TAKING THE HONOUR OUT OF 'HONOUR-BASED VIOLENCE'

REFRAMING HONOUR AND VIOLENCE

From Theory to Practice

UNDERSTANDING THE CANADIAN LANDSCAPE AND ITS IMPACT ON WOMEN, GIRLS, AND GENDER-DIVERSE INDIVIDUALS IN THE SOUTH ASIAN COMMUNITY

CASSA COUNCIL OF AGENCIES SERVING SOUTH ASIANS

SACAC South Asian Community Advisory Council

WOMEN'S MOSQUE OF CANADA

FUNDED BY:

UNIVERSITY OF TORONTO

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Leading Social Justice Collective, in partnership with the University of Toronto's School of Cities and United Way Greater Toronto

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LAND ACKNOWLEDGEMENTS

We are grateful for the opportunity to contribute to this work on land that has been home to generations of Indigenous peoples long before other nation groups arrived. Our efforts take place on the traditional territories of the Huron-Wendat, Haudenosaunee, and the Mississaugas of the Credit. These lands are part of the Dish with One Spoon Treaty, an agreement among the Anishinaabeg, Haudenosaunee, and allied nations to share and protect the resources around the Great Lakes. This territory is also covered by the Upper Canada Treaties.

Today, Tsi Tkaronto, the traditional Mohawk name for this area, meaning "trees in the water," and its surrounding regions continue to be home to Indigenous peoples. As settlers, we honor the generations of First Nations, Métis, and Inuit communities who have maintained a deep connection to these lands since time immemorial, and whose stewardship continues to shape and guide us today.

We acknowledge that the histories of colonization, land theft, and broken treaties have caused profound harm to Indigenous communities. These actions have disrupted traditional ways of life, marginalized Indigenous voices, and led to systemic inequities that persist today. As settlers on this land, it is our responsibility to reflect on these histories and recognize our role in Truth & Reconciliation.

While we focus on the care and contributions of Indigenous peoples, we also recognize the interconnected histories of other oppressed communities. The transatlantic slave trade forcibly displaced millions of Africans, creating enduring legacies of inequity for Black-African-Caribbean (BAC) peoples. Colonization has likewise shaped the experiences of racialized communities globally, compounding systemic injustices that must be addressed.

This acknowledgment calls us to meaningful action. We commit to listening to Indigenous voices, supporting their leadership, and standing in solidarity to uphold their rights and sovereignty. By reflecting on these histories and learning from them, we strive to honor the land and its peoples through our work toward justice and equity for all, including Indigenous, BAC, and racialized communities who continue to face systemic inequities.

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EXECUTIVE SUMMARY

'Honour-based violence' (HBV) is a serious violation of human rights that infringes on personal autonomy and the right to live free from fear, coercion, and abuse. It encompasses physical, emotional, psychological, and social forms of harm, often justified as a means of preserving family or community "honour." These dynamics disproportionately affect women and girls around the world and in Canada, particularly within South Asian communities, though HBV can also occur in other cultural and community contexts. Understanding who is most affected and the social pressures that sustain HBV is essential for developing effective, survivor-centered policies and support systems.

Despite some progress, significant gaps remain in legislation, training, research, and community engagement, particularly within South Asian communities in Canada. To better understand these gaps, we conducted a scoping review, complemented by focus groups and community consultations carried out as part of the *Taking the Honour Out of 'Honour-Based Violence'* initiative. Participants shared experiences illustrating the emotional and psychological impact of HBV, both in their countries of origin and after immigrating to Canada. Their stories demonstrate how cultural norms, family expectations, community pressures, and transnational influences shape HBV and affect survivors' access to services and support, highlighting the need for evidence-based, survivor-centered policies and programs.

Addressing HBV requires a comprehensive approach that combines legal accountability with survivor-centered services. Strong legal frameworks must recognize HBV as a serious form of violence and hold perpetrators accountable. At the same time, specialized support services—including shelters, counseling, legal aid, and rehabilitation programs—must be expanded and tailored to the specific needs of South Asian survivors, helping them escape abusive situations and rebuild their lives with dignity and independence.

Equally important is promoting cultural sensitivity and fostering community engagement. This involves working directly with South Asian community leaders, families, and grassroots organizations to address and challenge harmful beliefs, norms, and practices that enable or perpetuate HBV. Education and prevention programs in schools, workplaces, and community centers are also key to equipping individuals with the tools to recognize, resist, and speak out against HBV, while cultivating a culture rooted in gender equality and respect.

Tackling HBV is a complex, long-term undertaking, and success depends on collaboration among all stakeholders, including government institutions, law enforcement, community organizations, service providers, and survivors. By centering survivor voices, investing in education and prevention, and building culturally competent, trauma-informed support systems, Canada can move toward a society where no one is harmed in the name of 'honour', and all individuals—particularly women and girls in South Asian communities—can live freely and safely, with dignity and respect.

Full definitions of key terms used throughout this report, including 'honour-based violence,' are provided in Appendix A.

INTRODUCTION

2.1 ABOUT THE PROJECT

The *Taking the Honour Out of 'Honour-Based Violence'* project is a collaborative research initiative focused on addressing the health and well-being of South Asian women affected by HBV in the Greater Toronto Area (GTA) and across Canada. The term "South Asian" refers to people with origins to South Asian or the Indian subcontinent, including countries like India, Pakistan, Bangladesh, Afghanistan, and Sri Lanka (Buchigani, 2023). This project is a partnership between Council of Agencies Serving South Asians (CASSA), United Way Greater Toronto's South Asian Community Advisory Council (UWGT's SACAC), and Women's Mosque of Canada. This project is funded by UWGT and the Leading Social Justice Collective (LSJC).

COUNCIL OF AGENCIES SERVING SOUTH ASIANS (CASSA):

CASSA is a social justice organization representing over 120 agencies, groups, and individuals committed to empowering South Asian and racialized communities. They envision a Canada free from discrimination, where all communities shape the nation's political, economic, social, and cultural landscape. Their strategic priorities include advancing health equity, supporting immigration and settlement, promoting economic empowerment, combating racism and oppression, advocating for gender equity, and addressing online hate and hate crimes. They work in partnership with their members and other social justice organizations across the nation to achieve these goals.

UNITED WAY GREATER TORONTO'S SOUTH ASIAN COMMUNITY ADVISORY COUNCIL (UWGT'S SACAC):

UWGT brings together people from all walks of life to build a stronger, more equitable region, grounded in a longstanding reputation for trust, transparency, and integrity. UWGT's mission is to meet urgent human needs and improve social conditions by mobilizing community resources and fostering local solutions. Within this broader mission, UWGT's South Asian Community Advisory Council (SACAC) plays a vital role in highlighting the unique needs of South Asian communities, particularly in the areas of health, social services, and community engagement. SACAC works collaboratively with partners to remove systemic barriers, promote equity, and empower communities through culturally informed initiatives and advocacy efforts.

WOMEN'S MOSQUE OF CANADA:

Women's Mosque of Canada is a national organization empowering Muslim women through education, advocacy, and community engagement. It provides a safe, women-centered space for spiritual connection, healing, and leadership. The mosque advocates for women's rights,

offering support to those affected by violence and abuse. Focused on gendered spiritual learning, it emphasizes love, compassion, and non-violence, raising awareness of issues like HBV and empowering women to navigate cultural and social challenges.

LEADING SOCIAL JUSTICE COLLECTIVE (LSJC):

LSJC is a three-month professional development program co-hosted by UWGT and University of Toronto's School of Cities. The program equips private, public and not-for-profit individuals in the GTA with problem solving skills to address complex social issues that require cross-sectoral solutions. LSJC offers in-person and virtual network-building as well as professional development through interactive dialogue with accomplished leaders from across sectors, including real time project coaching and support for teams as they solve their challenges. They fund and support initiatives that address issues such as gender-based violence (GBV), racial inequality, and the empowerment of marginalized groups. Through research, activism, and policy advocacy, LSJC works to create systemic change and amplify the voices of those most affected by injustice.

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2.2 DISCLAIMERS

ENGAGING DIVERSE VOICES

This report was developed in consultation with community members, subject matter experts, and survivors with lived experience. At every stage of the project, we made a deliberate effort to engage diverse voices affected by HBV. We recognize, however, that HBV is experienced in different ways depending on intersecting factors such as gender, race, religion, immigration status, and socio-economic background. Despite our efforts to be inclusive, we acknowledge that not all perspectives may be fully represented in this report. We view this as part of an ongoing process and hope to build on this work with broader engagement in future phases, pending access to further support and resources.

USE OF THE TERM 'HONOUR-BASED VIOLENCE'

During our consultations, we specifically asked participants, including survivors and subject matter experts, for their views on the use of the term 'honour-based violence'. While several individuals expressed discomfort with the terminology—rightly noting that there is no honour in any form of violence—a collective decision was made to continue using the term for the purposes of this report. The term is widely used in legal, policy, academic, and service delivery contexts, and changing it solely within the scope of this small, community-based project risked disconnecting our work from established systems and broader efforts to date. We believe that any shift in terminology must occur at a larger scale, with leadership from impacted communities, researchers, and policymakers.

For a more detailed explanation of our rationale and approach to the term 'honour-based violence', including how it influenced the title of our project, **please refer to** **Section 2.4: Rationale for Using the Term 'Honour-Based Violence.'**

CLARIFYING INTENT AND AVOIDING STIGMATIZATION

Our intention in using the term 'honour-based violence' is not to vilify the South Asian community, or any culture or religion. We acknowledge that HBV is a complex issue that can occur across different cultural contexts. Our goal is to address this form of violence in a culturally sensitive and respectful manner, while advocating for the safety, dignity, and well-being of those affected. We aim to engage communities in meaningful dialogue and work collaboratively toward solutions that challenge harmful practices without undermining cultural identity.

POTENTIALLY TRIGGERING CONTENT

This report references real publicly reported cases of HBV, including the names of both survivors/victims and perpetrators. These details are included to acknowledge lived realities, provide context, and highlight the seriousness of HBV. However, we recognize that this content may be distressing or triggering for some readers, particularly survivors of violence. We encourage readers to prioritize their well-being when engaging with this report.

2.3 PROJECT PURPOSE AND OBJECTIVES

The purpose of this research is to deepen understanding of HBV as it occurs within South Asian communities in Canada, recognizing that HBV is shaped by intersecting cultural, gender, migration, and structural factors. While HBV is part of a broader continuum of GBV, its specific dynamics—including control tied to perceived family honour, collective decision-making, coercion by extended family members, and risks related to transnational ties—require targeted analysis. This project seeks to capture these complexities by centring the voices of South Asian survivors, service providers, and community leaders across the GTA.

In addition, the research aims to identify systemic and policy-level barriers that affect survivors' safety and access to support, including gaps in culturally responsive services, lack of awareness among mainstream systems, and barriers linked to immigration status, stigma, or fear of community repercussions. The purpose is not only to document experiences of HBV, but to inform stronger, more equitable approaches to prevention, early intervention, and survivor-centred support across social services, healthcare, education, and justice systems.

