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Determinants of Gender-Based Violence in Nepal: A Review of Recent Evidence

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Abstract

Background: Gender-based violence (GBV) remains a major global public health and human rights challenge, significantly impacting women's health and well-being. In Nepal, GBV is a pervasive societal crisis, with impacts that undermine the nation's progress. Recent evidence indicates that GBV persists at high levels, affecting women and girls across various settings, including schools and homes.

Objectives: This narrative review aims to synthesize recent evidence on GBV in Nepal, with a focus on examining its determinants across multiple ecological levels—including individual, relationship, household, community, and institutional factors—to inform evidence-based prevention programs and policy interventions.

Methods: This review is based on a synthesis of recent literature, including national surveys and empirical studies. The analysis is guided by a socio-ecological model, which recognizes that GBV is influenced by factors operating at multiple levels, from individual beliefs to broader societal structures.

Findings: The review confirms the high prevalence of GBV in Nepal. A recent cross-sectional study among secondary school female students in the Sarlahi district found that 45.33% had experienced lifetime GBV, broken down into psychological (39.56%), sexual (30.22%), and physical violence (16.89%). Key risk factors identified include:

- **Individual/Relationship Level:** Husband's alcohol use and poor marital communication are significant risk factors for intimate partner violence (IPV).
- **Household Level:** Economic stress, type of family, and gender-based discrimination within the family are associated with GBV experience.
- **Community & Societal Level:** Patriarchal norms, gender-inequitable attitudes, and the intergenerational transmission of violence (e.g., witnessing violence as a child) are deeply entrenched drivers of GBV. Despite existing laws, services for survivors remain fragmented, and emotional abuse is often overlooked due to a lack of physical evidence.

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Conclusion: GBV in Nepal is a complex issue driven by interconnected factors across the socio-ecological spectrum. While physical and sexual violence are documented, psychological violence is highly prevalent yet frequently overlooked by support systems.
Implication: There is an urgent need for a multi-sectoral approach to effectively prevent and respond to GBV. This should include:

- Strengthening institutional frameworks and multi-sectoral response services.
- Implementing community-based programs that challenge harmful gender norms and engage men and boys.
- Improving access to integrated services—including legal, psychosocial, and health support—for survivors, particularly in remote areas.

Keywords: Gender-Based Violence; Intimate Partner Violence; Socio-Ecological Model; Nepal; Prevention.

1. Introduction

Gender-based violence (GBV) in Nepal takes different forms — physical, sexual, psychological, and economic — and is perpetrated based on unequal power relations and socially superior norms excluding women.

Recent national surveys and local studies' analyses show the persistence of a high prevalence of IPV and other GBV types despite legal reforms and policy reforms. This article synthesizes and reviews recent evidence to describe prevalence patterns, identify determinants at ecological levels (individual, relationship, household, community), and recommend policy and program interventions from the latest publications and national datasets (Gautam et al., 2024; Sapkota et al., 2024). Recent research highlights that adolescents and young women in Nepal face high levels of exposure to gender-based violence (GBV) within homes and in schools. School- and community-based research have documented high prevalence of family-perpetrated physical violence, peer bullying, sexual harassment, and non-family sexual violence, showing that schools themselves can be spaces for GBV (Poudel, 2017).

Gautam et al. (2024) also found that nearly 45% of adolescent girls in Sarlahi had experienced lifetime GBV in the ways of physical, sexual, and psychological violence. These findings highlight the critical need for early prevention, sound child protection systems, and gender-transformative education initiatives addressing attitudes and behavior among girls and boys. College-level research also indicates widespread exposure to sexual violence and harassment among university students. Karki and Rawal (2023) indicated that while there is relatively high awareness of GBV among university students, reporting is low, and institutional policies are weak to protect students or facilitate help-seeking.

The research identifies lacunae in school-based prevention programs, reporting mechanisms, and survivor support. Overall, the findings suggest multisector interventions in schools and higher education institutions to address adolescent exposure to GBV and provide safe, gender-equitable learning environments. Despite the presence of legal policies and healthcare services addressing gender-based violence (GBV) in Nepal, there are glaring gaps in service readiness and assistance to survivors. Facility- and population-level research has indicated that pregnant women and IPV survivors rarely report exposure to violence to health workers, even at maternity or primary care facilities (Bhatta & Assanangkornchai, 2019; Rishal et al., 2018; Kurvinen et al., 2025).

