidence that when intervention target individuals who show early signs of alcohol abuse, (i.e., some hazardous and harmful alcohol use but are not severely dependent), relatively simple advice from health workers can have a positive effect. With respect to structural evidence, Heise (2011) in her review finds compelling evidence that reducing alcohol supply, enforcing drinking age, regulating the times alcohol is sold, and/or increasing the cost of alcohol has far reaching effects. At the community level, though only a few interventions have taken place in developing countries, integrating alcohol abuse with HIV programming is showing positive effects. For example, in India, the programme RISHTA (meaning relationship), began in 2001 and surveyed over 2,000 men. After the programme ended, a significant drop in overall alcohol use, reduction in risky activities with friends, more gender equitable attitudes, and reduction in extramarital sex was noted (Schensul et al., 2010). With respect to individual treatments, there is evidence that programmes like Alcoholics Anonymous works at individual level, though evidence of whether it works at population level is lacking (Ye & Kaskutas, 2009).

Heise (2011) notes that programmes that seek to only raise awareness through advocacy efforts may not be as effective in changing social norms, but can be helpful in starting a dialogue around important topics like VAWG. The one exception is Oxfam's "We Can Campaign" where an evaluation research in 21 sites over 5 countries (Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka) has shown that pairing communication strategies with local change agents may be responsible for reducing

acceptance of violence in the communities (William & Aldred, 2011). Solotaroff & Pande (2014) in their review found that We Can Campaign's evaluations have found that more than 3.9million "change makers" have been recruited across all 5 countries and that the programme has been effective (with variations between countries).

Currently, there remain a few weaknesses of existing programming efforts with boys and men and IPV both globally and in South Asia. Firstly, there is a strong need for evaluation studies to focus on South Asian countries in order to ascertain best practices which can also be adapted to different LMICs including those in resource poor settings. Ellsberg et al., (2015) state that "much research has been done on interventions for perpetrators, with little evidence of effectiveness" (p.1). In addition, there is a need to recognise that boys and men are not a homogenous group and therefore tailoring programming for these different groups is also critical. For instance, men facing high levels of poverty require a different approach given this vulnerability when compared to men who may not face the added stresses of economic strain. Moreover, targeting adolescent boys vs. older men need different tailored programme strategies. Additionally, when designing a programme, it is important to pay attention to the ways in which a focus on attitudes alone may neglect the structural violence and institutional inequalities which are shaping sexual and IPV (Edstorm et al., 2015). Perhaps this sole focus on changing attitudes may be why awareness raising programmes have been largely ineffective in creating social norm change (Heise, 2011). Moreover, as the literature has indicated, risk factors such as women's financial empowerment are complex and may have short or long term risks for the woman. Therefore, programmes with microfinance options that aim to provide economic empowerment must be cautious and ensure consistent and strong M&E. Taking cues from good programming that incorporate gender training with microfinance options may be a good start. Similarly, research indicates that since poverty is not a singular construct that places men at risk univocally, it is important to consider under what conditions poverty acts as a risk factor. For instance, Fulu et al., (2013) finds that in the UN multi-country study, factors related to poverty were only associated with IPV perpetration in the least developed countries, depression was a risk factor mainly in Cambodia and Bangladesh, and men's gender attitudes were important only in Bangladesh and Cambodia, which are countries that have more strongly inequitable attitudes to gender overall. Thus, adapting programmes from one context to another requires both caution and tailoring to that context.

Table 10: Programmes for boys and men involved in IPV globally

Name	Location	Date	Funder	Implementer	Target	Number of people reached	Aims	Main achievements
Global								
16 days activism against GBV	Over 70 countries ¹³	Nov and Dec 2015	UNFPA	Varied depending on country	Men and Women	N/A	To raise awareness and create forum for discussion between different religions to empower adolescent girls and end gender-based violence	N/A
Men as Partners	Started in South Africa; now in more than 15 countries in Africa, Asia and Latin America	Established in 1996	N/A	Engender Health	Urban, semi-urban and rural communities in 8 of SA's 9 provinces	N/A	To challenge the attitudes, values and behaviours of men that compromise their own health and safety as well as the health and safety of women, and to encourage men to become actively involved in preventing GBV	<ul style="list-style-type: none"> Shifting men's attitudes about gender and VAW In a post-training evaluation of attitudes among MAP participants in the Western Cape (http://www.endvawnow.org/uploads/browser/files/Men%20as%20Partners_Dean.pdf), 71% believed that women should have the same rights as men; 82% thought it was not normal for men to sometimes beat their wives
Program H	Brazil, Mexico, Bolivia, Colombia, Jamaica, India	2002-2012	MacArthur Foundation, USAID and SSL International	Promundo	In Brazil, low-income urban-based men aged 14-25	750	To encourage critical reflection about rigid norms related to manhood	<ul style="list-style-type: none"> Men reported Improved relationships Lower rates of sexual harassment and VAW Greater willingness to take on domestic work More gender-equitable attitudes and behaviours generally
South Asia								
ABA MERO PALO	Rupendehi and Kapilvastu, Nepal	May 2013 – April 2017	CARE Nepal	Dalit Social Development Centre (Kapilvastu) and Siddhartha Samudhyak Sansthan (Rupandehi)		N/A	The project focuses on facilitating and learning from innovative strategies to influence change-makers and root causes (drivers) of child marriage and early forced marriage in Nepal	N/A