OBJECTIVES

Conceptualizing 'Honour-Based Violence': Establish a comprehensive understanding of HBV by defining its forms, manifestations, and distinguishing features, emphasizing how it differs from other forms of GBV. Highlight its unique social, familial, cultural, and transnational dynamics, and explain why these characteristics necessitate targeted, culturally responsive, and multi-sector interventions.

Situating HBV in Social and Cultural Contexts: Examine HBV within South Asian communities in Canada, considering how gender norms, family honor, intergenerational expectations, migration experiences, and transnational influences interact to shape the occurrence, expression, and consequences of violence.

Mapping Prevalence and Global Patterns: Analyze Canadian and global data to identify HBV prevalence, distribution, affected populations, and recurring systemic patterns. Highlight structural, cultural, and policy-related barriers that influence reporting, access to services, and prevention, ensuring insights are relevant for the Canadian context.

Evaluating Interventions, Programs, and Policy Frameworks: Critically assess Canadian and global HBV interventions, including community-based programs, institutional practices, and legislative frameworks. Evaluate their effectiveness, cultural responsiveness, and adaptability, and identify evidence-informed lessons that can guide trauma- and survivor-centered improvements in Canada.

Centering Survivor Lived Experience: Amplify the perspectives of South Asian survivors, including women, youth, and LGBTQIA2S+ individuals, ensuring their lived experiences shape the research, enhance understanding of HBV dynamics, and directly inform actionable recommendations for culturally safe and effective responses.

Integrating Subject Matter Expertise: Draw on the insights of frontline workers, healthcare and legal professionals, educators, and community advocates to understand systemic challenges, service delivery gaps, and effective strategies for prevention, intervention, and long-term survivor support.

Developing Culturally Informed Training Tools: Create a trauma- and survivor-centered train-the-trainer module that equips frontline workers and service providers with culturally competent, evidence-based tools to recognize, prevent, and respond to HBV effectively, strengthening frontline capacity across sectors.

Producing Actionable, Equity-Focused Recommendations: Translate research findings into practical guidance for governments, policymakers, law enforcement, academics, frontline workers, service providers, and community organizations, enhancing HBV prevention, early intervention, multi-sector coordination, and survivor support through culturally safe, inclusive, and intersectional approaches.

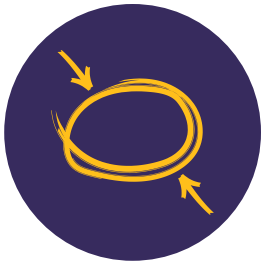
2.4 RATIONALE FOR USING THE TERM 'HONOUR-BASED VIOLENCE'

WHY WE USE THE TERM 'HONOUR-BASED VIOLENCE'

The term 'honour-based violence' is used in this project to accurately reflect a specific form of violence that is perpetrated under the pretext of preserving or restoring family or community "honour." This form of violence is distinct from other types of GBV, as it often involves multiple perpetrators, typically family members, and is rooted in deeply entrenched cultural, social, and religious norms.

This terminology was selected through consultations with both survivors and subject matter experts, including health service providers, researchers, advocates, and community leaders. While some expressed discomfort with the term, noting that "there is no honour in any form of violence," there was consensus that using the term remains important for clarity, alignment with policy and legal frameworks, and advocacy purposes. Changing the term solely for this project, given its community-based scale, could risk disconnecting the work from broader conversations and frameworks where HBV is already recognized.

By using the term 'honour-based violence,' our project aims to:



Highlight the Unique Motivations: HBV is driven by a perceived need to uphold or reclaim the family or community's "honour", often in response to actions or behaviors by individuals—typically women—that are seen as bringing shame or dishonor. The term helps emphasize these specific motivations, which are crucial for understanding the dynamics of the violence and developing effective interventions.

Address Cultural Sensitivity: Using this term allows us to engage with communities in a way that acknowledges their cultural context while also challenging harmful practices. It opens up a space for dialogue on how cultural values can be interpreted and practiced in ways that do not harm individuals, particularly women, girls, and gender-diverse individuals.

Enhance Awareness and Recognition: The term 'honour-based violence' is increasingly recognized in legal, policy, academic, and service delivery contexts both in Canada and internationally. Using this term ensures that our project aligns with these frameworks and contributes to a growing body of knowledge and advocacy aimed at addressing this specific type of violence.

Facilitate Targeted Support and Resources: By specifically identifying the violence as 'honour-based,' our project can more effectively advocate for targeted support and resources for those affected. It allows us to tailor our interventions to the unique needs of survivors, who may face complex social and familial pressures.

Promote Informed Policy and Legal Responses: The term helps in advocating for policies and legal responses that are informed by an understanding of HBV, ensuring that the nuances of this form of violence are considered in the development of protective measures and support systems for survivors.

We also recognize that HBV does not occur in a vacuum. It intersects with factors such as gender, age, faith, immigration status, socioeconomic background, and intergenerational power imbalances. Our use of the term is grounded in an intersectional lens that aims to understand and respond to the full context of each survivor's experience.

At the same time, we acknowledge the limitations of the term. It can unintentionally reinforce stereotypes or suggest that honour is an acceptable justification for violence. We use it with critical awareness and a commitment to avoiding stigmatization or generalizations about any culture or faith.

WHY WE NAMED OUR PROJECT "TAKING THE HONOUR OUT OF 'HONOUR-BASED VIOLENCE'"

While we retain the term 'honour-based violence' to ensure consistency with institutional frameworks, the title of our project—*Taking the Honour Out of 'Honour-Based Violence'*—reflects a deliberate attempt to challenge the premise that violence can ever be honourable.

By removing the concept of honour from the discussion, our project aims to:

Shift the Focus to the Violence: The term 'honour-based violence' often implies that the violence is justified by cultural or familial notions of honour. Our title challenges this notion by focusing solely on the abusive actions and the need for accountability, rather than legitimizing the violence through a mistaken belief in a cultural or moral basis.

Dispel Misconceptions: We seek to dismantle the harmful association between honour and violence, making it clear that violence is never justified. This approach reinforces the need for legal and social measures to protect and support those affected by HBV.

Promote Positive Change: The project encourages communities to redefine 'honour' in a way that respects and upholds the dignity, autonomy, and human rights of all individuals. By taking the "honour" out of the equation, we aim to foster healthy, supportive, and non-violent relationships within families and communities.

Empower Affected Individuals: The title reflects our dedication to empowering those impacted by HBV to reclaim their narratives and live free from the pressures of harmful cultural or social expectations. It underscores the importance of protecting individuals, regardless of the perceived impact on family or community honour.

Promoting Critical Dialogue: Quotation marks around 'honour-based violence' signal to the reader that the term is subject to ongoing debate and critique. It invites the reader to engage critically with the terminology and to question its appropriateness, especially in the context of efforts to prevent and address violence

In essence, *Taking the Honour Out of 'Honour-Based Violence'* reflects our commitment to addressing this issue with cultural sensitivity, survivor-centered language, and a focus on accountability, prevention, and justice. We remain mindful of the power of language to both illuminate and obscure—and we use it carefully, with the goal of protecting the rights and well-being of those affected.

3.1 DEFINING THE CONCEPT: WHAT CONSTITUTES 'HONOUR-BASED VIOLENCE'

WHAT IS 'HONOUR-BASED VIOLENCE' (HBV)?

'Honour-based violence' refers to acts of abuse committed by individuals or groups who believe a person, most often a family member, has brought shame or dishonour to the family or community. These acts, carried out to restore perceived honour, disproportionately affect women and girls, although men, boys, and LGBTQIA2S+ individuals can also be targeted. HBV is distinct in that it often involves multiple perpetrators, including extended family and community members, and is deeply rooted in cultural, social, and sometimes religious norms (Gill, 2022).

The term 'honour-based violence' is not a formal legal classification and has been subject to criticism for its potential to imply that such violence is culturally justified or acceptable. Nevertheless, it remains a widely used term in research, policy, and practice to describe this distinct and complex form of abuse (Royal Canadian Mounted Police [RCMP], 2021).

Distinguishing 'Honour-Based Violence' from Domestic Violence

Both HBV and domestic violence (DV) are forms of GBV, which encompasses harmful acts directed at individuals based on their gender, often rooted in power imbalances and societal norms. While they share some similarities—such as physical harm, emotional manipulation, and coercive control—they differ in motivation, context, perpetrators, and cultural influences. DV typically occurs within intimate or familial relationships and is driven by a desire for power and control, reflecting broader patterns of GBV that uphold gender inequality and patriarchal dominance. In contrast, HBV is rooted in collective ideas of honour and shame, often involving multiple perpetrators, including extended family or community members, who aim to restore the family's or community's reputation.

Treating HBV and DV as the same can lead to ineffective policies and inadequate support for those affected. Recognizing both as interconnected yet distinct forms of GBV allows for interventions that are sensitive to their unique dynamics, cultural contexts, and risks, ensuring more effective and survivor-centered responses.

Aspects	'Honour-Based Violence'	Domestic Violence
Motivation	To protect or restore family or community honour by punishing perceived violations of cultural, religious, or social norms (e.g., rejecting arranged marriage, seeking divorce, defying prescribed gender roles). (Gill, 2022)	To gain or maintain power and control within an intimate or familial relationship, often driven by jealousy, possessiveness, or a desire to dominate.
Targets	Primarily women and girls who challenge traditional roles or expectations. Men, boys, and LGBTQIA2S+ individuals may also be targeted if perceived as dishonouring the family or supporting someone who has transgressed norms. (Gill, 2022)	Can affect anyone in a close personal or intimate relationship with the abuser, regardless of gender, age, or cultural background, including spouses, partners, children, or elders.
Perpetrators	Usually multiple individuals, including immediate or extended family members (parents, siblings, cousins, uncles). The broader community may silently condone or actively encourage the violence. (Gill, 2022)	Typically a single individual, most often a current or former intimate partner, but can include other family members or caregivers in cases like elder abuse or child abuse.
Cultural Contexts	Rooted in specific cultural, traditional, or religious beliefs about honour and shame that legitimize control over behaviour and social conformity. (Gill, 2022)	Occurs across all cultures, socioeconomic statuses, and demographics, with no specific cultural or religious ties, although culture can influence reporting and intervention.
Planning and Pattern	Abuse, particularly 'honour killings', is often premeditated and coordinated through family or community meetings, sometimes accompanied by repeated threats, and is usually tied to perceived breaches of honour. Unlike DV, incidents are typically event-driven rather than following a cyclical pattern. (Gill, 2022)	Abuse may be spontaneous or premeditated, usually carried out by an individual rather than a group, and can escalate during periods of stress or conflict. It often follows a recurring cycle of tension, violent incident, reconciliation, and calm, reflecting the abuser's ongoing need for control.

