Combating gender-based violence (GBV) needs a country-specific multisectoral approach to implement primary prevention and promote gender equality and human rights. Women still face persistent barriers to the achievement of equality. GBV is a public health concern and impacts the entire family, not only the victims.
Combating Gender-based Violence in the South-East Asia Region

Gender, Women and Health (GWH)
World Health Organization
South-East Asia Regional Office (WHO/SEARO)

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UN Definition of Violence against Women

GENDER-BASED VIOLENCE
It means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.
The 16 Days of Activism Against Gender Violence
25 November–10 December 2008

SEAR countries and gender-based violence prevention

Gender-based violence (GBV) has been reported by 9 out of the 11 countries in the South-East Asia Region — Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. Four countries have enacted a domestic violence act — Indonesia (2004), India (2005), Thailand (2007) and Nepal (2008). Research and public advocacy on the awareness, prevention, protection and elimination of gender-based violence has been performed in the nine countries mentioned above.

A cause of GBV is patriarchal culture and reluctance to change family dynamics with traditionally less communication and gender inequality. Also patriarchal culture with high communication in gender equality reduced the GBV prevalence about 50%, as found in Indonesia (2008).

Primary prevention starts in early education for adolescents and gender awareness campaigns for the public, while secondary prevention is carried out through public services such as health facilities, police, social & community work and legal counseling. This is a multisectoral approach within multidisciplinary sciences. A strong network and systematic planning are needed for practical and integrated mechanisms on GBV prevention and handling in the health sector and community.

SEARO launched a policy brief on prevention of GBV in 2007. It is noted that Maldives has developed a Family Protection Unit (FPU) to support prevention and protection services on GBV. Indonesia has developed an Integrated Crisis Centre in hospitals for victims of GBV, while Thailand has developed a One Stop Crisis Centre (OSCC) for victims of GBV in the hospital services. Nepal has developed gender-sensitive health care for victims of GBV at the Maternity Hospital, Kathmandu, and conducted training for nurses on GBV and developed Information,
education and communication (IEC) material for prevention of GBV through a health facilities campaign.

GBV has affected not only women but also children and men. While adult woman victims of GBV are about 60-70%, child victims are 20-30% and men are about 6.1%. This is a global concern. We have to prevent GBV and eliminate not only violence against women but work towards the elimination of GBV in the family, society and community for a better world for all.
Ways forward in combating gender-based violence

It is often said that prevention is better than cure. The cause of gender-based violence is related to patriarchal culture and lack of communication in the family as found by Indonesian research (2008). This is in line with other SEA Region findings that women are mostly silent. Tools for preventing gender-based violence need to be created based on this, embodying gender equality, human rights and an egalitarian perspective in family and community, and between men and women. This tool may help health workers in primary prevention.

Primary prevention based in the community and health facilities is a key challenge within the multisectoral approach involving health, education, social and religious groups and other sectors. An early education needs to be designed to foster an egalitarian perspective of gender equality and equity starting in early childhood, towards the goal of elimination of gender-based violence in the family and community.

It is hoped that collaborative work among Gender, Women and Health Networks (GWHN) with many sectors and within multidisciplinary areas will support the action in combating GBV in the South-East Asia Region.
Web news

16 Days of Activism Against Gender-Based Violence (25 November–10 December 2007)

SEARO Policy Brief on Prevention of Gender-Based Violence

Nine out of the 11 Member states of WHO’s South-East Asia (SEA) Region highlighted issues of gender-based violence (GBV) during 2007. Most countries noted that a policy on the prevention of GBV was urgently needed. They were also of the opinion that such a policy could be integrated within the reproductive or maternal and child health policy.

Several countries including India, Indonesia and Thailand have promulgated a law on domestic violence while Nepal is in the process of doing so. In the SEA Region, GBV strategy has been implemented for the past 15 years through gender mainstreaming (GMS), developing plans of action, educating doctors and nurses, advocacy/awareness/sensitization and capacity-building activities at all levels involving decision-makers, programme managers and health personnel, through the knowledge management system and by establishing a national network/working group on Ministry of Health (MOH) services delivery. The latter work includes a joint ministerial decree of multiple sectors, the national action plan on violence against women (VAW), the National Commission on VAW, collaboration with other UN agencies, national data collection/situational analysis from several sources, strengthening family protection units in hospitals, referral systems, developing indicator on secondary prevention activity, mobilization of resources and partnerships.