13 Including Canada, USA, Belgium, France, Jordan, Brazil, Democratic Republic of Congo (DRC), Venezuela, Nepal, Indonesia.

Name	Location	Date	Funder	Implementer	Target	Number of people reached	Aims	Main achievements
South Asia								
Adolescent Development And Participation (ADAP) Programme	Mugu, Humla, Achham, Bajura, Saptari and Dhanusha, Nepal	N/A	UNICEF	N/A	Inter-faith communities, and adolescent girls and boys	N/A	ADAP aims to empower adolescents to initiate and sustain activities and interventions that create positive transformation in their families, communities and society as well as bringing about realisation of their rights. The programme seeks to ensure the systematic, ethical, meaningful and regular participation of adolescents at critical levels to make adolescent-sensitive national policies, plans and budgets	Growing from a pilot-level programme to national-level programme now in process of being phased/ scaled-up to many districts
Bell Bajao	India	Since 2008	MFA Netherlands, SAVE, Google, Oak Foundation, UN Trust Fund to End VAW	Breakthrough	General public	<ul style="list-style-type: none"> • 15,000+ youth and community leaders trained • 76,000+ people reached by community advocates • 240m+ exposed to multimedia campaign • 7.5m+ sensitised by video van 	To reduce domestic violence and highlight the role that men and boys can play in reducing violence	<ul style="list-style-type: none"> • Baseline and endline studies show that Bell Bajao has achieved an 11.5% increase in awareness about India's Protection of Women Against Domestic Violence Act and a 15% increase in requests for services for women • Reached more than 130m people and become part of mainstream conversation and the public lexicon in India • Increased knowledge and changed individual and community attitudes towards domestic violence (DV) • Changed individual behaviours and made significant headway in reducing stigma and discrimination against HIV-positive women
Building capacity of women for ensuring inclusive participation in decision-making	Nepal, six VDCs of Sunsari district	2015-2017	Dan Church Aid	Jagaran Nepal	Men and boys	N/A	Objective of the project is 'To ensure inclusive participation of women in decision-making in state policy, political and social institutions'	To increase active participation of women in decision-making within political parties, state mechanisms and social institutions

Engaging Men in GBV Prevention via Community Leadership Councils	India	2010	Promundo, UN Trust Fund to End VAW	Grameen Vikas Jan Sahbhagita Trust Jaunpur and Ujala Welfare Society	Men and women aged 18-48 (rural, low-income setting); the local leadership council, Panchayats, were targeted	150 young men through youth groups and community centres 1,500 young and adult men through advocacy campaigns and community outreach	To engage boys and men in ending GBV	Positive improvements in self-reported attitudes towards VAW, decline in self-reported use of physical violence, mixed results in self-reported changes to behaviour with the workshop participants; limited to no change among the community-wide sample
Goal for social cause	Nepal	N/A	N/A	Sathi, Nepal	Young men and boys/male players	N/A	Using football to create awareness about VAW in Nepal	N/A
Humqadam	Rawalpindi, Pakistan	N/A	N/A	N/A	Young men and boys	N/A	The intervention package in Rehmatabad consisted of numerous activities aimed at improving boys' and men's understanding of GBV and its link to masculinities	<ul style="list-style-type: none"> • Changes in attitudes towards VAW, including IPV • Participants' increased ability to draw a line between what society/religion thinks and what their own views are • Greater acknowledgement of women's potential and the need for more gender-equitable male roles in relationships with women • Boys more likely to say that a woman should not tolerate violence in order to keep the home together
Men's Action to Stop Violence against Women Campaign (MASVAW)	India	2001	Unanimous decision to not be funded since it's a platform	Centre for Health and Social Justice	Men and boys of all ages (universities, schools, elders, etc.)	State-wide community intervention initiative	<ul style="list-style-type: none"> • To increase the visibility of VAW and facilitate the process of challenging attitudes and beliefs around it • To increase awareness among men about VAW as a larger social issue • To motivate men to shun violence, protest against violence, support survivors and provide new role-models 	<ul style="list-style-type: none"> • Men gained a new definition of violence while recognising their own violence • Growing realisation among men that social change is not only about changing others but about changing themselves as well • Reduction in coercive sex • Men developed a greater understanding of VAW and their own culpability
Mobilising Men	India	2010	UNFPA	Centre for Health and Social Justice	University campuses, within govt, and with Dalit communities	N/A	To challenge some of the most common forms of institutional VAW, in the workplace, on campus and in the community, by mobilising men	N/A