Aspects	'Honour-Based Violence'	Domestic Violence
Forms of Abuse (not limited to)	• **Physical Abuse:** Beatings, burning, stabbing, mutilation, or 'honour killings', among others, often carried out by multiple family members to punish perceived breaches of family or community "honour." • **Emotional & Psychological Abuse:** Manipulation, threats, guilt, shame, intimidation, or constant monitoring, used by family or community to enforce conformity and "restore honour." • **Sexual Assault (SA)/Violence:** Sexual acts, coercion, or threats, used to punish perceived dishonour (e.g., rejecting arranged marriage), enforce compliance, or control behaviour. • **Financial Abuse:** Controlling access to money, education, or employment to enforce compliance with family or community "honour," often through collective pressure. • **Social Abuse:** Restricting movement, education, work, social contact, or community engagement, including isolation and social ostracism, to control behaviour and enforce "honour" norms. • **Cultural or Spiritual Abuse:** Using cultural, religious, or community norms to justify abuse, including forced or child marriage, harmful practices like female genital mutilation (FGM), and moral policing to maintain perceived "honour."	• **Physical Abuse:** Hitting, slapping, choking, or other forms of bodily harm, carried out by one individual (partner or family member) to assert power, control, and intimidation within the relationship. • **Emotional & Psychological Abuse:** Threats, intimidation, gaslighting, humiliation, surveillance, or coercion, used by a partner or family member to control or dominate the victim. • **SA/Violence:** Rape, sexual coercion, or unwanted sexual contact, among others, used by a partner or family member to exert power, control, or punish the victim. • **Financial Abuse:** Controlling a partner's access to money, employment, or resources to create dependency and maintain power within the intimate relationship. • **Social Abuse:** Limiting movement, contact with friends or family, or community engagement, including stalking or harassment, to isolate the victim and increase dependence.

THEORETICAL FRAMEWORKS ON 'HONOUR-BASED VIOLENCE'

Understanding HBV requires a multi-dimensional approach that goes beyond individual behaviour and examines how broader social, cultural, and structural forces shape the phenomenon. HBV is not simply a private or domestic matter, it is embedded in systems of power, reinforced through cultural narratives, and often sustained by collective social structures. The following frameworks provide insight into how HBV functions, why it persists, and how it can be effectively addressed.

Patriarchal Control and Gendered Violence Framework

Patriarchy is a system of social structures and practices that institutionalizes male power over women and children within the family and society at large. In such societies, women are often undervalued and assigned a lower status compared to men. This institutionalized male dominance is deeply embedded not only in family life but also across cultural, social, and legal institutions. Within this hierarchical order, expectations of honourable behaviour differ significantly for men and women. Men are expected to actively protect the dignity of their families by controlling, and at times oppressing, their female relatives. Conversely, women are considered the symbolic bearers of group identity, whether kinship groups, villages, castes, or classes, and must remain chaste and pure to preserve the family's honour. This system of control often manifests in violence aimed at enforcing conformity, notably through HBV. (Altınbaş, 2021)

HBV is a highly gendered form of violence, primarily targeting women and is often enforced through men's policing of those who challenge patriarchal norms. It functions as a mechanism of control, justified by socially constructed systems of honour, values, and traditions (Gill, 2010). Central to these systems is the distinction between masculine honour, linked to achievements and social status, and familial honour, tied to women's sexual purity, modesty, and obedience. Women who deviate from these expectations—such as rejecting arranged marriages, seeking divorce, dressing immodestly, or losing virginity (even as a result of SA)—are perceived as threats to family reputation and social standing (Altınbaş, 2021).

Unlike typical DV, which often involves a single abuser, HBV commonly involves multiple family members who collectively enforce conformity and uphold honour codes. This reflects broader cultural and social pressures to maintain patriarchal norms, where women's behaviour is treated as a public concern rather than a private matter. The involvement of extended family members, including female relatives, in perpetuating violence and control is normalised and sometimes demanded by these social structures. Fear of social stigma, exclusion, and intense familial pressure often silences victims, sustaining cycles of violence and control.

While legal frameworks and international human rights standards, such as those established by the United Nations, provide mechanisms for accountability, they are insufficient on their own to prevent HBV. True prevention requires cultural transformation that challenges entrenched patriarchal power dynamics, dismantles honour-based control mechanisms, and advances gender equality at all social levels.

Intersectional, Postcolonial, and Structural Violence Framework

HBV must be understood through an intersectional lens, which reveals how overlapping systems of oppression shape how HBV is experienced and responded to. Kimberlé Crenshaw's (1991) concept of intersectionality emphasizes that no form of violence occurs in isolation; rather, it is filtered through the unique positioning of the individual within multiple social hierarchies to produce unique experiences of violence and marginalization. For example, a South Asian woman experiencing HBV may face compounded barriers due to limited English proficiency, precarious immigration status, or LGBTQIA2S+ identity, all of which intersect with patriarchal control within her family or community. These overlapping identities often leave survivors underserved or overlooked by mainstream systems that are not equipped to address their complex realities. Without accounting for intersectionality, interventions risk being either culturally insensitive or insufficiently protective.

Postcolonial theory further illuminates how HBV is problematically represented in dominant discourse and policy frameworks. Edward Said's (1978) concept of Orientalism and Gayatri Spivak's (1988) critique of the trope "white men saving brown women from brown men" both reveal how Western narratives often depict non-Western communities as inherently violent and regressive. This framing allows HBV to be treated as a cultural pathology of immigrant or Muslim communities, rather than as a symptom of broader systems of inequality and marginalization. Consequently, policy responses tend to focus on punitive or surveillance-based interventions rather than addressing the socio-economic and political conditions that sustain HBV. Postcolonial critique thus challenges the racialized assumptions embedded in GBV policies and urges a shift toward decolonized, community-led responses.

Lastly, the lens of structural violence helps to contextualize how institutional systems reinforce and reproduce HBV through neglect and systemic exclusion. Structural violence refers to the deeply embedded social arrangements and power imbalances within political, economic, and institutional systems that systematically harm marginalized individuals and communities by restricting their access to resources, opportunities, and protections (Montesanti & Thurston, 2015). In the case of HBV, survivors often encounter systemic barriers such as unemployment, inaccessible shelters, culturally incompetent healthcare and legal services, and immigration laws that tie women's status to their abusers. These institutional failures prevent survivors from escaping violence and effectively criminalize vulnerability. Structural violence shifts the focus from individual perpetrators to the broader societal structures that enable and normalize harm. Addressing HBV, therefore, requires not only community education and intervention, but also systemic reform that prioritizes culturally safe, anti-racist, and survivor-centered approaches.

Collective Violence and Social Control Framework

HBV is embedded within collectivist social structures in which responsibility, punishment, and control are distributed across the family or community rather than resting with individuals (World Health Organization [WHO], 2002). In these contexts, a woman's perceived deviation from expected norms—whether related to relationships, appearance, independence, or sexuality—is seen not simply as personal misconduct but as a threat to the family's collective social standing. This perceived dishonour triggers a communal response, where multiple relatives, sometimes including female family members, feel morally obligated to discipline or punish the individual in order to restore the family's reputation.

Social control is maintained through both informal and formal mechanisms. Gossip, community judgment, and peer pressure act as powerful deterrents, while sanctions may be administered through customary systems such as family councils or community elders. These systems not only enforce conformity but also reinforce intergenerational values, making honour-based expectations feel both normal and inescapable. Because violence or punishment is often enacted collectively, individual accountability is diluted, and community complicity makes intervention more difficult. Victims may face backlash not just from one person but from entire networks, further isolating them and limiting their access to support.

HBV is not an isolated phenomenon. It shares important structural features with other forms of collective violence. Like HBV, these forms of violence are driven by shared ideologies, a sense of group obligation, and the defense of collective identity. Some key types include (WHO, 2002):

Mob Violence: Mob violence is spontaneous, emotionally charged group violence carried out by crowds. It can involve assault, intimidation, or vandalism, often fueled by shared grievances or desires for retribution. The group typically lacks centralized leadership or formal coordination, and responsibility is diffused among participants, making accountability difficult.

Tribal or Ethnic Conflict: Tribal or ethnic conflict is violence between groups rooted in historical grievances, competition for resources, or political tensions. It may involve massacres, displacement, or targeted attacks. These conflicts are often intensified by colonial histories and elite exploitation of divisions. They are frequently exacerbated by colonial legacies, territorial disputes, and elites who exploit ethnic divisions for power.

Gang Violence: Gang violence is organized collective violence used to assert dominance over territory, illicit markets, or rival groups. It often involves extortion, intimidation, assault, and murder. This form of violence thrives in contexts of poverty, inequality, and weak state presence.

State-Sanctioned Violence: State-sanctioned violence refers to harm carried out or endorsed by governments or authorities to maintain control, suppress dissent, or enforce policy. It includes police brutality, military crackdowns, genocides, and state-sponsored terrorism. Such violence is often institutionalized, with perpetrators shielded from accountability and justified under the guise of national security or law and order.

Religious Extremism: Religious extremism involves violent acts committed in the name of religion or ideology, often supported by group participation or endorsement. This can include terrorist attacks, hate crimes, or communal violence. It typically arises from the manipulation of faith or doctrine to justify violence against perceived enemies, non-believers, or rival sects.

Social Violence (Culturally Sanctioned / Tradition-Based Violence): Social violence refers to harmful practices justified or legitimized by cultural or traditional customs. Examples include HBV, FGM, and child marriage. These acts disproportionately affect women, girls, and gender-diverse people, and are often upheld by the community.

Effective prevention requires more than targeting individuals; it demands challenging the community values, power dynamics, and cultural norms that uphold it. Lasting change depends on community-led efforts that support survivors, engage cultural leaders, and transform harmful traditions from within.

3.2 HISTORICAL AND SOCIAL CONTEXT: ROOTS AND DRIVERS OF 'HONOUR-BASED VIOLENCE'

HBV has deep historical roots tied to ancient social structures that emphasized family honour, lineage, and communal reputation. In many pre-modern and traditional societies, honour was inseparable from social standing, kinship ties, and community cohesion. The control of women's sexuality and behaviour was often central to maintaining these collective ideals, as women were regarded as carriers of family honour and purity. These values were reinforced through customs, religious doctrines, and laws that varied across regions but shared a common emphasis on protecting family reputation by regulating gender roles strictly.

Historically, HBV practices emerged alongside patriarchal systems that granted men authority over women's bodies and choices. This control was legitimized not only by cultural norms but also by social and sometimes legal sanctions. Transgressions of prescribed gender norms were not seen as individual failings but as threats to the entire family or community's honour, prompting collective enforcement that could include punishment or violence. For example, in South Asian communities, *izzat* (Urdu, Hindi, and Bengali term for "honour") is closely tied to women's conduct, action, and social performance, with family prestige depending on their conformity to cultural, religious, and class-based norms (Gill, 2009). Because izzat is seen as residing in women's bodies and choices, its preservation often comes before individual autonomy and reinforces patriarchal control (Gill, 2009).

Colonial histories have shaped the persistence and transformation of HBV. Colonial powers formalized traditional honour systems into laws or regulations as tools of control, while western narratives often portrayed these practices as "exotic" or "barbaric," oversimplifying their social complexity. Diaspora communities, including South Asians in Canada, have carried these traditions into new contexts where they may adapt or intensify due to migration pressures, identity preservation, and community cohesion. Although legal reforms, human rights movements, and shifting social attitudes have challenged some HBV practices, the phenomenon continues to persist in many communities, evolving in form but still primarily enforcing conformity to collective honour codes and patriarchal values.

