



GENDER-BASED VIOLENCE PREVENTION AND RESPONSE PHASE II PROJECT (GBVPR II): BASELINE STUDY BRIEF

December 2022

Background

Gender-based violence (GBV) is pervasive in Nepal. Women and girls continue to face various forms of violence throughout their life, regardless of their caste, ethnicity and socio-economic status.

To address the problem of GBV, UNFPA implements the Gender-based Violence Prevention and Response Phase II (2020-2024) project, in partnership with the Swiss Agency for Development and Cooperation (SDC) and the Royal Norwegian Embassy (RNE) in Nepal. The project seeks to reduce all forms of GBV and discrimination against women and girls in 19 municipalities of Province 1 and Sudurpaschim Province through focused interventions to change harmful social and gender norms that perpetuate gender inequality and GBV, enhance access to quality, multi-sectoral services for GBV survivors, and strengthen gender-responsive policies and budgeting.

The purpose of the baseline study was to provide a benchmark against which progress can be measured over the course of the project implementation and to provide evidence-based recommendations to inform programming.

Methodology

The baseline study adopted a mixed-method approach to collect data on key indicators of the project's logical framework. Quantitative and qualitative data were collected through various methods which was complemented by secondary data from a desk review of existing literature.

Key data sources

Surveys (Total: 3,293)

- 1,070 married men and women enrolled in couple programming
- 1,207 men and women from communities in project sites
- 593 adolescent boys and girls in school enrolled in life skills programming
- 216 GBV survivors served by One-Stop Crisis Management Centers (OCMCs) and shelters supported by the project
- 207 multi-sectoral GBV service providers getting trained from project sites

Interviews (Total: 114)

- 16 married men and women enrolled in couple programming
- 15 GBV survivors served by OCMCs and shelters supported by the project
- 64 multi-sectoral GBV service providers getting trained from project sites
- 19 local government officials involved in budgeting processes

Focus group discussions (Total: 115)

- 115 adolescent boys and girls in school enrolled in life skills programming

Desk reviews (Total: 94)

- 1 federal government budget
- 2 provincial government budgets
- 19 local government budgets
- 72 research studies and other documents

Key Highlights

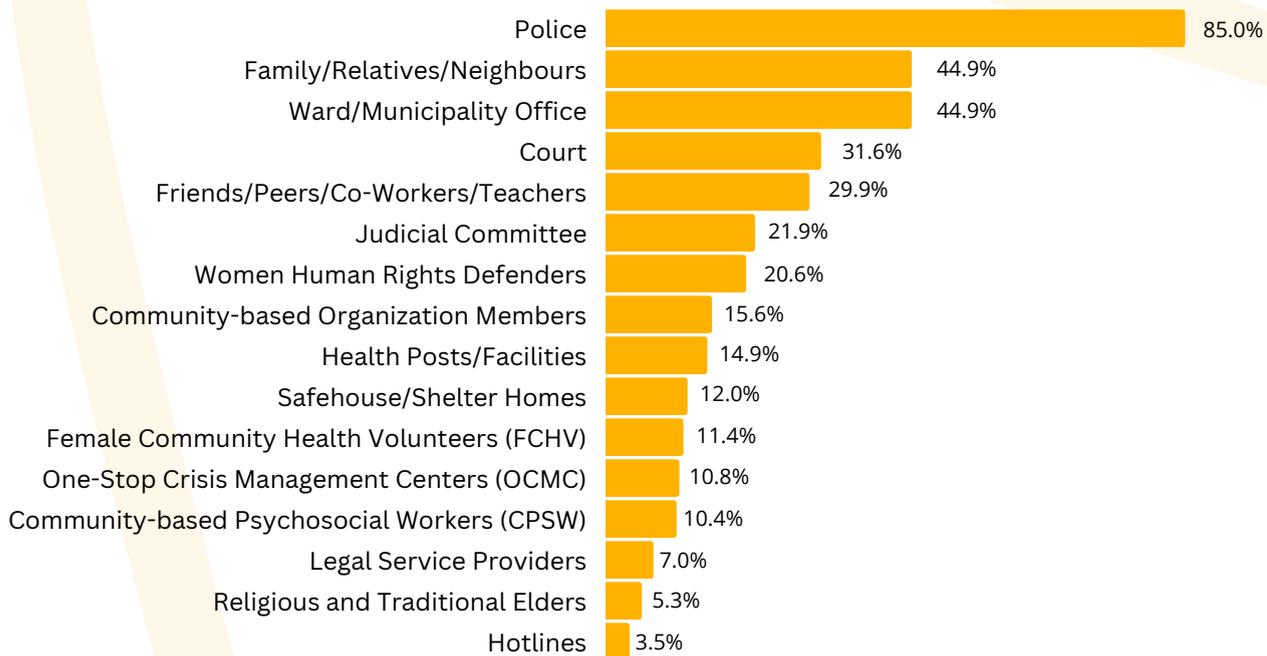
1 One in five ever-married women (21.7%) experienced intimate partner violence (IPV) or in law-abuse or both in the past 12 months, while levels of agency among women are also low, with 33.3% of married women deciding on their own healthcare only. The limited bodily integrity and autonomy of women is intricately linked to the presence of gender-inequitable attitudes and norms, especially among men and boys.