Name	Location	Date	Funder	Implementer	Target	Number of people reached	Aims	Main achievements
Parivartan: engaging coaches and athletes in fostering gender equity	Mumbai, India	2008-2012	Nike Foundation, ICRW, Apnalaya, Mumbai School Sports Association, Breakthrough	Apnalaya, Breakthrough and Mumbai School Sports Association	Cricket coaches and mentors in schools and community; adolescent boys in community	336 athletes	<p>By engaging cricket coaches and mentors, the programme seeks to:</p> <ul style="list-style-type: none"> – raise awareness about abusive and disrespectful behaviour; – promote gender-equitable, non-violent attitudes – teach skills to speak up and intervene when witnessing harmful and disrespectful behaviours. <p>By becoming partners in preventing violence and promoting gender equity, the male coaches/mentors and athletes thus would contribute to transforming damaging social norms that condone abuse against women and girls and improve their safety</p>	<ul style="list-style-type: none"> • Positive shift in gender attitudes • Decline in sexually abusive behaviours • Coaches/mentors less likely to justify men's control over their wife's behaviour
Raabta (in English 'contact')	Islamabad, Pakistan	2000 to 2004	N/A	Rozan	N/A	4,000 male and female newly recruited and serving police officers of various ranks including constables through to senior superintendents	<p>Improve the relationship between the police and communities in Pakistan by providing training to increase the self-awareness and life skills of police personnel, to improve their knowledge of gender issues, and to enhance their capacities to deal effectively and sensitively with cases of VAWG</p>	<p>Key achievements of the Rabta programme include Rozan's formal partnership with police leadership and the institutionalisation of its training module into the official training curriculum for new recruits and serving officers. The programme has developed incrementally over the past 11 years in response to changing gender relations and feedback from participants and partners. In its first two phases (2000-2004), and in partnership with Islamabad Police and the National Police Academy, it trained more than 4,000 police officers</p>
Protecting Human Rights	Bangladesh	2011-2016	USAID	Plan Bangladesh, Bangladesh National Woman Lawyers' Association, International Center for Research on Women, and 18 local NGOs	Boys, girls, men and women	N/A	<ul style="list-style-type: none"> • Improve mutual understanding and effectiveness between key actors involved in reducing violence and strengthening other interwoven human rights • Increase access to and willingness of survivors to seek justice through formal and informal sectors • Expand immediate and longer-term support to survivors of DV • Increase awareness on DV and related human rights issues at national and local levels 	N/A

SAFE	Dhaka, Bangladesh	2010-2014	N/A	Bangladesh Legal Aid and Services Trust, Marie Stopes Bangladesh, We Can Campaign, Population Council, ICDDR,B	Females aged 10-29; males aged 18-35; community members	N/A	SAFE worked in the community and in service delivery locations to improve access to critical sexual and reproductive health (SRH) and violence-related services offered in conjunction with prevention programmes	Engaging men through interactive group sessions was most effective in addressing gender-inequitable attitudes among males and females in the community <ul style="list-style-type: none"> • SAFE is the first programme in the developing world demonstrating a reduction in spousal violence against women and girls in the community • Physical or sexual spousal violence against adolescent girls reduced when both females and males were offered group sessions • Economic violence against adolescent girls increased when only females were targeted, but decreased when men were targeted • Interactive female group sessions reduced economic violence against women aged 20-29
SAKCHAM III	Makawanpur, Chitwan and Kapilbastu, Nepal	January 2013-December 2015	Austria Development Cooperation and nationally run by CARE Nepal	Dalit Social Development Centre, Kapilvastu Kalika Community Women's Development Centre, Chitwan Rural Women's Service Centre Makwanpur	Men campaigners and supportive men as change agents for gender equality	N/A	SAKCHAM III seeks to strengthen and build the capacity of women-led cooperatives in collaboration with government offices, initiate 'gender violence-free' VDCs and women empowerment strategies in collaboration with government (DDC, WCO, VDC) by creating awareness in both men and women groups	NA
SUMARGA: The Power of Informed Reproductive Decisions	Nepal (20 out of 75 districts)	2003	CREHPA	District-based NGOs	Couples (husband and wife)	N/A	Contribute towards improving maternal health by creating positive environment to enable women and couples to make informed decisions on pregnancies, including termination of unintended pregnancies through alliances, partnerships, mobilisation, education, research and advocacy initiatives	N/A