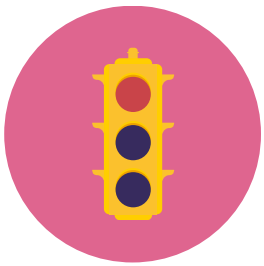
Forced Marriage (FM): FM is a union where one or both parties do not give free and informed consent. Coercion may include threats, deception, or physical violence, and victims are sometimes taken abroad under false pretenses. It is often linked to family honour, immigration control, or economic gain.

Child Marriage: Child marriage is a marital union where at least one party is under the age of 18. It is often justified as protecting family honour, securing economic stability, or reinforcing community ties. The practice disproportionately affects girls, depriving them of autonomy, education, and safety.

Dowry-Related Violence: Dowry-related violence refers to the harassment, abuse, or murder connected to disputes or dissatisfaction over dowry payments. Women may be mistreated by husbands or in-laws if demands are unmet. It transforms economic bargaining into a form of coercion and gendered violence.

'Honour' Killings/ Femicide: 'Honour' killings are the intentional killing of individuals, mostly women and girls, perceived to have brought shame to their families. Femicide more broadly refers to the killing of women because of their gender. These acts are often triggered by behaviors considered transgressive, such as rejecting FM, seeking divorce, engaging in pre-marital relationships, surviving SA, or challenging traditional gender roles.

Female Genital Mutilation (FGM): Female genital mutilation is the partial or total removal of female genitalia for non-medical reasons. It is often justified as preserving purity or ensuring marriageability. The practice causes severe physical and psychological harm and is internationally recognized as a human rights violation.



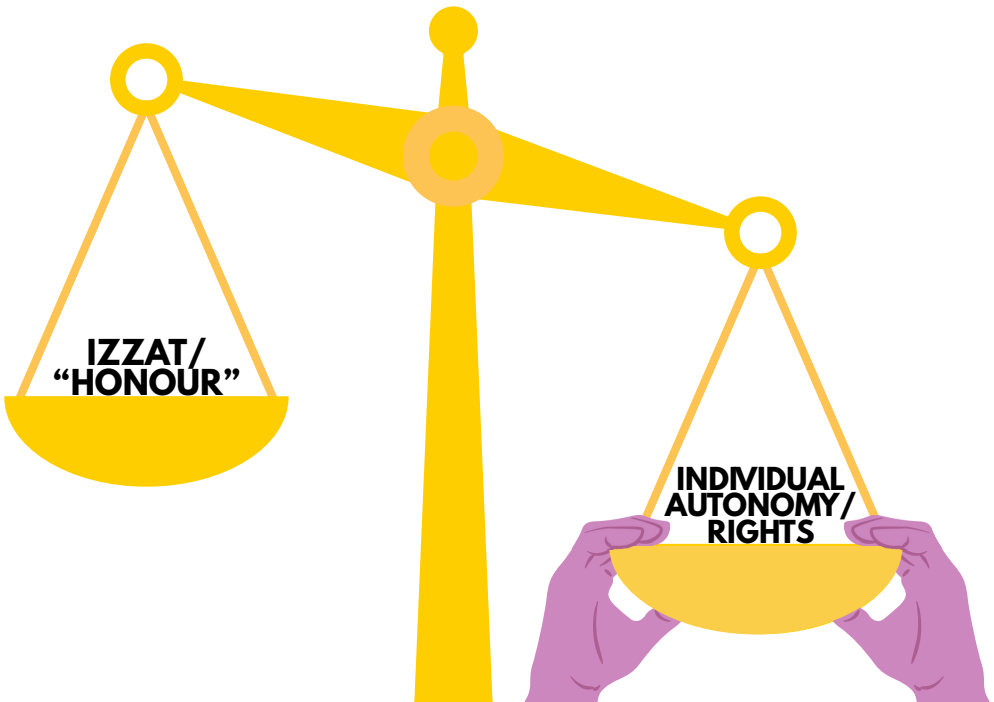
Sexual Assault and Stigma: Survivors of SA or rape may experience compounded harm, not only from the immediate act of violence but also from the responses of family and community members. Families may engage in victim-blaming, coercion, or even further violence, driven by the belief that the survivor's experience has tarnished family honour.

Female Infanticide & Sex-Selective Abortion: Female infanticide and sex-selective abortion involve killing newborn girls or terminating pregnancies based on fetal sex. These practices are rooted in son preference and beliefs that daughters are burdensome or dishonourable. They contribute to distorted sex ratios and reinforce systemic gender inequality.

Policing of Women's Conduct: Family and community members also enforce social, cultural, or religious expectations around women's behaviour, appearance, and life choices. This policing can target individuals who wear "westernized," non-traditional, or revealing clothing, pursue independence, higher education, or a career, or otherwise challenge traditional gender roles.

Violence Against LGBTQIA2S+ Individuals: Individuals who do not conform to heteronormative expectations, including those who identify as LGBTQIA2S+, are particularly vulnerable. They may face harassment, physical or sexual violence, forced "conversion" practices, rejection by family or community, and exclusion from social and economic life.

These practices are often embedded in complex family and community dynamics, which can hinder intervention and support for survivors. Understanding these specific manifestations within their cultural and community contexts is essential for designing effective, culturally sensitive prevention and support strategies.



3.3 SCOPE OF THE ISSUE: NATIONAL AND GLOBAL PREVALENCE

'HONOUR-BASED VIOLENCE' IN THE CANADIAN CONTEXT

In Canada, HBV is a serious yet often underreported issue. While there is no specific criminal offence categorized as 'honour-based violence' in the Criminal Code, several high-profile cases have brought national attention to this form of violence, typically perpetrated within families or close-knit communities to protect or restore perceived honour. Many cases are captured under DV, family violence, or homicide laws, making it difficult to assess the full scope of HBV in the country.

According to the Department of Justice Canada, a preliminary review of court documents and media reports identified approximately a dozen 'honour' killings between 1999 and 2009 (Muhammad, 2010). In 2015, federal officials testifying before the House of Commons' Standing Committee on Citizenship and Immigration reported that 24 cases of 'honour' killings had been recorded in Canada since 2009 (Standing Committee on Citizenship and Immigration, 2015). Experts cautioned, however, that this number is likely an underrepresentation due to the absence of a formal classification for HBV in Canada's criminal justice system.

In Canada, the Department of Justice has officially recognized several cases as documented honour-based killings, based on court records and detailed investigations. These cases provide clear examples of violence motivated by perceived family dishonour and cultural or patriarchal control:

- **Amandeep Kaur Dhillon – Mississauga, ON (2009)**

On January 1, 2009, Amandeep Kaur Dhillon (22) was fatally stabbed in the basement of a Mississauga grocery store. Her father-in-law, Kamikar Singh Dhillon, pleaded guilty to second-degree murder in June 2010. He told investigators he killed Amandeep because she was going to dishonour the family by leaving his son for another man. The father-in-law was sentenced to life imprisonment with no parole eligibility for 15 years. (Muhammad, 2010)

- **Aqsa Parvez – Mississauga, ON (2007)**

Aqsa Parvez (16) was a high school student who resisted her family's strict expectations around wearing the hijab and adhering to conservative gender roles. Her refusal to conform was perceived as a threat to the family's honour. In December 2007, Aqsa was strangled to death by her father, Muhammad Parvez (57), and brother, Waqas (26) in an act that shocked the nation and became one of Canada's most widely publicized HBV cases. (Muhammad, 2010)

- **Shafia Family Murders – Kingston, ON (2009)**

The murders of sisters Zainab (19), Sahar (17), Geeti (13), and their stepmother Rona Mohammad Omar (52) shocked Canadian society. Mohammad Shafia (56), his second wife, Tooba Mohammad Yahya (39), and his son Hamed Shafia (18) were convicted of drowning the four in a car submerged in a canal, motivated by the belief that the women had brought dishonour by adopting Western lifestyles, engaging in romantic relationships, and violating strict behavioural codes. (Muhammad, 2010; BBC, 2018)

- **Khatera Sadiqi and Feroz Mangal – Ottawa, ON (2006)**

In September 2006, Khatera Sadiqi (20) and her fiancé, Feroz Mangal (23), were gunned down outside an Ottawa shopping plaza. Hasibullah Sadiqi (23), Khatera's brother, was convicted of their murders and sentenced to life imprisonment with no parole eligibility for 25 years. The killings were motivated by anger over Khatera's engagement, which was not authorized by their father, representing one of Canada's first cases where the prosecution argued "honour killing" to prove premeditation. (Muhammad, 2010)

- **Kalwinder Dulay, Gurdawr Dulay, and Mukesh Sharma – Calgary, AB (1991)**

Kulvinder Dulay killed his younger sister Kalwinder, her husband Gurdawr Dulay, and Mukesh Sharma, the man they lived with. He claimed responsibility as the eldest son for "cleansing" the family honour because his family disapproved of Kalwinder's marriage. He was convicted of two counts of first-degree murder and one count of second-degree murder and received mandatory life sentences. (Muhammad, 2010)

- **Subramaniam – Ontario (2006)**

Sugirthanraj Kailayapillai was sentenced to life imprisonment without parole eligibility for 14 years for the 2006 killing of his wife, Subramaniam. He hung her body in their garage and sent their young daughter and mother-in-law to find it. He claimed his wife's "bad character" and extramarital relationship dishonoured the family, leading to her murder. (Muhammad, 2010)

- **Farah Khan – Toronto, ON (1999)**

Muhammad Khan was convicted of first-degree murder for beating his five-year-old daughter, Farah Khan, to death. He claimed he acted to restore honour because Farah was the child of his first wife and another man. His wife, Fatima Khan, was convicted of second-degree murder related to the case. (Muhammad, 2010)

- **Adi Abdul Humaid – Ontario (1999)**

Adi Abdul Humaid was convicted of first-degree murder for killing his wife, claiming he lost control due to suspicions of infidelity rooted in cultural and religious beliefs. The Supreme Court of Canada rejected cultural beliefs as a legal defense, affirming that violence motivated by such beliefs contradicts Canadian values of gender equality. (Muhammad, 2010)

- **Amandeep Atwal – British Columbia (2003)**

Rajinder Singh Atwal was convicted of second-degree murder for killing his daughter, Amandeep Atwal (17), who died from multiple stab wounds. He disapproved of her secret romantic relationship and was sentenced to life imprisonment with no parole eligibility for 16 years. (Muhammad, 2010)

- **Kanwaljeet Kaur Nahar – Ontario (2001)**

Kanwaljeet Kaur Nahar was fatally stabbed by her husband, who was later convicted of second-degree murder. During the trial, he claimed cultural provocation, arguing that her lifestyle—reportedly involving smoking, drinking alcohol, and socializing with men—had brought dishonour to the family. However, this defense was rejected at both the trial and appeal levels. (Muhammad, 2010)

In addition to these officially recognized cases, there are several other tragic incidents widely reported in Canadian media that exhibit characteristics suggestive of honour-based killings. However, these cases have not been formally classified as honour-based killings by the Department of Justice Canada, reflecting ongoing challenges in identification and classification. This list is not exhaustive, as many cases likely remain unreported or unrecognized due to cultural stigma, lack of awareness, and systemic barriers.