Protection of victims is one of the important challenges. This is done through the implementation of one-service crisis centres (OSCC) as reported by Indonesia and Thailand in July 2007. The criminal code and reporting system has also been developed, along with capacity for health and human resources and referral mechanism systems. Due attention is also given to health providers’ protection against pressures from the perpetrators.
The recommendations of a policy brief on prevention of GBV from countries were agreed to by 10 Member States in Kuta, Bali in July 2007 as follows:

(1) Development of gender-sensitive assessment tools of evidence and prevention.

(2) Harmonization of related laws.

(3) Systematic data collection on violence against women (VAW).

(4) Improve coordination/networking among ministries/stakeholders.

(5) Ensure adequate funds to support the awareness, protection and prevention activities.

(6) A high level of political commitment.
Country News: (See SEARO website: www/searo.who.int)

Thailand – Domestic Violence Act 2007

Maldives – White Ribbon Campaign 2007 and Violence against women

Thailand Domestic Violence Act

Title: Domestic-Violence Victim Protection Act

B.E. 2550 (2007)

Effective date: 13 November 2007 (Ninety days after 14 August 2007, which was the date this Act was announced in the Royal Gazettes volume 124, Section 14a, page 1.

Legalized on 25 July 2007 by His Majesty King Bhumiboladulyadej as advised and concurred by the National Legislation Council.

Justification: Domestic violence is unique since it happens among family members and close relatives. It differs from violence among the general population who are non-relatives. To solve domestic violence problems using the existing criminal laws is therefore not appropriate since those laws are designed to penalize criminals or offenders, not to rehabilitate them and/or protect victims of the violence in the family.

This new act offers different approaches, methods, and procedures from those based upon criminal laws, thus providing offenders with chances to improve themselves, stop repeated violent actions, and restore a good family relationship. Children and minors in families also have the right to get protection from the state against violence and unfair treatment. Therefore, this act was promulgated.
Gender-based violence

Web news

16 days of Activism against Gender Violence: (25 November–10 December 2006)

In relation to the global campaign for Women’s Rights initiated by the Center for Women’s Global Leadership in the United States of America, the world has recognized “16 days of Activism Against Gender Violence” starting in 1991. The event occurs annually from 25 November to 10 December.

Many countries are pursuing special activities to combat violence against women (VAW). This involves collaborative work among government, nongovernmental organizations (NGOs) and civil society organizations (CSOs). The Gender, Women and Health unit (GWH) in the WHO South-East Asia Regional Office (SEARO) is taking up this important issue since it is a public health concern and impacts the entire family, not only the victims.

Violence against women has many forms. It has an impact on reproductive and sexual health. Women victims suffered not only physically but also psychologically and there are further effects on the family. Statistics show a 50-70% co-occurrence of violence against women and abuse of children. About a quarter century ago, in 1979, the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) was adopted, which concerns equal access and equal opportunity for men and women and equality of men and women throughout the life-course.

Violence against women is happening in communities and countries around the world, cutting across classes and social status, race, age, religion, jobs, and urban/rural and national boundaries.
According to the United Nations Declaration in 1993, violence against women (VAW) is “[any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life].”

Since September 2001, the World Health Organization has been a core partner, together with UNICEF and the Office of the United Nations High Commissioner for Human Rights, of a working group to support the United Nations study on Violence against Children. WHO studies revealed that about one in five females and 5-10% of males reported childhood sexual abuse. [1]

In 1995, the Beijing Platform For Action (BPFA) recommended among other things, “the promotion of research and data collection on the prevalence of different forms of violence against women, especially domestic violence, and research into the cause, the nature and consequences of violence against women and the effectiveness of measures implemented to prevent and redress it” (Para 129a); violence against women is stated as one of the 12 areas of concern for women’s advancement.
In February 1996, WHO held its first Expert Consultation on Violence against Women. The multicountry study on women’s health and domestic violence is a key research initiative undertaken by WHO in collaboration with local institutions. The first activity was in 2002;\textsuperscript{[1]} Bangladesh, Brazil, Japan, Namibia, Peru, Tanzania and Thailand participated. It was noted that 13-61% of women reported being physically assaulted and 6-47% reported sexual assault by an intimate partner at some point in their lives. It was somewhat related to social and economic factors.