Missed chances result from infrequent routine screening for violence, variable referral routes, and healthcare workers with no training to identify or act on survivors. Therefore, survivors

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are subjected to violence for extensive periods and lack proper access to early intervention. These discontinuities in service are additionally complicated by mental health needs and organizational issues. IPV survivors tend to be depressed, anxious, and suicidal as well but official help-seeking is minimal (Kurvinen et al., 2025).

Sapkota et al. (2024) point out that inconsistent enforcement of laws, violation of confidentiality, social coercion to reconcile, and access restrictions to legal services further discourage reporting and obfuscate justice. Together, these findings suggest that universal incorporation of GBV screening and referral, strengthening legal enforcement, and access to mental health care are critical to improved outcomes among survivors.

2. General Objective

To examine and incorporate the determinants of gender-based violence in Nepal at individual, relational, household, community, and institutional levels to inform evidence-based prevention programs, policy interventions, and survivor support structures.

3. Methods

This is policy-oriented narrative review that is synchronized with the recent, policy-relevant literature (2017–2025).

The author prioritized: (1) recent national or DHS-based secondary analyses; (2) Nepal-based peer-reviewed, empirical studies; and (3) systematic reviews and mixed-methods investigations of risk factors for GBV in Nepal.

Screened targeted PubMed/PMC, PLOS journals, NepJOL, MedRxiv/Preprints, and publisher websites; the author selected studies providing empirical analysis (quantitative or qualitative) and those that were accessible publicly or had a DOI/PMCID where possible. The results were synthesized thematically across ecological levels. This is not a systematic review (no official PRISMA flow here), but it attempts to provide full representation of recent studies relevant to policy and programming (Gautam et al., 2024; Sapkota et al., 2024).

4. Findings

National and subnational studies consistently report high GBV prevalence. Secondary analysis of the Nepal Demographic and Health Survey (NDHS 2022) and recent publications based on NDHS report lifetime IPV prevalence as between around 23–28% in women aged 15–49 years (different in different studies and inclusion/exclusion of emotional violence).

School-based studies refer to unusually high lifetime GBV among adolescent girls — e.g., a nationally representative school survey conducted in Sarlahi had lifetime GBV prevalence ≈45%.

Systematic reviews of Nepalese studies identify husband's alcohol use, low education level, history of exposure to violence in childhood, and region/caste vulnerability as recurring risk factors. These trends in prevalence indicate the spread of GBV by provinces, ages, and settings (Gautam et al., 2024; Sapkota et al., 2024). 4.1

4.1.1 Individual & relationship level determinants of Gender-Based Violence in Nepal

Educational Attainment Low educational levels for women and their partners remain a primary determinant of intimate partner violence (IPV) in Nepal. Various analyses of Nepal Demographic and Health Survey (NDHS) data and community-based studies have consistently shown that lower education for either spouse is associated with higher IPV risk (Sapkota et al., 2024).

Education is empowering women by having more rights knowledge, increased self-esteem, and communication ability, as well as helping to shift gender attitudes of men.

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Similarly, Clark et al. (2019) showed that women with poor levels of formal education were more vulnerable to IPV, and that education was a safeguard against physical and psychological violence.

These findings indicate that educational programs targeting both genders may reduce violence acceptance and lower risk.

4.1.2 Partner Alcohol and Substance Use

Partner drinking is among the most consistent proximal predictors of IPV in Nepalese settings. Sapkota et al. (2024) demonstrated that alcohol consumption by the husband or partner enhanced the risk of IPV perpetration, both as an aspect of cultural acceptability of drinking and aggression arising due to stress. Bhatta and Assanangkornchai (2019) also noted that drug use by husbands during pregnancy and postpartum increased intimate partner violence risks, and alcohol use screening in partners in antenatal care can serve as an early intervention point. These simultaneous findings highlight the urgent need for alcohol control and psychosocial counseling components in GBV prevention programs.

4.1.3 Controlling Behavior, Male Employment, and Economic Stress

Male controlling behavior, unemployment, and financial adversity are interconnected processes that aggravate IPV risk. Sapkota et al. (2024) discovered that the economic dependence of women—due to limited job opportunities and patriarchal culture—weakens women's power to leave violent relationships. Dhungel et al. (2017) also supported this finding, showing that among garment factory worker women, economic dependence on husbands was a primary source of IPV risk.