- **Yasmin Ali Mohamed – Toronto, ON (2023)**

Yasmin Ali Mohamed (29) was violently assaulted in her apartment and died from her injuries. A man known to her, Omar Kadeem Sharras Reynolds (30) was charged with second-degree murder. The case has been classified as femicide, with trauma listed as the cause of death. (Rocca, 2023)

- **Naheed Askaryar – Vaughan, ON (2022)**

Naheed Askaryar (64) was found dead in her home, which was engulfed in flames. An autopsy revealed that she died from stab wounds. Her nephew, Ahmad Shekeb Askarzada (43), was charged with first-degree murder and arson. Family members believe the allegations against Askarzada may be related to the fact that Naheed helped arrange a marriage for him that ultimately did not work out. The case has been classified as femicide. (Jackson & McDonald, 2022)

- **Pawanpreet Kaur – Mississauga, ON (2022)**

Pawanpreet Kaur (21), a recent Sheridan College graduate known for her kind nature and strong family ties, was shot and killed at a gas station by her former boyfriend, Dharam Singh Dhaliwal (30), who was out on bail for previous kidnapping and SA charges involving her. His brother, Pritpal Dhaliwal (25), and mother, Amarjit Dhaliwal (50), were also charged with accessory to murder. The case has been classified as intimate partner femicide (Rocca & McDonald, 2023)

- **Davinder Kaur – Brampton, ON (2022)**

Davinder Kaur (43), mother of four, was found fatally stabbed in Sparrow Park, Brampton, after reportedly agreeing to meet with her estranged husband, Nav Nishan Singh (44). Peel Regional Police charged Singh with first-degree murder (CBC News, 2023). The case has been classified as a femicide, based on the violent nature of the crime and the familial relationship involved (CBC News, 2023).

While each of these cases occurred under unique circumstances, they share common patterns of GBV, coercive control, and efforts to regulate women's autonomy through cultural or familial notions of honour. Many victims remain invisible in national statistics due to systemic challenges such as inadequate data collection, the absence of a formal HBV classification, cultural stigma, and gaps in legal and social responses. These factors complicate efforts to fully understand and address HBV in Canada.

‘HONOUR-BASED VIOLENCE’ IN THE GLOBAL CONTEXT

Globally, HBV is a deeply pervasive and systemic form of GBV, with actual cases believed to far exceed reported statistics due to widespread underreporting and misclassification. The United Nations Population Fund estimates that approximately 5,000 women and girls are killed each year in honour-related incidents (UNFPA, 2000; Muhammad, 2010). ‘Honour killings’ have been documented worldwide, including in Afghanistan, Bangladesh, Brazil, Egypt, Iran, Jordan, Lebanon, Nigeria, Peru, the United States, Türkiye, the United Kingdom, Italy, Norway, Sweden, and Germany, with particularly high incidences in South Asian countries such as India and Pakistan (Muhammad, 2010). In India and Pakistan alone, human rights organizations estimate that over 2,000 women are killed annually in honour-related attacks (UNFPA, 2000).

Beyond these fatal outcomes, HBV finds expression through harmful practices aimed at controlling women and girls to protect family or community honour. For example, over 130 million women and girls worldwide have undergone FGM, a procedure often justified by honour-based norms prioritizing purity and marital eligibility (UNFPA, 2000). FGM is most prevalent in parts of Africa, the Middle East, and Southeast Asia. Additionally, approximately 650 million girls globally have been forced into child marriage, frequently to avoid shame or safeguard family honour (UNFPA, 2000; Occhiuto, Tarshis, Todd, & Gheorghe, 2024). These marriages occur mainly in South Asia, Sub-Saharan Africa, and parts of the Middle East, but are also present in diaspora communities across Europe and North America. HBV’s influence extends further through social restrictions—of the 300 million children without access to education globally, two-thirds are girls, and women represent two-thirds of the 800 million illiterate adults worldwide (UNFPA, 2000). Together, these examples illustrate how HBV functions as a system of control rooted in patriarchal norms and sustained across cultures and geographies.

Although HBV is recognized globally, reported numbers likely underrepresent the true scale, as many survivors do not come forward due to intersecting barriers. Cultural taboos and fear of bringing shame to one’s family often silence victims, while concerns about retaliation or further harm from family or community members can prevent reporting. Racialized or immigrant survivors may experience a lack of trust in law enforcement and the justice system, stemming from both historical and ongoing discrimination, stereotyping, and neglect. In some cases, community or religious leaders pressure survivors to remain silent, encouraging private resolution rather than engaging with legal systems viewed as external to the culture. Language and cultural barriers further restrict access to appropriate support, particularly where services are not offered in one’s native language or through culturally competent frontline workers. Additionally, survivors who are legally or financially dependent on their abusers—such as immigrant women reliant on their partners for housing, immigration status, or financial security—may feel unable to report abuse or seek help. Together, these barriers not only prevent survivors from seeking help but also obscure the true global prevalence of HBV, highlighting the need for culturally sensitive and accessible interventions.

3.4 NATIONAL LESSONS: STRATEGIES AND PRACTICES TO ADDRESSING 'HONOUR-BASED VIOLENCE'

GOVERNMENT-LED APPROACHES

Legal Recognition and Refugee Protection

In Canada, HBV is primarily addressed through existing criminal laws such as DV, family violence, assault, and homicide statutes, as there is currently no distinct criminal offence specifically categorized as 'honour-based violence.' However, Canadian courts are increasingly recognizing HBV motives during trials and sentencing, allowing cultural and familial contexts to inform judicial decisions and ensure appropriate accountability.

One of the most significant areas where HBV has been legally acknowledged is within Canada's refugee determination system, where courts have accepted HBV as a legitimate ground for protection under refugee and immigration law. Individuals, particularly women, have been granted asylum in Canada based on a well-founded fear of persecution due to HBV in their country of origin. This makes the refugee determination system one of the few areas in Canadian law where HBV is explicitly acknowledged and addressed, underscoring its status as a serious human rights violation even as domestic criminal systems struggle to formally define or track it. The following cases illustrate how HBV has been treated in Canada's refugee determination process: (Muhammad, 2010)

- **Tabassum – Pakistan (2009)**

Tabassum (44), a woman from Pakistan, feared she would be killed by her husband's family after they accused her of dishonouring them by touching men's hair at work and allegedly living with a man in Canada. Initially, her claim was dismissed by the Pre-Removal Risk Assessment (PRRA) officer, but the court found this decision unreasonable given clear evidence that the Pakistani government failed to protect women from 'honour killings'. The court overturned the PRRA decision, affirming Canada's recognition of her well-founded fear and its commitment to protecting individuals at risk *(Tabassum v. Canada, 2009 FC 1185)*.

- **Syed Family – Pakistan (2005)**

A mother and her two sons fled Pakistan after one son had a relationship with a girl who was later killed by her family. The boy was beaten, and a fatwa (a formal ruling by an Islamic religious scholar) was issued against the entire family. The Refugee Board initially granted protection to the son but rejected the claims of the mother and other son. On judicial review, the court found that the Board failed to recognize the broader risk posed to all family members by the fatwa, thereby extending protection to those at risk. This case highlights Canada's legal system's role in ensuring comprehensive protection for families fleeing HBV *(Syed v. Canada, [2005] F.C.J. No. 1710)*.

Federal Collaborations & Initiatives

The Department of Justice Canada played a foundational role in addressing HBV through interdepartmental collaboration and targeted initiatives during the late 2000s and early 2010s. Together with Status of Women Canada, a federal agency dedicated to promoting gender equality and supporting women's rights, it co-chaired an interdepartmental working group on early and FM, HBV, and FGM. This working group included participation from 13 federal departments and agencies and served as a central point for coordinated federal action (Government of Canada, 2014).

Beginning in 2009, the Department of Justice Canada organized a series of sector-specific workshops with police, Crown prosecutors, victim services, child protection officials, and shelter workers to support frontline capacity-building. During this period, it also funded research papers on FM and 'honour' killings, produced public legal education materials such as the multilingual pamphlet *Abuse is Wrong in Any Language*, available in 12 languages, and supported a variety of prevention and response projects across the country (Government of Canada, 2014).

Building on earlier federal initiatives and in response to growing public attention following the high-profile Shafia case, the RCMP, in collaboration with the Department of Justice Canada's Family, Children and Youth Section, launched a targeted national law enforcement training initiative in 2014. Led by Superintendent Shahin Mehdizadeh, the RCMP developed an online course titled *Honour Based Violence and Forced Marriage Awareness for Police Officers*. Now available through the Canadian Police Knowledge Network, the course educates police officers, government staff, and other first responders on the cultural, investigative, and victim support dimensions of HBV and FM. Mehdizadeh emphasized the importance of cultural awareness in law enforcement, stating, "It's critical to start educating our front-line officers on certain aspects of different cultures and dealing with them" (Government of Canada, 2014; RCMP, 2013).

In addition, the Government of Canada provides resources through the Department of Justice Canada's family violence initiatives, which include information on HBV (Department of Justice Canada, 2024). These resources explain how these culturally specific abuses occur within families and communities, highlight the legal frameworks addressing such violence, and offer information on support services available to victims, emphasizing the need for culturally sensitive legal responses. Victim services organizations also play a critical role in supporting survivors by working closely with police to develop safety plans and connect victims with essential services such as food, clothing, shelter, and interpretation. These organizations provide information on legal rights and referrals to lawyers or other support services. Furthermore, the Office of the Federal Ombudsperson for Victims of Crime operates independently from the government to advocate for victims' rights and ensure their voices are heard within the federal justice system (Department of Justice Canada, 2024; Office of the Federal Ombudsperson for Victims of Crime, 2024).

Research and Risk Assessment Tools

Further research and prevention efforts have advanced through Status of Women Canada. In 2012, it launched a call for proposals aimed at preventing and eliminating violence against women and girls (VAWG), explicitly including violence committed in the name of "honour." By 2007, Status of Women Canada had approved more than $2.8 million in funding for community-based projects addressing harmful cultural practices such as HBV and FM. These projects have supported education, outreach, and direct services tailored to the needs of affected communities (Government of Canada, 2014).

Complementing these efforts, the Canadian Domestic Homicide Prevention Initiative with Vulnerable Populations (CDHPIVP) developed a series titled *Domestic Homicide in Immigrant and Refugee Populations: Culturally-Informed Risk and Safety Strategies Brief*. The CDHPIVP, a federally funded research project, works collaboratively with community organizations, academics, and service providers to develop evidence-based strategies aimed at improving risk assessment, safety planning, and prevention of domestic homicide among vulnerable populations in Canada. The Brief highlights the use of risk assessment tools such as the Domestic Abuse, Stalking and Honour Based Violence (DASH) tool to identify and manage DV risk, including HBV. However, it also recognizes DASH's limitations in capturing culturally specific dynamics rooted in patriarchal norms common in immigrant and refugee communities. To address this, the Brief emphasizes the culturally tailored PATRIARCH tool, designed to incorporate factors such as family honour, patriarchal control, and community pressures unique to these populations. Both tools are part of a broader, culturally informed approach promoted by the CDHPIVP to improve risk assessment and safety planning within Canada's legal and criminal justice systems, ensuring responses to HBV are sensitive to cultural contexts and better protect vulnerable survivors (Canadian Domestic Homicide Prevention Initiative, 2018).