The Forty-ninth World Health Assembly (1996), in resolution WHA 49.25, declared violence to be a leading worldwide public health problem. In 1997, resolution WHA 50.19 endorsed WHO’s integrated plan of action for a science-based public health approach to violence prevention and called for its continued development.

The 109th session of the WHO Executive Board (EB) in January 2002 proposed tasks in the areas of surveillance, research, prevention, treatment and care for victims and advocacy for the prevention of violence (EB109/15). In January 2003, the 111th session of the EB endorsed the follow-up implementation of the recommendations of the World Health Organization report on violence and health by developing guidelines for each of the recommendations and by strengthening prevention of violence and injuries.

In understanding that gender is related to cross-cutting issues of many sectors, gender sensitivity and analysis are used to develop gender perspectives in health policies and programmes. The WHO gender policy for integrating gender perspectives in the work of WHO was announced in the year 2002, with the goal to contribute to “better health for women and men through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between men and women”.

In the SEA Region, countries’ activities have been ongoing since 2003 for addressing this issue. In addition to the aforementioned study in Bangladesh and Thailand, Bhutan, India, Indonesia, Maldives, Myanmar, and Sri Lanka have been giving specific attention to the topic through research activities.
The public health response by Member States for prevention and control of violence, addressed by the World Health Association in 2003, includes activities related to:

1. capabilities to prevent violence;
2. surveillance systems for fatal and non-fatal cases of violence;
3. services for survivors;
4. research capacity for violence prevention;
5. systematic documentation for good and best practices of prevention;
6. model prevention programmes;
7. development of national policies for violence and injury prevention;
8. and promoting and strengthening country and regional capabilities to evaluate activities and the impact of the report and advocacy campaign.
Country activities
**Bangladesh**

In December 2005, a study about factors associated with spousal physical violence against women in Bangladesh was published in *Studies in Family Planning 36*(3). It found that personal, economic, social and cultural factors combined to cause the abuse. However, gender norms and crime levels remain generally unexplored. The study revealed that 19% of urban and 16% of rural women reported experiencing physical abuse in the 12 months prior to the survey. Household income showed no relationship to the occurrence of physical violence. The findings indicated that the strongest factor associated with husbands’ violence toward their spouses is the history of abuse of the husband’s mother by his father. The second most important factor associated with domestic violence is lack of communication between spouses.

Higher educational attainment among husbands and the woman’s age also had an influence. Conventional gender norms are stronger in rural than urban areas. This study suggested promoting boys’ education to address the problem of domestic violence and promote spousal communication.

The WHO country office has been holding meetings with various partners, including government counterparts in injury and violence prevention, UNICEF and United Nations Population Fund (UNFPA) to map out a future strategy to translate the recommendations of the WHO multicountry study into action in Bangladesh.

**Bhutan**

A one-week Introductory Training Programme on Community-based Support Systems took place in June 2005. The training was focused on creating awareness about gender, gender-based violence and in particular domestic violence. It provided basic skills in counseling and GBV data collection.

The training was participated in by 50 RENEW Volunteers (Respect, Educate, Nurture and Empower Women) a non-governmental
organization from the six zones of the Thimpu city corporation. The
volunteers came from different professional backgrounds: wives of
armed forces personnel, working women, non-formal education learners
(NFE), NFE instructors, housewives and a few male volunteers. The
unique aspect of this particular training was noted. It was facilitated
and resourced by Bhutanese nationals. A focus group discussion on
domestic violence was held after the training.