Clark et al. (2019) further found that male dominance and dowry pressures directly impacted violence, and women reported normalized control as a normal aspect of an accepted marital life.

Thus, promoting women's economic independence through work programs and livelihood diversification can reduce their exposure to controlling behavior and violence.

4.1.4 Childhood Exposure to Violence

Exposure to child or parental abuse has been established to strengthen an intergenerational cycle of violence. Sapkota et al. (2024) found that children exposed to domestic violence in childhood were far more likely to witness or perpetuate IPV as adults. These results highlight the necessity of early intervention and family-oriented violence prevention programs focused on addressing the root causes of acquired aggression and domesticating non-violent conflict resolution.

4.1.5 Social Norms and Community Influence

Although personal qualities have a part to play, social context may amplify their impact. Clark et al. (2018) illustrated in a multilevel analysis that community-level gender norms independently predict the risk of IPV. Women resident in communities where social norms endorsed wife-beating were more likely to be exposed to violence, regardless of whether they themselves were educated or believed in husband violence. This norm diffusion illustrates how the expectations of society influence relationship patterns, making community-level norm change a critical prevention measure.

4.1.6 Violence During Pregnancy and Postpartum Periods

Pregnant women are under-detected but highly affected victims of domestic violence.

Hospital-based research in Kathmandu revealed 21–28% of pregnant women to have been physically or psychologically abused, predominantly linked with partner drug use, domestic violence, and poor antenatal screening (Bhatta & Assanangkornchai, 2019; Rishal et al., 2018).

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Low rates of victim reporting were reported by Rishal et al. (2018), which refers to lost health system opportunities for early detection.

The inclusion of IPV screening and counseling within maternal health services can therefore be an effective harm-reduction policy.

4.1.7 Infrastructure and Household Stressors

Physical infrastructure constraints can indirectly influence IPV risk. Using NDHS 2016 data, Choudhary et al. (2020) established that limited household access to water is associated with higher IPV risk, which may be due to domestic tension, time pressures, and bargaining power among women being enhanced. The findings underscore the fact that GBV prevention needs to transcend behavior change interventions to include addressing structural differences in infrastructure and resource access. At the individual and relationship levels, determinants of GBV in Nepal bring together a system that interconnects education, economic dependency, alcohol use, controlling behavior, and social norms to affect women's exposure. Research findings collectively indicate that awareness- and law-based interventions are not sufficient; sustainable change can only be achieved through connected education, livelihood, and community norm-transformation programs (Clark et al., 2018; Dhungel et al., 2017; Sapkota et al., 2024).

4.2 Household & socioeconomic determinants

4.2.1 Poverty, Food, and Income Insecurity

Household economic disadvantage and poverty are consistently associated with increased gender-based violence (GBV) risk in Nepal.

Households experiencing ongoing income insecurity, constricted livelihood choices, or food insufficiency exhibit heightened household tension and conflict, which can turn into violence. Sapkota et al. (2024) observed that economic stress and women's dependency on male earnings increase IPV risk by suppressing survivors' autonomy and decision-making power.

Besides, infrastructural poverty, i.e., in-household water scarcity, was also observed to increase intra-household conflict and time burden among women and indirectly violence (Sapkota et al., 2024).

These findings indicate that GBV risk is not just a personal issue but is embedded deeply within economic insecurity and resource inequality.

4.2.2 Family Structure and Extended Households

Family structure of living arrangements impacts GBV processes. In joint or extended families, the presence of multiple controlling actors such as mothers-in-law or brothers-in-law can amount to increased surveillance, mobility confinement, and even normalization of violent practices (Sapkota et al., 2024). Extended families might offer networks of support, but they will also perpetuate hierarchical gender norms and confine the autonomy of women.

Some studies reveal that women in nuclear families experience more overt partner violence, while women in joint families experience emotional or psychological abuse from multiple perpetrators, indicating the necessity of context-sensitive examination of power dynamics within the family.

4.2.3 Caste, Ethnicity, and Regional Disparities

Caste and ethnic ranking persist to play a role in differential exposure to GBV in Nepal. Women from historically excluded groups—Dalit, Madhesi, and certain Janajati groups—are subject to intersecting vulnerabilities of economic exclusion, prejudiced social norms, and inadequate access to the justice system (Sapkota et al., 2024). The Nepal Demographic and Health Survey (NDHS) 2022 Further Analysis Report has found that prevalence of GBV varies significantly

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by province and is higher in the Terai/Madhesh and certain rural hill districts (Dhital et al., 2024).