Of all the study participants, 53.3% agreed that a woman/girl should ask a male household member for permission before she leaves the home, and 43.4% agreed that a woman's most important role is to take care of her home and children and cook for her family. Furthermore, a third of the participants (33.4%) reported at least one justification for physical IPV or psychological abuse perpetrated by the mother-in-law against their daughter-in-law, whereas acceptability for help-seeking by GBV survivors is moderate on average.

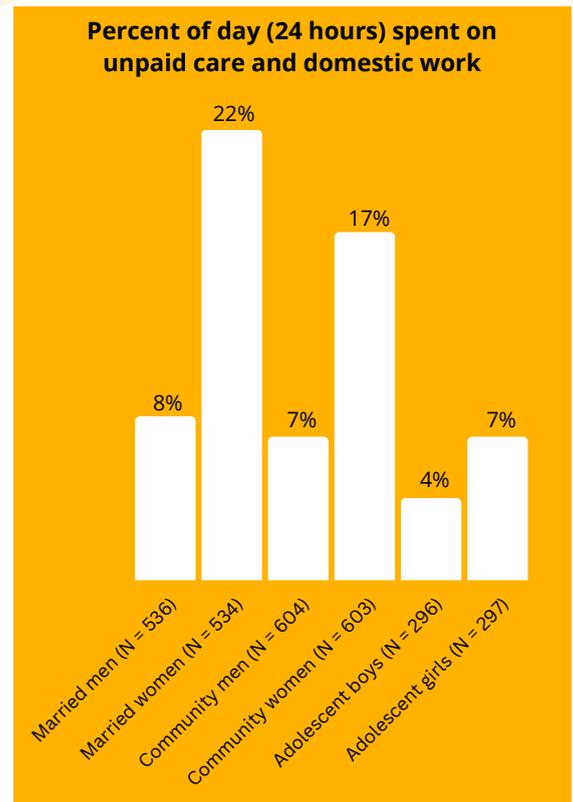
2 Awareness of available GBV response services, especially essential services supported by the project such as community psychosocial workers (CPSWs), One-Stop Crisis Management Centres (OCMCs) and shelters, is low among both community members and GBV service providers. CPSWs, OCMCs and shelters were recognized as a source of support for GBV survivors by no more than 12% of the study sample.

Awareness of available support for GBV survivors (N = 3,077)



These gaps in awareness may partially explain the low levels of help-seeking among women and girls subjected to violence. Only 10.4% sought help or told anyone about the violence that they experienced in the past 12 months, while 22.6% ever disclosed violence. Reporting to GBV response services is especially low at 4.3%. Furthermore, lack of awareness of available services and incomplete knowledge of GBV forms among informal sources of support, such as family members and friends to which violence is disclosed most commonly, limits their ability to facilitate access to formal support for GBV survivors.

3 Considerable gender differences exist in multiple research areas, including acceptability of IPV, knowledge of discriminatory social and gender norms as a root cause of GBV, recognition of OCMCs and shelters as GBV services, and the share of household chores. These differences highlight the importance of focusing on men and boys as target groups of prevention interventions. Even though 97.5% of men and boys in the study sample agree that men and women should share household chores, they spend about two times less time on unpaid care and domestic work than women and girls. In terms of attitudes towards domestic violence, gender disparities are particularly pronounced among adolescents. While 53.0% of boys in the adolescent sample agreed that a husband or mother-in-law is justified in abusing a woman for at least one specified reason, only 26.9% of girls agreed. It is clear that harmful attitudes held by men and boys not only contribute to the persistence of GBV, but also to limited help-seeking.



4 There are crucial disparities in key measures among districts, including GBV prevalence, acceptability of help-seeking and knowledge of GBV, but strong trends were difficult to discern given the high degree of variability across indicators within districts. The observed differences may also be confounded by the socio-demographic characteristics of the study participants in the targeted districts of the project, necessitating further analysis. There is insufficient evidence to assess if clustering of risk for GBV exists.

5 Married women enrolled in couple programming reported less IPV (16.9%) than other married women in their communities (19.4%), suggesting that the prevention interventions may not reach the most vulnerable couples. The criteria for selecting couples to participate in the prevention interventions may not be adequate or strictly applied. The low risk of violence also makes it difficult to determine change over time as there is little room for improvement. This finding may relate only to the first group of couples engaged in the prevention interventions.



6

Critical gaps in survivor-centered care exist. Significant deficits in training of GBV service providers and workplace preparedness hinder the provision of quality services and appropriate referrals for GBV survivors.