Name	Location	Date	Funder	Implementer	Target	Number of people reached	Aims	Main achievements
Training for battered women's advocates and activists on Women's Human Rights – addressing domestic violence and sexual assault	Nepal(1 out of 75 districts)	NA	NA	Sathi,Nepal	Men and women in the community	NA	The objective of this training workshop is: <ul style="list-style-type: none"> • to make participants understand domestic violence and sexual assault as international human rights abuses • to develop skills and strategies to address the problem 	NA
Unite to End Violence Against Women campaign	Saptari, Sunsari and Rauthat district, Nepal	17-Mar-15	UNFPA	Y-PEER Nepal	Men and boys	400 men and boys	Engaging men and boys to end the violence that women are facing	N/A
We Can campaign	Afghanistan, Bangladesh, India, Nepal, Pakistan, Sri Lanka	2004-2010	Oxfam	Oxfam	Men and boys	N/A	We Can was Oxfam GB's largest-scale intervention on VAW. Its overall goal was to reduce the social acceptance of VAW across six countries of South Asia. Within six years it aimed to achieve: <ul style="list-style-type: none"> – a fundamental shift in social attitudes and beliefs that support VAW – a collective and visible stand by different sections of the community against VAW – a popular movement to end all VAW – a range of local, national and regional alliances to address VAW 	<ul style="list-style-type: none"> • Contributed to transforming attitudes, expressed in broader public awareness of VAW-related issues • Work against VAW has been mainstreamed into development organisations, schools, police and institutions of local governance • Attitudinal and institutional changes promoted by the campaign reflect good practice in VAW prevention, and are therefore likely to contribute to reducing the incidence of VAW. However, due to the complexity of the issue and the diffuse nature of campaign activities, the exact scope and nature of this contribution is unknown
Women and Children Service Centre, District Police Office	75 Districts on gradual basis, Nepal	2013-2017 for Doti and Dhanusha	Nepal government	Nepal police of respective district	Women, men and other local and district stakeholders and Nepal police	N/A	To take steps in raising awareness for reducing GBV, to provide redressal support to victims of violence, to establish women and children committees in local areas and networks between district committees of women and children service centres to address GBV. To train police in how to address GBV, instal necessary systems such as female police, and to facilitate interactions between women and children of local committees and other stakeholders for addressing GBV	Established local-level committees but no reports of what had been achieved so far

Women in Health, Education, Environment and Local Resources (WHEEL)	Bhaktapur, Parsa and Dhading, Nepal	1999-2003	Austrian government through UNFPA	UNFPA for national level	Women, men and adolescents	N/A	The overall goal is to contribute toward increased gender equality. At the same time, it aims to improve women's empowerment through participatory development efforts, which comprise: poverty alleviation, women's access and control over natural resources, and diversification of work opportunities	The project brought about an increased access to quality educational inputs (formal and non-formal) and reproductive health information and services for women, men and adolescents in the project areas
Yari-Dosi Intervention	Mumbai, India	2005-2006	Population Council New Delhi	N/A	Men and boys	N/A	The programme attempts to stimulate critical thinking about the gender norms that promote risky behaviour and to create support for those that promote care and communication	<ul style="list-style-type: none"> • Participants moved from denying that gender norms mattered to challenging these norms and behaviours • After the intervention, participants reported less support for inequitable gender norms • Decreases in harassment and risk behaviour were noted post-intervention
South America								
Construction of Violence-free Masculinities	Lima, Peru	2009-2011	Oxfam Quebec	Centro Mujer Teresa de Jesus	Migrants who had come to Lima from other areas of Peru	N/A	To modify and change the beliefs, values, attitudes, and behaviours of men who are aggressors. Objectives also included: <ul style="list-style-type: none"> – to recognise the social construction of masculinity – for men, who are violent towards their intimate partners, assume responsibility for their violence and reflect on their violent behaviour – for participants to end their violence 	<ul style="list-style-type: none"> • Decrease in psychological violence • Creation of spaces that challenge how masculinity has been constructed and raised the possibility of building new masculinities, pointing to a new way of what it means to be a man, of relating to one's partner, of being a parent, of showing affection and emotion • Following intervention, majority of participants were very driven about spreading the message that being a man does not have to mean being violent • Wives reported changes in the power dynamics within their relationships
Engaging Young Men via the Public Health System	Chile	N/A	Promundo, UN Trust Fund to End Violence Against Women	Cultura Salud	Young men 14-19 (urban, middle- to low-income)	N/A	To engage boys and men in ending GBV	Positive improvements in self-reported attitudes towards VAW, decline in self-reported use of physical violence, positive improvements in self-reported changes to behaviour