Regional disparities in access to legal, police, and health services also constrain survivors' opportunities for accessing help.

Such structural differences reinforce the triad of social identity, spatial marginalization, and exposure to violence.

4.2.4 Evidence from NDHS Further Analysis (2022)

The NDHS 2022 Further Analysis Report (Dhital et al., 2024) combined trends of a number of DHS waves of data, and results showed that household poverty, alcohol consumption by the partner, lower levels of education, and past exposure to violence by parents were the strongest predictors of both partner and non-partner violence. The report also highlighted significant geographic clustering of GBV in certain provinces and among marginalized ethnic and caste groups, which has implications for the effectiveness of spatially targeted prevention and response interventions. This evidence indicates the complex interaction of socioeconomic, cultural, and geographic determinants of GBV risk in Nepal.

4.2.5 National Analysis of IPV Determinants and Persistence

A recent national-level study conducted using the 2021–2022 NDHS data reported that approximately 27% of females aged 15–49 years had undergone lifetime IPV, and physical and psychological forms were found to be most common (Shaikh, 2025). The study also established that IPV was consistently linked with alcohol consumption by partner, low levels of education, and attitudinal acceptance of wife-beating. Despite increased awareness drives and policy reforms, such trends have shown minimal variation across time, a sign of entrenched socio-cultural acceptability of violence in intimate relationships.

This stagnation necessitates a renewed focus on structural transformation and strict implementation of GBV laws.

4.2.6 Socioeconomic Determinants and Mental Health

Consequences Socioeconomic determinants also decide the mental health outcomes and coping strategies of the survivors. Kurvinen et al. (2025) found that women experiencing IPV in Nepal are disproportionately at increased risk for depression, anxiety, and suicidal ideation. The study also found very low rates of formal help-seeking, particularly among economically dependent women.

Sexual IPV and controlling acts were the best predictors of adverse mental health outcomes, and this suggests that social isolation and non-economic independence add to the psychological effect of violence.

These results justify the importance of GBV and mental health services integrated at the community and clinical levels. At the family and socioeconomic level, Nepal's GBV is driven by a confluence of poverty, gendered power relations, family configuration, and structural inequalities tied to caste and geography. Dependence and poverty limit women's capacity to refuse or leave violence, while regional and cultural norms facilitate its acceptability. NDHS tests findings and recent national studies indicate that GBV response requires a cross-sector solution integrating economic empowerment, social protection, mental health services, and special support for vulnerable populations (Dhital et al., 2024; Kurvinen et al., 2025; Shaikh, 2025; Sapkota et al., 2024).

4.3 Community, norms, and institutional determinants

4.3.1 Patriarchal Norms and Social Acceptance of Violence

Patriarchal community-level norms, son preference, and acceptability of wife-beating are highly interlinked with higher IPV risk in Nepal (Sapkota et al., 2024). The violence is

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influenced by the norms as well as reporting the violence, since women fear social stigma or retaliation from their kin.

Tomar et al. (2024) demonstrated that the social networks of individuals, who are their opinion takers of value and with whom they share frequent interaction, shape gender-inequitable attitudes.

This network effect means that social norms are spread locally, continuing cycles of violence even in families where individual attitudes might be less accepting of IPV.

The reality that these norms persist means that prevention must address both individuals and the broader community in efforts to reverse entrenched patriarchal values.

4.3.2 Male Frames of Reference and Informal Social Control

Men's frames of reference and practices are central to determining GBV. The ODI "Male Lens" report by Ghimire and Samuels (2017) found that economic poverty, cultural constructions of masculinity, alcohol use, and acceptance of wife disciplining are central drivers of IPV. Traditional family-mediated conflict resolution and customary norms could undermine formal protective mechanisms, depriving survivors of effective redress.

These are pointers to the necessity of male-focused programming like economic empowerment and gender-transformative education to address violence's root causes at the community level.

4.3.3 Institutional and Service Availability Factors

While Nepal has enacted legislation against domestic violence and opened a few one-stop service centers, enforcement is erratic, and survivors risk suspicion from the authorities, fear of backslash, or confidentiality issues (Sapkota et al., 2024; Gautam et al., 2024). Weak links between health, legal, and social services also interfere with timely seeking of assistance. Institutional capacity building, including police sensitization training, streamlining the referral system, and protecting confidentiality, is needed to improve access to support for survivors.