COMMUNITY-LED APPROACHES

Between 2012 and 2015, several community-based organizations in Canada were funded by Status of Women Canada to develop initiatives that addressed HBV within racialized communities. These initiatives aimed to strengthen the capacity of service providers, shift harmful community norms, and support survivors through culturally relevant and trauma-informed approaches. While the term 'honour-based violence' was widely used at the time to describe violence committed in the name of family or community "honour," the framing itself became a subject of critical reflection.

In 2015, representatives from funded organizations, including the Canadian Council of Muslim Women (CCMW), testified before the House of Commons Standing Committee on the Status of Women to share their learnings. A key recommendation was to reconsider or even eliminate

the use of the term 'honour-based violence.' Advocates argued that such language risked reinforcing cultural stereotypes, validating the perpetrators' rationale for violence, and contributing to the stigmatization of certain racialized and religious communities. Instead, some suggested situating HBV within the broader framework of "femicide", defined as the killing of women and girls because of their gender, as a way to focus on patriarchy and systemic gender inequality rather than perceived cultural norms. (House of Commons Standing Committee on the Status of Women, 2015)

While these testimonies offered valuable insights, they are not without limitations. The proposed shift toward gender-neutral or universal terms like "femicide" may risk erasing the specific mechanisms and manifestations of HBV experienced by women in certain cultural, religious, or migration contexts. Our own consultations, interviews, and focus groups conducted between 2024–2025 suggest that the term 'honour-based violence' continues to hold meaning for many survivors and practitioners. Several participants emphasized that naming the violence for what it is, particularly when it is tied to issues like FM, family control, or sexuality, is essential for visibility, advocacy, and tailored intervention.

Additionally, our outreach extended to communities that were less prominently represented in the earlier 2012–2015 initiatives, including 2SLGBTQ+ South Asians, refugee women, and newly arrived diasporic groups. These communities revealed evolving forms of HBV, including digital surveillance, transphobic family violence, coercion through conditional sponsorship, and new patterns of community silencing. Their experiences suggest that while foundational critiques of the HBV label remain valid, there is also a continued need to recognize HBV as a distinct—though interconnected—form of GBV.

The following summary table provides high-level insights into how community-led responses to HBV were initially conceptualized and implemented. While resources specifically addressing HBV remain limited, these foundational models have shaped the evolution of culturally responsive, survivor-centered, and systems-aware approaches to HBV in Canada. **The full details of each initiative are provided in Appendix B.**

Organization	Year	Resource / Toolkit	Focus / Purpose	Key Components	Target Population
Canadian Council of Muslim Women (CCMW)	2013	*Violence Against Women: Health and Justice for Canadian Muslim Women* (Cross, 2013)	Provide culturally and faith-sensitive resources for understanding and responding to violence against Muslim women in Canada	Overview of violence types (DV, FM, HBV, FGM, femicide), legal/social frameworks, community/ faith perspectives, practical guidance for service providers	Muslim women in Canada; service providers, frontline workers
South Asian Women's Centre (SAWC)	2013 – 2015	*There Is No "Honour" in Violence Against Women and Girls (Inter-Agency Strategy)* (Kanagasabapathy, 2016)	Address HBV in South Asian communities through community-informed, culturally competent interventions	Three-pillar framework (Advocacy, Education, Implementation), intersectional survivor-centered tools, community engagement, service provider guidance, case studies	South Asian women and girls; service providers, community stakeholders

Organization	Year	Resource / Toolkit	Focus / Purpose	Key Components	Target Population
South Asian Legal Clinic of Ontario (SALCO)	2016	*Forced/ Non-Consensual Marriages : A Toolkit for Service Providers* (Chokshi, Khanna, & Silim, 2016)	Equip service providers to identify, prevent, and intervene in forced/non-consensual marriages	Identification tools, step-by-step intervention protocols, safety and legal guidance, prevention strategies, anti-oppressive framework, case studies/ training	South Asian youth and families; service providers, legal professio-nals
Barbra Schlifer Commemorative Clinic	2020	*Intimate Partner Violence Risk Identification and Assessment (IPV RIA) User Guide* (Coelho, Dewolf, Brockie, & Keren, 2020)	Support service providers and legal advocates in identifying and responding to IPV, including HBV, in family law contexts	Three-part risk assessment, recognition of HBV/extended family control, legal/court guidance, survivor-centered/ intersectional lens, practical tools and training materials	Survivors of IPV, including HBV; legal professio-nals, service providers

3.5 GLOBAL LESSONS: STRATEGIES AND PRACTICES TO ADDRESSING 'HONOUR-BASED VIOLENCE'

HBV is a pervasive issue encountered in many countries, often shaped by complex intersections of culture, gender, and legal systems. While HBV may not always be explicitly defined in national legislation, numerous states have developed policies, coordinated frameworks, and specialized support mechanisms to address its unique challenges. The following table summarizes select countries—namely the United Kingdom (UK), Sweden, the Netherlands, Germany, and Türkiye—that have adopted structured approaches to tackling HBV. This overview is not intended as an exhaustive comparative study of every aspect of each country's response but aims to illustrate key features, strengths, and limitations. Many other countries have diverse strategies and responses, which remain critical to the global understanding and prevention of HBV. **Full details of each country's initiatives are provided in Appendix C.**

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
UK	HBV is legally framed as So-Called Honour Based Abuse (SCHBA), with FM explicitly criminalized under the Anti-Social Behaviour, Crime and Policing Act 2014. Civil remedies include Forced Marriage Protection Orders (FMPOs) and lifelong **(Cont.)**	Emergency call-takers and frontline officers are trained to detect early indicators of SCHBA using the Domestic Abuse, Stalking, and Honour-Based Violence (DASH) Risk Identification, Assessment, and Management Model. High-risk cases are referred to **(Cont.)**	Victims can access helplines, safe housing, legal aid, advocacy, counseling, and culturally sensitive support through organizations such as Karma Nirvana, the Henna Foundation, BAWSO Women's Aid, and Southall Black Sisters. **(Cont.)**	Despite comprehensive legislation and multi-agency frameworks, policies often adopt a gender-neutral or culturally framed approach, obscuring the patriarchal and gendered nature of HBV. Minimal training for police, **(Cont.)**

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
UK	anonymity for victims. SCHBA functions as an umbrella term for abuse disguised as protecting "honour," covering coercion, physical assault, sexual abuse, and FM, often perpetrated collectively by family or community members. Multi-agency coordination is guided by Crown Prosecution Service (CPS) protocols and local authorities such as Leeds City Council. (CPS, 2023; Leeds City Council, 2024)	to Multi-Agency Risk Assessment Conferences (MARC). While specialized domestic abuse and stalking units manage interventions, conducting confidential interviews, assessing coercive control, and navigating complex social dynamics. (Richards, 2025; Hosey, 2020)	National initiatives like the Halo Project and Freedom Charity provide timely interventions and awareness campaigns for victims of FM, FGM, and HBV. Services also cater to male victims via the Men's Advice Line. (CPS, 2023)	combined with reliance on cultural explanations, limits effective protection, and the collective nature of abuse poses ongoing challenges for intervention. (Hosey, 2020)

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
Sweden	HBV is legally recognized under general DV laws, with "honour" formally designated as an aggravating factor in sentencing (Chapter 29, Section 2, Swedish Penal Code, 2020). The Swedish Gender Equality Agency (SGEA) coordinates national policy, research, and training, supported by the National Action Programme (2024–2026) with 132 targeted measures. Specialized **(Cont.)**	Police, social workers, educators, healthcare staff, and youth workers receive specialized training on early identification, trauma-informed care, cultural sensitivity, legal rights of victims, child protection, and HBV-specific risk assessment. E-learning modules and sector-specific guidelines are provided by SGEA, the National Board of Health and Welfare, and MUCF. Specialized centres train professionals **(Cont.)**	Victims can access shelters, confidential helplines, legal aid, counseling, advocacy, culturally sensitive support, and education programs through organizations including Terrafem, TRIS, Fempowerment, and Bris. Services are multilingual and inclusive for migrants, racialized groups, LGBTQIA2S+, and undocumented individuals. Centralized information is provided via Informationsverige.se. **(Cont.)**	Even with strong legal frameworks and extensive victim support, perpetrator rehabilitation and understanding remain limited. Research highlights complex social dynamics, including patriarchal and collectivist family pressures, transnational influences, and masculine norms, which are insufficiently addressed in interventions. HBV is often conflated with general DV in public discourse, **(Cont.)**

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
Sweden	knowledge centres, including the National Centre against Honour-Based Violence and Oppression (NCH) and the National Centre for Knowledge on Men's Violence Against Women (NCK), guide prevention and intervention efforts. (Cinthio, Staaf, & Ouis, 2022; SGEA, 2025a; Government of Sweden, 2024; County Administrative Board of Östergötland, n.d.; Uppsala University & Uppsala University Hospital, 2025)	and students, and support multi-agency collaboration. (SGEA, 2025b; National Board of Health and Welfare, 2024; European Commission, 2024)	Support includes accompaniment to court or medical appointments, protection orders, and multi-agency case coordination. (Informationsverige, 2025)	potentially obscuring its gendered and cultural dimensions. (Cinthio et al., 2022)

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
Nether-lands	HBV is addressed under general DV and criminal law, including acts such as FM and FGM. Dutch immigration law provides protective residence permits for at-risk victims, enabling access to support services. Knowledge dissemination is coordinated through governmental websites (huiselijkgeweld.nl) and institutes such as Atria, the Dutch Institute on Gender Equality and Women's History, which offer research, policy advice, **(Cont.)**	Police officers, youth welfare workers, and social service professionals receive practice-based training through the Netherlands Police Academy, with emphasis on identifying warning signs, risk assessment, and culturally sensitive intervention. Interdisciplinary collaboration with Veilig Thuis (national advice and reporting centre) strengthens coordination across sectors. Case studies, simulations, and reflection on cultural bias help develop professional judgment and support **(Cont.)**	Victims can access confidential services and shelters such as Safe at Home *(Veilig Thuis)*, Fier, and Blijf Groep. Services include counseling, legal aid, advocacy, culturally sensitive support, and educational programs. Victims who are minors or migrants may receive additional protection and residence support, with coordinated case management among police, social services, and NGOs. (Girls Not Brides, n.d.; Blijf Groep, n.d.)	While the Netherlands has robust frameworks and professional capacity, gender-neutral policy approaches can obscure the structural and patriarchal dimensions of HBV. Social pressures and cultural factors affecting women and girls may be insufficiently addressed, limiting prevention and protection measures. (Van Wijk, 2020)