Name	Location	Date	Funder	Implementer	Target	Number of people reached	Aims	Main achievements
South America								
Using Football to Reach Men in GBV Prevention	Rio de Janeiro, Brazil	N/A	Promundo, UN Trust Fund to End Violence Against Women	Promundo	Men aged 15-64 from urban, low-income setting	129	<ul style="list-style-type: none"> To increase participants' knowledge of different forms of gender inequities and of different forms of VAW To promote an increase in men and boys' capacities to denounce VAW in their communities 	Positive improvement in self-reported attitudes towards VAW, decline in self-reported use of physical violence
Africa								
Creating Futures/Stepping Stones	South Africa	2014	Joint Gender Fund, NORAD, Swedish SIDA and South African Medical Research Council	Project Empower	18-34 years, men and women	Over 2,700 participants in 70 villages	This is a training package on gender, HIV, communication and relationship skills and has been used in over 30 countries to promote communication and relationship skills within communities	<ul style="list-style-type: none"> Men and women improved their monthly earnings, felt less stressed about their work situation Men and women had more gender-equitable attitudes Men reduced controlling behaviours towards partners, while women felt less controlled by partners Findings (in comparison to Stepping Stones evaluations alone) suggest women require change in their material circumstances to be able to use knowledge from gender-transformative programmes to reduce violence
South America								
Mobilising Men	Kenya	2010	UNFPA	Men for Gender Equality Now	Students on university campuses and men within transport sector in Juja, near Nairobi	N/A	To challenge some of the most common forms of institutional VAW, in the workplace, on campus and in the community by mobilising men	N/A
Mobilising Men	Uganda	2010	UNFPA	IDS, Refugee Law Project	Forced migrants, in formal settlements operated by Ugandan govt and within communities of forced migrants living in Kampala	N/A	To challenge some of the most common forms of institutional VAW, in the workplace, on campus and in the community by mobilising men	N/A

One Man Can (OMC)	South Africa	2006	N/A	Sonke Gender Justice, Western Cape Office of the Directorate Social Dialogues and Human Rights, UNICEF, South African Development Fund, International Organization for Migration (IOM), Western Cape Department of Housing and Local Government	General public	N/A	To support men and boys to advocate for gender equality, to promote and sustain change in their personal lives, and to change the gender norms driving the rapid spread of HIV. The OMC campaign is rooted firmly in the belief that all men can become advocates for gender equality and active participants in efforts to respond to HIV and AIDS.	<ul style="list-style-type: none"> • Greater degree of public awareness and discussion around HIV, stigma and the problems of GBV
SASA!	Uganda	2009 ongoing	N/A	Raising Voices, CEDOVIP, Makerere University, London School of Hygiene & Tropical Medicine (LSHTM)	N/A	N/A	To address the imbalance of power between men and women as a core driver of VAW and HIV	<ul style="list-style-type: none"> • Reduced reported social acceptance of physical violence in relationships among both women and men • Increased social acceptance of the belief that there are circumstances when a woman can refuse sex with her partner • Reduced levels of physical partner violence
The Male Norms Initiative	Addis Ababa, Ethiopia	June – Nov 2008	PEPFAR	Hiwot Ethiopia, EngenderHealth	Young men	N/A	To promote gender-equitable norms and reductions in IPV among young men	<ul style="list-style-type: none"> • Increased support for gender-equitable norms • Reduced partner violence • Lower risk of HIV and other STIs
Europe								
Young Men Initiative	Bosnia and Herzegovina, Croatia, Serbia	2007-2010	Norwegian Ministry of Foreign Affairs	CARE International	Young men aged 13-19	N/A	To work with young men in secondary schools to address social norms around gender, promote healthy lifestyles and non-violence with their peers, girls and boys	Increased uptake of gender-equitable attitudes related to violence, homophobia, family dynamics and SRH

8. Conclusions and evidence gaps

Our review has indicated that intimate partner violence is a cause for global concern with an estimated 30 percent of women globally experiencing some of violence – physical, sexual, and/or psychological. In South Asia, prevalence of intimate partner violence has been shown to be the highest of any region, with 43% of women experiencing some form of violence. Different types of IPV have been defined and reported on both globally and in South Asia. The most widely reported form of violence is physical violence, but this may be a result of this form of violence being most easily measurable. Other equally important, and sometimes hidden forms of violence include sexual violence, psychological violence, and economic violence. In Bangladesh, estimates of IPV for lifetime prevalence range from 28 percent to 74 percent while past-year physical prevalence are 4 percent to 34 percent. In Pakistan, lifetime prevalence for women aged 15-49 for physical violence was 26.8 percent, for psychological violence was 32.2 percent, and at least 3 types of controlling behaviours were 8 percent. In Nepal, the lifetime prevalence is 28 percent.