4.3.4 Child Protection and School-Level Factors

Schools are themselves spaces of GBV, including peer harassment, teacher abuse of students, and gendered bullying (Poudel, 2017). Poudel's ethnographic research in Nepal shows that poor child-protection mechanisms allow violence to dominate and socialize violence from early life. These findings indicate that there is a need for implementing school-based prevention interventions, robust reporting systems, and child-protection systems to reduce early exposure to violence and to socialize non-violence among youth.

4.3.5 Synthesis of Community-Level Evidence

Sapkota et al. (2024) in their systematic review also found that community norms embracing violence, male alcohol consumption, spouse's low education, poverty, and exposure to intergenerational violence always forecast IPV risk. Prevention aimed at these causes by sectors at the community, school, and institutional levels is central to reducing GBV prevalence. Those involving social norm modification, male engagement, education, and greater institutional enforcement have the greatest potential for sustainable effect.

The literature considered aims towards an ecological model in which individual risks (e.g., poor education, childhood violence), partner behavior (alcohol, controlling behavior), family economy (poverty, economic dependence), and community values (patriarchy, tolerance of violence) interact.

Partner alcohol use, for example, can provoke violent incidents in households where male dominance is already tolerated; simultaneously, poverty and economic dependence constrain survivors' alternatives to leave and deter reporting.

The high prevalence among young people shows family-level and school/community exposures drive early vulnerability, which can persist to adulthood.

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The majority of studies are cross-sectional; thus, causal links need to be confirmed by longitudinal or interventional study designs (Gautam et al., 2024; Sapkota et al., 2024).

5. Conclusion

Recent research confirms that GBV (including IPV) in Nepal is still very high and is determined by interplaying factors at individual, relational, household, and community levels: low education levels, partner intoxication, poverty, exposure to violence during childhood, and patriarchal ideology. Policies and programs must be multi-level — bundled into survivor-centered service strengthening, education and economic empowerment, male engagement and community norm change, and improved data and evaluation systems — in an attempt to reduce prevalence and improve survivor outcomes.

6. Programmatic implications & recommendations

Based on the gravity of the new evidence, the following is recommended: 1. Increase multi-sectoral, survivor-focused services: Enhance One-Stop Crisis Management Centres and make confidential, trauma-aware care integrated in primary health services; add mental-health and legal counseling and robust referral mechanisms. Implement training of health and police staff in survivor-focused methods (Gautam et al., 2024; Sapkota et al., 2024).

2. Education and norms work: Invest in girls' retention, adult literacy, and school-based gender equality curricula that engage boys. Combine economic-empowerment programs for women with male-engagement and norms-change interventions to reduce backlash risk (Gautam et al., 2024; Sapkota et al., 2024).

3. Partner alcohol use & harmful masculinities: Implement community interventions and brief treatment/referral for harmful alcohol use; support programs that promote positive, non-violent masculinities (Sapkota et al., 2024).

4. Strengthen data, monitoring, and strong evaluations: Continue NDHS and routine surveillance; fund longitudinal cohorts and implementation studies on testing multi-component packages (economic + norms + services), ideally with randomized or strong quasi-experimental designs. Disaggregate data by age, caste/ethnicity, and province (Sapkota et al., 2024).

5. Legal access and outreach: Improve police responsiveness and legal aid to communities; carry out public awareness campaigns that emphasize legal protection and confidentiality; engage leaders at the local level to shift norms and reduce stigma (Sapkota et al., 2024).

Stakeholder recommendations

6. Government: Prioritize one-stop service budgeting, boost legal aid, and maintain NDHS/monitoring systems continuous data collection disaggregated by age, province, caste/ethnicity.

7. Health sector: Make confidential GBV screening mandatory in primary and maternal care with referral routes for psychosocial and legal support.

8. Education sector & schools: Integrate GBV prevention and gender equality into the curriculum; improve reporting and child protection procedures within schools.

9. Civil society & researchers: Scale and measure norm-change activities targeting men and communities; facilitate longitudinal and impact evaluation studies.

Transparency Statement: The author confirms that this study has been conducted with honesty and in full adherence to ethical guidelines.
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