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
Nether-lands	and public education to standardize detection and response. (European Institute for Gender Equality, 2020; IND, n.d.; Government of the Netherlands, 2020; Atria, n.d.)	trauma-informed approaches (Government of the Netherlands, n.d.; Netherlands Police Academy, 2024)		
Germany	HBV is prosecuted under broader DV and GBV laws, including provisions of the Criminal Code (*Strafgesetzbuch*) and the Act on Protection against Violence (Gewaltschutz gesetz). Federal and state governments coordinate **(Cont.)**	Training on DV and HBV is integrated into university and vocational programs for police, judges, social workers, and healthcare professionals. Continuous professional development emphasizes culturally sensitive, victim-centered approaches. National **(Cont.)**	Victims can access legal aid, counseling, safe housing, advocacy, culturally sensitive support, and public awareness initiatives through organizations such as Terre des Femmes and Papatya e.V. Services also include multi-agency case **(Cont.)**	Despite comprehensive legal and civil society frameworks, HBV is often framed publicly as a "foreign" or immigrant problem. Policy responses emphasize criminalization and integration over systemic prevention, with limited long-term support for **(Cont.)**

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
Germany	through national action plans and the Federal-Länder Working Group on Domestic Violence, promoting consistent implementation . Courts reject cultural justifications in honour-related crimes, applying strict punishment for acts such as 'honour killings', FM, and FGM. (Germany, 2020)	guidelines standardize risk assessment, victim interviewing, and inter-agency cooperation. (Germany, 2020).	coordination, risk assessment, and specialized support for minors, migrants, and refugee victims of HBV. (End FGM European Network, n.d.; Yurdakul & Korteweg, 2019).	grassroots civil society initiatives. Intersectional and gendered dynamics of HBV remain underexplored. (Yurdakul & Korteweg, 2019)
Türkiye	HBV and GBV are legally addressed under Law No. 6284, which provides emergency interventions, protective orders, and support **(Cont.)**	Police officers, judges, prosecutors, and health professionals are trained to identify and respond to DV and HBV cases. Specialist units conduct risk **(Cont.)**	Victims receive support through feminist, faith-informed, and community-led organizations such as KAMER Foundation, Mor Çatı Women's **(Cont.)**	Although Türkiye has comprehensive legislation and civil society support, enforcement remains inconsistent. Institutional gaps, resource **(Cont.)**

Country	Legislative & Policy Framework	Professional Capacity & Training	Victim Support	Gaps & Challenges
Türkiye	services for women, children, and family members regardless of nationality or legal status. Türkiye ratified the Istanbul Convention in 2011 but withdrew in 2021, maintaining domestic protections and obligations under other international human rights law. Violence Prevention and Monitoring Centres (ŞÖNİM) operate in all 81 provinces, coordinating prevention, reporting, and victim support. (UK Home Office, 2025; Mor Çatı Women's Shelter Foundation, n.d.)	assessments, issue protective orders, monitor compliance, and follow up with victims. Local risk management teams support provincial-level interventions. (UK Home Office, 2025)	Shelter Foundation, and Havle Women's Association. Services include emergency shelter, legal aid, counseling, risk assessments, community education, and advocacy programs tailored for women at risk of HBV. (KAMER Foundation, n.d.; Havle Women's Association, n.d.)	limitations, uneven implementation across provinces, and societal attitudes that frame DV as a private or family matter undermine effective protection. Withdrawal from the Istanbul Convention further constrains alignment with international HBV standards, monitoring mechanisms, and best practices. (UK Home Office, 2025)

METHODOLOGY

4.1 RESEARCH DESIGN

This study followed a multi-phase research process aimed at understanding and addressing HBV within South Asian communities in the GTA. The research design was informed by an initial scoping review, the findings of which are summarized in Section 3 (Background). This early review provided critical context and helped identify service gaps, areas lacking culturally appropriate intervention, and themes that warranted further exploration. Building on those insights, the project moved into a series of primary research phases focused on survivor engagement, expert consultation, training development, and community outreach.

The research included the following phases:

Consultations with Survivors and Subject Matter Experts: Consultations were conducted with survivors of HBV and a diverse range of subject matter experts, including health service providers, researchers, community advocates, and leaders. These discussions explored how HBV is understood, the effectiveness of existing intervention strategies, and the availability of services across health, mental health, and practical support systems. The consultations offered a nuanced understanding of survivor experiences and community needs.

Analysis and Synthesis of Consultation Findings: The insights gathered through consultations with survivors and subject matter experts were carefully analyzed to identify key themes, service gaps, and opportunities for intervention. These findings, along with context provided by the earlier scoping review, were synthesized and incorporated into this report to inform the development of practical recommendations. An abridged version of the findings was also produced to support public awareness and reduce stigma without perpetuating harmful stereotypes.

Development of Culturally Informed, Trauma- and Survivor-Centered HBV Training Module: A training module for frontline workers, informed by consultation findings and earlier research, building on the work of the Women's Mosque of Canada, adapted for both urban and rural South Asian communities. The module incorporates a 'training-of-the-trainer' approach and a pilot with law enforcement, social service agencies, and healthcare providers, equipping participants with tools to recognize, respond to, and prevent HBV.

Dissemination of Report, Findings and Recommendations to Relevant Stakeholders: Distribution of the report, findings, and recommendations to healthcare providers, social service agencies, organizations working in the GBV sector, law enforcement, educators, policymakers, and community advocates. The aim is to strengthen HBV prevention, intervention, and survivor support through coordinated, culturally informed, and trauma- and survivor-centered practices.

4.2 DATA COLLECTION METHODS

A mixed-methods qualitative approach combining secondary and primary data collection was used to explore HBV in South Asian communities. This approach allowed for a comprehensive understanding of both the systemic landscape and the lived experiences of those impacted by HBV. Data collection strategies were designed to center survivor voices, reflect cultural nuance, and inform practical, community-based solutions.

Secondary Data Collection

Scoping Review: A comprehensive review of academic literature, grey literature, books, public data repositories, and media sources was conducted at the project outset. This review explored the nature and complexity of HBV, examining its cultural and social roots as well as how it manifests across different communities. It assessed the extent and patterns of HBV both within Canada and globally, reviewed current intervention efforts, and drew lessons from international experiences. These insights provided a comprehensive foundation for understanding the multifaceted challenges of HBV—including under-reporting and gaps in culturally appropriate services—and guided the development of consultation questions and the overall research focus. **A detailed summary of these findings is provided in Section 3 (Background).**

Case Studies: A small number of in-depth case studies were selected to humanize the data and illustrate the real-life impacts of HBV on individuals and families. These examples highlight the complex dynamics of control, honour, and violence. The purpose of these case studies is to show that reported numbers severely underestimate the reality of HBV and to provide service providers with concrete, grounded examples of what HBV looks like in practice.

Primary Data Collection

Subject Matter Experts Working Across Sectors on 'Honour-Based Violence': Participant engagements were conducted with a broad range of subject matter experts, such as healthcare professionals, social workers, researchers, advocates, community leaders, and law enforcement personnel. Experts offered deep insights into terminology, professional challenges, systemic gaps, and practical recommendations to strengthen prevention, intervention, and support for survivors.

Women with Lived Experience of 'Honour-Based Violence': Participant engagements focused on women with lived experience of HBV and GBV. Participants shared their personal stories and reflections on the influence of community and culture, impacts on well-being, access to support, resilience, and how their voices can be amplified to raise awareness and promote change.

LGBTQIA2S+ Individuals with Lived Experience and Professionals Working in the Field: Participant engagements were held with people who identify as LGBTQIA2S+ and have lived experience of HBV, as well as professionals who work closely with these communities. Discussions focused on the unique challenges these participants face, their perspectives on HBV and "honour" terminology, gaps in available services, and recommendations for enhancing culturally sensitive prevention and support tailored to their needs.

4.3 ETHICAL CONSIDERATIONS & CONFIDENTIALITY

Given the sensitive nature of HBV and GBV, participant safety, privacy, and dignity were prioritized throughout data collection. Participants were fully informed of the study's purpose, their voluntary participation, and their right to withdraw at any time. They were also made aware of the possibility of emotional distress, and protocols were in place to pause or terminate sessions as needed, with follow-up support offered.

Consultations were offered in both group and individual formats, with facilitators providing culturally sensitive, trauma-informed support tailored to each group. This included community-identified facilitators, such as LGBTQIA2S+ facilitators for relevant sessions, alongside mental health support providers. Participants received compensation for their participation.

All transcripts were anonymized, and both transcripts and audio recordings were stored securely in a protected Google shared folder. All recordings and transcripts were deleted following the publication of the report.

4.4 LIMITATIONS OF THE STUDY

This study faced several limitations that should be considered when interpreting its findings. First, recruitment challenges and the sensitive nature of HBV and GBV contributed to a relatively small sample size, which may not represent the full diversity of experiences within the GTA. Some participants were uncomfortable sharing in group settings or chose to speak off the record, reducing the range and depth of perspectives captured. Barriers such as language differences, cultural stigma, and mistrust further impeded participation, potentially excluding more marginalized subpopulations, including recent migrants or individuals with precarious legal status.

Second, while ethical safeguards such as anonymization and strict confidentiality protocols were essential to protect participants' safety and dignity, they also constrained the inclusion of rich contextual detail. In some cases, this limited the ability to explore the full complexity of individual narratives or intra-community dynamics. Moreover, the heterogeneity of participants' migration statuses, cultural affiliations, and social positions enriched the dataset but introduced analytical complexity, making it difficult to generalize findings beyond the immediate study context.

Third, the research unfolded within a broader structural context of systemic racism, under-resourcing of culturally specific services, and persistent societal stigma. These macro-level factors shaped both the lived experiences of participants and their willingness or ability to engage in research. While these structural conditions were acknowledged, they were not the primary focus of analysis and should be more fully addressed in future, intersectionally grounded studies.

Furthermore, the study primarily centred on the experiences of women and girls in heteronormative relationships, reflecting the demographics of the participant pool. While intentional efforts were made to include LGBTQIA2S+ individuals, particularly within South Asian communities, these voices remain underrepresented. This highlights the need for targeted research exploring how intersectional identities—including gender, sexuality, disability, religion, migration status, and socioeconomic position—shape experiences of HBV in Canada.

Finally, the positionality of the research team, including cultural and linguistic alignment with participant communities, may have shaped both access and interpretation, though efforts were made to mitigate bias through the involvement of community-based facilitators and trauma-informed methodologies.

Given these limitations, the findings should be interpreted with caution. There remains a critical need for continued, community-led, and culturally grounded research that amplifies the diverse and often-silenced voices of those affected by HBV.