Though only a few projects have focused on male report of perpetration of violence, estimates from global studies indicate that IPV as reported by boys and men ranges from 5 percent to 80 percent. In Bangladesh, emotional violence is most common, followed by sexual violence, physical violence, and economic violence. In Pakistan, the lifetime prevalence of marital physical abuse reported by men was 49.4 percent. In Nepal, there were no male reported estimates of IPV. Studies that use male reported prevalence of IPV find that the degree of incidence is higher than when they only use women-report of IPV and thus, there is an urgent need for future population-based studies on IPV to triangulate both men and women's reports of IPV. There is also a need to clearly differentiate between severe and non-severe forms of violence and pay more attention to measuring hidden forms of violence such as psychological and economic violence.

Research on the consequences of IPV indicates that violence has an impact on both its victims and its perpetrators. However, the research on male perpetrators has predominantly focused on the impact on the mental health of those who perpetrate IPV. There is a strong need to understand whether there are any other consequences of IPV for male perpetrators besides mental health and whether there are any regional variations in these

consequences. There is also a need to understand the lifetime mental health consequences of IPV for adolescent male perpetrators given that adolescence is a crucial time to intervene to prevent future IPV. Negative impacts of IPV for victims include a negative impact on physical, mental and sexual health, on economic outcomes both at national and individual level, and a severe impact on children who are both witnesses of abuse or are victims of abuse themselves. Though men can also be victims of IPV, they are less likely to experience physical harm and are less likely to be afraid of reporting the abuse.

Focusing on male perpetrators of IPV, existing research has identified numerous risk factors that increase the likelihood of a boy/man committing IPV. Using the social ecological theoretical framework, risk factors at the individual level include being in poverty, having less education for male perpetrators (though this relationship is complex), experiencing violence and child abuse in childhood, being younger in age, abusing alcohol and drugs, and having poor mental health. At the household level, risk factors include women's limited economic empowerment and decision making, household SES, and quality of relationship between couple. At the community level, risk factors include social norms around harmful notions of masculinity and sexuality, acceptance of violence in the community. Regional specific risk factors at community level also include norms around dowry, son preference, and norms around religion condoning violence. Our findings from the review suggest that more research is needed to disentangle complex relationships between risk factors for male perpetrators and IPV at all three levels. Additionally, research needs to account for system-level effects – such as globalisation, access to media and technology, and political landscape given almost no studies were found on such macro-level risk factors.

Though programming efforts have for the most part focused on women victims and survivors of IPV, there are a growing number of efforts targeting men and boys, though they are predominantly in HIC. In LMICs, and South Asia more specifically, programmes that engage men and boys with documentation are those that promote community education through advocacy campaigns, that include social marketing components as part of their programmes, that ask men to critically reflect on their attitudes and behaviours, that use school-based curriculum to influence

change, and those that target more specific behaviours like alcohol misuse. However, given that sexual violence and physical violence are correlated with different antecedents, programming efforts should not attempt to address both types of violence as a homogenous entity.

Evaluation efforts have been predominantly focused on high income countries despite there being programmes on boys and men and IPV in LMICS. Nevertheless, there is evidence that group-based face to face discussions have been most effective in bringing about social norm change in LMICS. Few examples of good programming include Programme H, Bell Bajao!, Men As Partners, and Parivartan. The review indicated that there is an urgent need for evaluation studies on existing programming efforts on men and boys in South Asia. Globally, programmes that have

added a gender-equality training component to existing microfinance components have proven to be effective (e.g., Intervention with Microfinance for AIDS and Gender Equity or Stepping Stones) suggesting that there is a need to scale-up (but diversify and contextualise) good programming from HICs to South Asia.

Programmes targeting adolescent perpetrators and adolescent dating violence are only in HIC, with most of them being implemented in the United States. Programmes such as Safe Dates need to be implemented in South Asia and must be tailored for such contexts. For instance, since dating violence is less likely to occur in South Asian countries, acid attacks on women are common and could be addressed using components of successful dating violence prevention programmes in HICs.