Domestic violence and abuse situations exist in Bhutan, though
women in Bhutan enjoy far more equality than women in other
countries. The existence of violence against women cannot be denied
or dismissed.

Regarding prevalence of domestic violence, there was a mix of
responses. The NFE learners felt that domestic violence is comparatively
less in the country and that it has reduced compared to the past. On
the contrary, male participants believe domestic violence to be very
common and much more prevalent than actually reported. A male
participant from the armed forces said “It is very common, with five to
seven cases reported to the office every day”. Similarly, the educated
working women perceived prevalence of domestic violence (i.e. physical
beating) to be as high as one in five, and even higher if other forms
of violence such as verbal abuse are included. Wives of armed forces
personnel believed that there is more verbal abuse but on the whole
less physical violence.

A majority agreed that domestic violence is more prevalent in
urban areas than in rural communities, for the following reasons:

(1) More exposure to leisure life involving squabbles and jealous
behaviours that finally result in violence;

(2) a trend among men to have extramarital affairs and the fear
of HIV/AIDS;

(3) educated husband with an illiterate wife who was brought from
the village and who previously worked as his housekeeper;

(4) not having the support of the extended family; and

(5) absence of the old rural tradition of support, negotiation,
providing counsel and mediation for couples with problems.
The three factors most cited as having a negative influence on domestic violence were:

1. alcohol consumption;
2. financial pressure; and
3. jealousy arising from suspicion of a spouse’s fidelity.

**India**

Statistics showed that women experienced violence during pregnancy and this contributed to 16% of maternal deaths (Population Council, USAID, 2006). A total of 7000 dowry-related deaths occurred yearly, of which 5000 women were killed or burnt by husband/inlaws. Sex selection/female foeticide are also prevalent, with the sex ratio (0-6 years) dropping from 976/1000 to 927/1000 (1991-2001).

The Protection of Women from Domestic Violence Act 2005 cleared by the President on 13 September 2005 has been in force since 26 October 2006. The legislation gives women who are married or in live-in relationships legal protection against abuse or threat of abuse. Domestic violence under this act includes abuse or the threat of abuse—whether physical, sexual, verbal, emotional or economic—including harassment by way of unlawful dowry demands to the woman or her relatives. Another notification has been issued by the Ministry of Women and Child Development to lay out the implementation of the act for protection officers, service providers and counselors.

**Indonesia**

The Elimination of Domestic Violence Law No 23/2004 was announced on 22 September 2004. It was a long process and collaboration among government, nongovernmental organizations and communities from the declaration of the elimination of violence against women (1999) to push forward into action through the legislative process.

The Ministry of Women Empowerment has worked together with the Ministry of Health, Ministry of Social Affairs and Police of the Republic of Indonesia and has set up joint agreement on domestic
violence handling and services in 2002. It includes facilitation for shelter, protection from perpetrators, and medico-legal counseling. By the implementation of the act, wide advocacy/socialization, public dialogue, training of trainers, local regulation and financial support have been undertaken. The Ministry of Health, in collaboration with the WHO country office, has developed a manual for health workers in primary health care for prevention and handling of violence against women and children, along with the training of trainers for gender mainstreaming in health for about 500 personnel. Some studies were also performed to search for the causes of gender-based violence.

After the act was announced, many women had brought charges under it; however, many of them dropped their cases because they had no power to maintain themselves after their husbands stopped providing support and also because of intimidation coming from the husband’s family, during the period of trials. Prevention is therefore important. Gender-based violence is a priority programme for women’s empowerment and mother’s health in Indonesia.

**Maldives**

The Maldives Ministry of Gender and Family, with financial support from UNFPA and UNICEF, completed the data collection phase of study on women’s health and domestic violence using the WHO multicountry study methodology in 2006. Under a memorandum of understanding signed between the Ministry of Gender and Family (MG&F) and WHO, WHO has provided technical assistance to the MG&F to adapt and finalize the questionnaire for the country context; to train interviewers and supervisors; and to be involved in data entry and processing.