While there is variation across service providers and sectors, a tendency to encourage reconciliation, insist on information that survivors do not wish to disclose and not involve survivors in decisions about care was most consistently observed. In terms of workplace preparedness, inadequate space to ensure privacy and confidentiality during interactions with survivors and insufficient language capabilities were found to be crucial challenges.

7

Coordination across multi-sectoral GBV response services is weak, which hinders the ability to fully respond to the needs of survivors.

While formal and informal sources of support play a crucial role in connecting survivors to OCMCs and shelters, there is a lack of onward referral from those service delivery points to legal support, civil and vital registration, and economic empowerment opportunities, which were recognized as unmet needs of survivors by all types of GBV service providers and survivors.

8

GBV survivors seeking help in the OCMCs and shelters report mostly positive outcomes following service utilization. However, the benefits seem tentative.

50.7% of the survivors seeking help in the OCMCs and shelters in the past 5 months reported that the violence had stopped. The majority of the survivors who accessed services in the OCMCs and shelters also reported that their situation was better, they had more self-esteem and confidence, and they knew better how to protect themselves.

Yet, the survivors demonstrated moderate scores on a safety-related empowerment scale assessing their ability to achieve safety goals (2.1 out of 4), support needed to move towards safety (2.0 out of 4), and perceived trade-offs that must be made to keep safe (1.8 out of 4). They also expressed concerns about future violence, especially those accommodated in the shelters during the study.

9

Budget allocations of local governments for programs and policies to promote gender equality and women's empowerment (GEWE) are scant relative to the scope of GBV.

In the targeted municipalities of the project, they range from 0.09% to 1.13% of the total budgets for the fiscal year 2021-2022. Even when budget is secured and allocated, local governments often cannot fully utilize the funds allocated for GEWE due to limited personnel, lack of awareness of procedures for spending funds and the redirection of funds to prioritize other development issues.

10

Some outcome indicators in the project's logical framework may need further consideration or refinement to ensure credible and useful evidence is generated to track progress.

It is challenging to correctly and precisely identify the percentage of government budget allocated to programs and policies to promote GEWE due to a lack of standardization. Survivor satisfaction with services provided by OCMCs and shelters is also difficult to monitor given very high baseline ratings (99%), which will not provide a meaningful benchmark for measuring progress over time.



Recommendations

1. **Ensure that the most vulnerable couples are recruited to participate in the prevention interventions**, with an emphasis on persons of a marginalized caste or ethnicity, particularly those with a history of IPV or other form of GBV. Assess if the current selection criteria are adequate and applied consistently.
2. **Enhance engagement with men and boys** to address gaps in knowledge of root causes and harmful consequences of GBV, as well as formal support services, attitudes about the acceptability of GBV and help-seeking, and behaviors such as dominant decision-making and low contribution to unpaid care and domestic work.
3. Expand family members' **knowledge of the forms, root causes and harmful consequences of GBV, as well as the available services for GBV survivors**.
4. **Make survivor rights visible at service delivery points**, in particular OCMCs and shelters, to establish a benchmark against which services might be judged and establish expectations for survivor-centered care.
5. **Address deficits in training within and across different types of service providers** and advocate for more survivor-centered workplace elements to enhance quality of care for GBV survivors.
6. **Enhance knowledge and use of referral pathways among service providers, and involve the police in gender-transformative training** to minimize unmet needs for survivors, especially those related to income generation, legal support, and civil and vital registration.
7. Establish **linkages to existing economic empowerment programs for GBV survivors and participants of prevention interventions**, including men to alleviate pressures to migrate and facilitate their engagement in prevention programming. Advocate with project donors for the inclusion of economic empowerment support or coordinate with other development partners to work on these issues.

8. **Further investigate differences in key indicators across project sites** to provide more nuanced insights into differences according to location and potential clustering of risk for GBV.

9. Integrate communications work targeted at adolescent girls, women, and family members with the power to influence reporting by GBV survivors to **publicize availability of multi-sectoral GBV response services, with a particular emphasis on CPSWs, OCMCs and shelters**. Conduct a mapping to identify the most appropriate format and channels for communication with the different target audiences.

10. Include information to **enhance the acceptability of GBV reporting and minimize stigma of help-seeking** in the prevention interventions and community outreach of service providers. Highlighting stories of help-seekers who received support from their communities can be useful to shift expectations of negative social sanctions.

11. **Develop case studies of successful gender-responsive budgeting in Nepal** for use in advocacy with government, highlighting its social and economic benefits.

12. Advocate with and build the capacity of local governments to **improve standardization of budget forms and specificity in budget categories** to enable more precise estimation of GEWE budget allocations.

13. **Explore the use of mystery client observations for routine monitoring** to assess survivor-centered care and/or replace the indicator on survivor satisfaction in the logical framework with survivor empowerment.





The baseline study report will be available at the UNFPA Nepal website nepal.unfpa.org in 2023.

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