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Annex A: Search Plan

Overview of aim and targets

A literature review will be conducted based on systematic principles. Overarching themes to be explored will be male perpetration of IPV. Within that we will include global studies on IPV (both quantitative and qualitative) and global interventions around VAWG, specifically men's perpetration of IPV. Specific research questions are outlined below in section 1.3. Sources for the reviews will include: peer reviewed journal articles and books, policy documentation from government and international agencies, and grey literature (including NGO reports and evaluations). A report providing an overview of the state of knowledge around men's perpetration of IPV will be produced from this comprehensive search.

Outline of the research methodology

This review will use the following combinations of systematic and rapid review principles to search for and assess literature. In terms of searching, we will use:

- Specific research questions ensuring they are not too broad (refer to 1.3)
- An outline of our search methodology
- Clear inclusion and exclusion criteria
- Short key informant interviews with experts in the field, can also be used to identified other key informants
- A backward and forward snowballing process from included research studies and wider grey literature (using Google scholar and the 'cited by' function), relevant literature reviews and systematic reviews
- Management of references in an excel document
- Clear documentation of the process of literature search (e.g., databases used, search strings used and their yield).

We will keep a record of which key words led to which sources – so that we can identify gaps.

- Saving documents grouped by theme into a dropbox and hard drive
- Know when to stop: we will be realistic about the breadth possible in the short time frame.

Research questions: literature areas to explore

1. How is IPV understood globally and in South Asia?
2. What factors drive male perpetration of IPV at individual, household, and community level, globally and in South Asia?
3. What does research indicate about adolescent male IPV specifically, globally and in South Asia?
4. What programmes exist that are focussed on prevention of men's perpetration of IPV globally and in South Asia?

Search parameters

Our search will initially involve a maximum of five tiers, though this is likely to evolve and expand as search strings prove fruitful or not. Using Boolean searching (AND, OR, NOT), we will focus on location (Global); types of evidence (including intervention evaluations, national and regional levels and rates of intimate partner violence); themes (including words relating to IPV, such as domestic violence); types of programming/interventions; and terms related to social norms (such as beliefs, attitudes and perceptions).

Attempting to cover these five tiers in searches will guide results to be as relevant as possible to our research questions. Using additional inclusion/exclusion criteria will guide the process even further (see page 82).

Table A1: Search Parameters



List of search strings

Using different combinations of AND, OR and NOT, we will use key words (annex B). We will test these strings: if search results in too many/too few hits or do not include relevant studies, we will revise the strings.

Resources	CREATE
Databases	DFID
Google	Eldis
Google Scholar (used 'cited by' function)	FAWE
Scopus	FORWARD
SocInfo	GSDRC
PubMed	ICRW
Econ Lit	IDS
IBSS	IRC
British Library of Development Studies	JPAL
Journals	London School of Hygiene and Tropical Medicine
Development in Practice	Liverpool School of Tropical Medicine
Gender and Development	MenEngage
JAMA	Oxfam
Journal Epidemiology Community Health	Partners for Prevention
Journal for Adolescent Research	Plan
Journal of Development Effectiveness	Population Council
Journal of International Development	Poverty Action Lab
Journal of Partner Abuse	Promundo
Men and Masculinities	RECOUN
Psychology Women's Quarterly	Restless Development
Sex Roles	Save
The Lancet	Sonke Gender Justice
Women's Studies International Forum	STRIVE
World Bank Research Working Paper Series	The Communication Initiative
World Development	UCL Institute of Global health
Websites	UN Women (Virtual Knowledge Centre to End VAWG)
3ie	UNAIDS
ActionAid	UNFPA
Adolescent Girls Initiative	UNICEF
African Gender Institute	UNRISD
AWID	UN Women
Better evaluation network	Web of Knowledge
Camfed	Women's Worldwide Web
CARE	World Bank impact evaluations database
Care Evaluation Database	World Health Organisation
Coalition for Adolescent Girls	Young Lives

Inclusion and exclusion criteria

Language	Is the study in English?	If not, exclude
Publication type	Is the paper a Master's thesis?	If yes, exclude
	Is the paper a doctoral thesis – unpublished?	Include if focused on IPV
	Is the paper a systematic review?	If yes, include
	Is the paper a peer reviewed journal article?	If yes, include
	Is the paper a report from INGOs, international organisations or local NGOs?	If yes, include
	Is it a working paper?	If yes, include
Location	If global, is it a seminal study?	If not, exclude unless it is South Asia
Population	Adolescents	If yes, include
	Adult males	If yes, include
	Survivors of GBV	If yes, include
Outcomes	Does the paper assess changes in norms, attitudes, behaviour or practices regarding IPV?	If not, exclude
	Does the paper focus on an intervention, law or policy related to IPV?	If yes, include
Design	Does the research design involve triangulation or comparison between comparable groups intervention?	If unsure, include
	RCTs	If yes, include
	Qualitative studies	If yes, include
	Quantitative studies	If yes, include
	Mixed methods	If yes, include
Focus	Does the study look at VAWG or IPV or male perpetrators?	If not, exclude
	Does the study include a focus on political economy?	If yes, include
Year	Is the study after 1990?	If not, exclude