The Maldives cross-sectional household survey of women aged 15 to 49 was designed to be nationally representative and covered over 2500 households spread across the whole country. The ministry released initial results on prevalence rates of violence on 25 November 2006 to coincide with the International Day for the Elimination of Violence against Women and then the complete report by December 2006. The results from this study will be used in education campaigns, advocacy, policy development and the establishment of much-need support services for women living with violence.
Recognizing gender-based violence as a public health issue, the Maldives tertiary hospital, the Indira Gandhi Memorial Hospital (IGMH), established the Family Protection Unit under the Department of Obstetrics and Gynecology in August 2005. The unit was initially established as a one-year pilot project, with the support of the Ministry of Gender and Family, Ministry of Health and funding from UNFPA and UNICEF, to provide support to victims of gender-based violence and child abuse. After the completion of the pilot phase, the unit has become a permanent establishment providing medical examination, including forensic investigation; in-hospital, short-term counseling; and referral to outside agencies. The unit has dealt with 85 cases of gender-based violence since August 2005.

In 2006, as part of a multisectoral approach in addressing gender-based violence, four participants from IGMH, police and the Ministry of Gender and Family recently undertook training on “Forensic Investigation of Rape Cases”, conducted by the Amity Institute of Advanced Forensic Science and Research and Training in India.

**Myanmar**

To promote gender considerations in health issues during the biennium 2004-2005, a government project on women’s health conducted a series of trainings on gender and women’s health at the central and states/divisional levels. In order to impart knowledge on gender issues to states/divisional training teams, a four-day workshop was held especially to promote gender analysis tools and to initiate gender mainstreaming in health performance. A workshop was conducted using participatory learning methodology.

Two research activities were conducted to explore the “role of gender in rural communities of two selected townships in Myanmar” and “Knowledge, attitude and practice on gender issues amongst Basic Health Staff (BHS)”. It is crucial to explore the existing situation of BHS and gender considerations before initiating gender mainstreaming into health policy and programmes.

Gender roles—husband and father, wife and mother—were explored. Access and control of resources such as education, food
sharing, decision-making in family expenditure, decision-making during illness and recreation were also investigated. Although in this study quarrels between husbands and wives were probed during qualitative assessments (focus group discussions (FGDs), the questions were not specifically about violence but general family quarrels. It was also found that quarrels between husbands and wives among the rural poor were common. It ranged from verbal fights to physical fights, usually based upon economic problems and not family or community problems. It was revealed that the persons beaten were not always wives but sometimes the husbands who were drunk.

Exploring the role of gender in rural communities provided inputs for further implementation of gender considerations in health provision and care.

Further exploration of gender roles in urban and peri-urban areas was studied during 2006-2007 biennium, with more questionnaires regarding domestic violence and in-depth interviews. Later findings showed that communication plays a very important role in family life.
Further planned activities

Pressure on women, who are the main victims of domestic violence and most close to other family members (children, elderly) further disturbs harmony in family life. It potentially affects community life and national life.

Despite the empowerment of women, who could improve knowledge, healthy lifestyles and harmony in the family, the situation seems to be that women are still facing the persistence of traditional beliefs and patriarchal culture, including the belief that the man is superior in the family. But human rights assert the equality of human beings; this may be supported by religious beliefs and morality.

In the 2006-2007 biennium, three countries in the SEA Region planned multicountry activities (MCAs)—Indonesia, Myanmar and Nepal—in women’s health (WMH) areas, including gender mainstreaming and combating gender-based violence. This action will be followed up in the future.

GWH Highlights on Gender-based Violence in 2006-2008

16 Days of activism against gender violence has been celebrated with two important dates–25 November, the International Day for the Elimination of Violence Against Women, and 10 December, Human Rights Day. The following material is important documentation for the SEARO celebration during 2006-2008 to sign a next landmark on Gender-based Violence prevention in combating the issue within the South-East Asia Region

New Delhi, November 2009
WHO/SEARO
Combating gender-based violence (GBV) needs a country-specific multisectoral approach to implement primary prevention and promote gender equality and human rights. Women still face persistent barriers to the achievement of equality. GBV is a public health concern and impacts the entire family, not only the victims.