Key informants

- Dr. Ravi Verma
- Dr. Shireen Jejeebhoy
- Dr. Gary Barker
- Dr. Martha Bragin
- Dr. Ritu Mahendru
- Dr. Emma Fulu
- Dr. Kathryn Yount
- Dr. Ruchira Naved
- Dr. Anita Ghimire
- Dr. Rozina Karmaliani

Key informant interview protocol

Liaise with experts on:

- Who (people, organisations) are working most prominently on IPV globally?
- Anyone specifically looking at engaging men and boys (e.g. Promundo)?
- Could you direct us to some seminal articles on IPV?
- Any programmes that you are aware of on this topic that we should be looking at? (may not just focus on IPV but could be one component of a broader programme). Any documentation round these? Any evaluations, studies, etc.?
- Are you familiar with any quantitative or qualitative data collection tools which have been used to collect data/ measure IPV (e.g., IMAGES) especially those focusing on male perpetrators?
- Which are the key journals we should be searching through?

-
- Which are the key websites we should be searching on?
 - Given evidence gaps, what sub themes should we focus on within IPV?
 - Are you aware of any specific databases that we should be looking at on GBV/IPV?
 - For our inclusion criteria, from which year do you think we should start looking at articles (e.g., 1990)?
 - Are there any other key people we should be talking to?

Annex B: Search Strings using AND/OR/NOT

Research question	Search terms
What is IPV? Male	AND Violence AND Women
What is IPV? Male	AND Drivers AND Violence AND Women
What is IPV? Male	AND Violence OR Intimate partner violence AND Women AND South Asia
What is IPV? Male	AND Beaten OR Battered AND Assaulted AND South Asia OR Bangladesh OR Nepal OR Pakistan
Factors of IPV Male	AND Drivers AND Beaten OR Battered OR Assaulted AND South Asia OR Bangladesh OR Nepal OR Pakistan
Factors of IPV Male	AND Drivers AND Violence AND Women AND South Asia OR Bangladesh OR Nepal OR Pakistan
Male	AND Violence against women and girls OR Intimate partner violence AND South Asia OR Bangladesh OR Nepal OR Pakistan
Factors of IPV Male	AND Drivers AND Violence against women and girls OR Intimate partner violence OR Domestic violence OR Sexual coercion OR Marital violence
Factors of IPV Male	AND Drivers AND Violence against women and girls OR Intimate partner violence AND South Asia OR Bangladesh OR Nepal OR Pakistan
Adolescent male IPV	AND Adolescent AND Male AND Violence against women and girls OR Intimate partner violence OR Domestic violence OR Sexual coercion
Adolescent male IPV	AND Adolescent AND Male AND Violence against women and girls OR Intimate partner violence AND South Asia OR Bangladesh OR Nepal OR Pakistan
Social norms IPV	AND Social norms OR Gender norms AND Intimate partner violence OR Domestic violence OR Sexual coercion
Social norms IPV	AND Social norms OR Gender norms AND Violence OR Intimate partner violence AND South Asia OR Bangladesh OR Nepal OR Pakistan
Social norms IPV	AND Attitudes OR Beliefs OR Perceptions AND Violence OR Intimate partner violence OR Domestic violence
Social norms IPV	AND Attitudes OR Beliefs OR Perceptions AND Violence OR Intimate partner violence OR Domestic violence AND South Asia OR Bangladesh OR Nepal OR Pakistan
Political economy IPV	AND Male AND Intimate partner violence AND Political economy AND South Asia
Political economy IPV	AND Male AND Intimate partner violence AND Political economy AND South Asia AND Bangladesh OR Nepal OR Pakistan

Annex B: (contiued)

Research question	Search terms
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence AND South Asia OR Bangladesh OR Nepal OR Pakistan
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence AND Men
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence AND Masculinity
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence AND Men AND South Asia OR Bangladesh OR Nepal OR Pakistan
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence AND Adolescents AND South Asia OR Bangladesh OR Nepal OR Pakistan
Programming Intervention IPV	Programming Intervention OR Programming AND Violence against women and girls OR Intimate partner violence OR Domestic violence AND Masculinity AND South Asia OR Bangladesh OR Nepal OR Pakistan
Programming Preventing/prevention IPV	Programming Preventing/prevention OR Violence against women and girls OR Intimate partner violence OR Domestic violence OR South Asia OR Bangladesh OR Nepal OR Pakistan

Effective shoe strings



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