4.5 PARTICIPANTS DEMOGRAPHICS

Participant Group	Number of Participants	Description	Organizations Consulted
Subject Matter Experts Working Across Sectors on 'Honour-Based Violence'	20	Professionals with extensive experience, often decades, supporting South Asian, Muslim, and other racialized communities affected by GBV and HBV. Several were also identified as survivors of HBV. They represent healthcare, social services, legal services, policing, community and non-profit organizations, education, and policy advocacy.	Aura Freedom, City of Toronto–Housing Unit, Laadliyan, Nisa Homes, Ontario Federation of Indigenous Friendship Centres (OFIFC), Ottawa Police–Victim Witness Unit, Punjabi Community Health Services (PCHS), South Asian Legal Clinic of Ontario (SALCO), Sakeenah Homes, South Asian Women's Centre (SAWC), The I Do! Project (Forced Marriage Collective), United Way Greater Toronto–South Asian Community Advisory Council, Victim Services of Peel, Victim Services of Toronto, Women Support Network, Women's Mosque of Canada
Women with Lived Experience of 'Honour-Based Violence'	13 (6 off-record)	Cisgender, heterosexual South Asian women. Included second- and first-generation immigrants (via refugee claims, family sponsorship, student visas, work permits).	N/A
LGBTQIA2S+ Individuals with Lived Experience and Professionals Supporting Affected Communities	6	South Asians who identify as LGBTQIA2S+ with lived experience of HBV and professionals who work closely with LGBTQIA2S+ communities affected by HBV. Included second- and first-generation immigrants.	Krasman Centre, SOCH Mental Health

KEY FINDINGS & RESULTS

5.1 SUBJECT MATTER EXPERTS WORKING ACROSS SECTORS ON 'HONOUR-BASED VIOLENCE'

Key findings draw from consultations with 20 subject matter experts, some of whom identified as survivors, conducted through individual interviews and group consultations.

Participants highlighted the complex, systemic, and cultural challenges in recognizing and responding to HBV, emphasizing the need for culturally nuanced and intersectional approaches. They described a contested understanding of "honour," noting that differing interpretations complicate both community understanding and intervention strategies. Participants explained how violence within families and communities is often normalized or minimized, and emphasized the erasure of grassroots expertise in mainstream service frameworks. Discussions underscored the intersectionality of HBV, including its connections to race, gender, immigration, faith, and colonial legacies. Participants reflected on the ways power operates within family structures and institutional responses, pointing to the need for culturally nuanced, systemic approaches to prevention and intervention. A thematic analysis follows, supported by anonymized participant quotes. **Full details of the guided discussion questions are provided in Appendix D.**

THE CONTESTED MEANING AND PRACTICAL USE OF 'HONOUR-BASED VIOLENCE' TERMINOLOGY

One of the most urgent and recurring themes in the consultations was discomfort with the term 'honour-based violence.' Participants voiced strong critiques of how the term is racialized, reinforcing colonial assumptions that paint certain communities as inherently violent or backward. They explained that the language of "honour" often functions as a cultural shorthand used by institutions to signal danger or otherness, thereby stigmatizing South Asian, Muslim, and other racialized communities.

At the same time, some participants acknowledged the term's practical utility, particularly when survivors themselves use it to describe their experiences. They cautioned that while the term should be interrogated, removing it altogether might erase the very conditions it seeks to expose. Several advocated for modified versions such as using quotation marks to problematize the concept while preserving its recognizability.

> *"For me. It's not. Should we use this terminology or not? Because I think it is both racist and colonial in its construction. And also it is based on very specific experiences and realities."*

"Everyone in our community knows what we're talking about when we use that word."

"There's no honour in 'honour-based violence'... putting the term 'honour' in quotations and acknowledging the aspect of 'there's actually no honour in this'... that's what we're trying to do."

"I always like to ask myself, whose benefit are these questions for? Because I find that so often when we get into the dialogue of terminology, it's more for the benefit of academia and agencies, and less about survivors."

These reflections point to the importance of community-led definitions, cautioning against top-down decisions made for institutional clarity rather than survivor validation. Ultimately, participants urged that language choices should be made in consultation with those most affected, recognizing the political, emotional, and cultural work that naming entails.

PERPETRATORS BEYOND MALE FAMILY MEMBERS

The consultation challenged dominant narratives that frame HBV solely as a male-perpetrated form of VAWG. Participants emphasized that honour-based control is often reinforced by multiple family members, including women who act as enforcers of patriarchal norms. Mothers, sisters, and aunts were frequently named as individuals who surveil, shame, and discipline others to uphold family reputation.

This theme revealed how power operates within family systems not just through overt violence, but through everyday practices of regulation, silence, and conditional acceptance. One participant described how women with limited agency may reinforce violent structures in order to protect their own fragile status within the household. This dynamic is what several referred to as the "patriarchal bargain", a survival strategy that complicates clear victim/perpetrator binaries.

Experts added that the burden of honour and violence impacts women and girls' self-worth and future generations, with young women often lacking examples of healthy relationships. Pressures to marry, sometimes under coercion or stigma, compound this problem. Participants called attention to the need for broader definitions that recognize women as both victims and perpetrators.

"Within the community we have women who are also perpetrators... we're also seeing women as perpetrators who are helping to commit this violence against other women."

"What we're not talking about is the power dynamics that includes women... sisters and moms who feel the young women are violating the family's reputation."

"That minimal amount of power... is dependent on the people around you upholding a certain image that you have."

"Honour rests on the shoulders of women and girls in our community... Women are also involved in HBV, pressure marriage, and [sex] selective abortions. A part of the problem."

These insights call for a more layered understanding of HBV, one that accounts for how gendered violence is reproduced not only by men but by whole systems of relational expectation, shame, and control. They also underscore the need for service providers to recognize complex family dynamics when assessing safety and risk.

ERASURE OF GRASSROOTS EXPERTISE AND THE CYCLES OF INSTITUTIONAL AMNESIA

Participants expressed deep frustration about how institutions fail to acknowledge the long-standing contributions of grassroots and community-led initiatives. They described a repeated pattern where racialized women build successful support models only for their work to be overlooked, underfunded, or later co-opted by mainstream organizations with greater access to resources and policy influence. This lack of stable funding leaves organizations unable to sustain case management, retain trained staff, or provide specialized support.

This erasure is not merely symbolic; it has material consequences. The sidelining of racialized and survivor-led expertise results in services that are out of touch with community realities. As one participant pointed out, cycles of institutional amnesia mean that "new" HBV initiatives often reproduce the same gaps and mistakes as previous ones.

Grassroots groups also highlighted the scarcity of reliable data on HBV, especially for vulnerable populations such as temporary foreign workers, international students, and undocumented individuals, who often remain invisible in official statistics. This invisibility increases their risk and hinders effective policy responses.

"There's a lot of systemic racism that happens within the process... where smaller groups or minority groups that are doing the work—it's not recognized. Then it gets put again as though it's this new phase of things."

"Every 5 years something new comes up... yes, that's okay, because we are in progress... but we need to do this dance by making sure that the priorities are part of this process."

"The hidden number in Ontario, the number of South Asian people or Muslims with temp status or no status is massive and they are even more vulnerable as clients."

NEGLECTING THE QUIET HARMS OF 'HONOUR-BASED VIOLENCE'

Another recurring theme was how HBV often goes unrecognized in institutional settings, particularly when it manifests in non-physical forms. Several participants noted that early warning signs, such as restricted movement, surveillance, emotional manipulation, and forced secrecy, are frequently dismissed or normalized by both families and service providers. These patterns of control, they argued, are culturally embedded and thus harder to identify within dominant GBV frameworks.

Participants discussed how institutions often fail to ask the right questions, focusing instead on individual perpetrators rather than examining collective dynamics. In many cases, providers overlook the roles played by multiple family members, making it difficult to understand the full scope of coercion and complicity.

The institutional focus on physical violence also leads to survivor silencing, especially around emotional and spiritual abuse (the misuse of religious or spiritual authority to control, shame, or silence survivors). Survivors often face gaslighting or minimization from trusted professionals and faith leaders, causing retraumatization and preventing meaningful healing.

"The notion is that, 'oh, like at least he didn't hit you,' right?"

"There are so many things that happen in the community that are so normalized... that it's not even considered 'honour-based violence.'"

"If that one person was taken out of the picture, how would your mom react? How would your aunts and uncles react? Would those people continue to uphold and continue to perpetuate the same forms of violence?"

"The increased risk doesn't come from being South Asian or Muslim or Black—it comes from the fact that it's not just one perpetrator. So many people have bought in."

Experts highlighted gaps in awareness and access, noting many women return to unsafe homes due to financial dependence, family pressure, or lack of alternatives. Survivors often fear police, face victim-blaming, and struggle with complex, culturally inappropriate services. There is a critical need for cross-sector training to identify HBV beyond physical abuse, and for trauma-informed, survivor-centered interventions that include life skills and long-term support. Participants emphasized the importance of listening to survivors' language, mapping extended harm networks, and challenging the assumptions that only visible injuries constitute violence.

RETRAUMATIZED AND SILENCED IN INSTITUTIONAL SUPPORT

Participants emphasized the retraumatizing experience of navigating multiple institutions while seeking help due to weak inter-agency collaboration. Survivors frequently had to retell their stories to healthcare providers, law enforcement, and shelter staff, many of whom lacked awareness of HBV or its culturally specific dynamics. Each retelling reopened emotional wounds, reinforcing feelings of vulnerability, mistrust, and exhaustion, and often discouraged survivors from seeking help in the future.

Shelters, healthcare providers, law enforcement, and social services often operate in silos, with conflicting policies, poor information-sharing, and inconsistent approaches to HBV. This

fragmentation meant that critical details were overlooked, cases were poorly coordinated, and survivors navigated a patchwork of services with limited guidance or protection.

Participants also described experiences of gaslighting and victim-blaming, which intensified feelings of vulnerability and mistrust. Survivors reported being made to question their own experiences or blame themselves for the abuse they endured, leaving them further silenced by the very people who should have provided support.

"I had to tell my story to the hospital staff, then again to the police, and once more at the shelter. It was retraumatizing."

"I was gaslit. I was made to believe everything is my fault... What it does—it is so damaging."

"When I was going through my trauma, I was pretty much silenced by the people who should have supported me."

Together, these accounts highlight the urgent need for trauma-informed, culturally sensitive practices that validate survivor experiences and provide coordinated support across healthcare, law enforcement, and social services.

GENDER-TRANSFORMATIVE APPROACHES AND PROMOTING COMMUNITY DIALOGUE

Participants emphasized that effective HBV prevention requires early intervention and strategies that challenge harmful gender norms and works to shift attitudes and behaviors. Prevention should begin within families through gender-transformative approaches. Young women and girls should be equipped with knowledge about healthy relationships, consent, and their rights to support their autonomy, while boys, young men, and elders should be engaged to challenge and shift gender norms toward healthier and more respectful family dynamics.

Programs can be implemented in schools and community groups through interactive workshops, peer mentoring, and structured curricula that encourage dialogue and critical reflection. These initiatives must be contextually sensitive, culturally appropriate, and sustained over time to have meaningful impact. However, political reluctance, stigma, and limited resources remain significant barriers to implementing these initiatives widely and effectively.

Beyond families and schools, faith institutions were identified as both sites where HBV is perpetuated and potential partners in prevention. Rigid interpretations of cultural or religious norms can reinforce control over women and girls, but collaboration with spiritual leaders and trusted community members—through workshops, dialogue circles, or mentorship programs—can promote values-based transformation while addressing resistance to entrenched norms.

"We need to look into the upstream framework... what are some unhealthy gender norms that are so embedded in our systems?"

"It's not just the language—it has to be a paradigm shift."

"Our values are formed in faith institutions and the conversations we have at the dining table... If we can capitalize on some of those spaces, we can make a lot of change."

Ultimately, preventing HBV requires coordinated, community-driven efforts that combine gender-transformative approaches within families, youth education, and engagement with faith institutions to challenge harmful norms and promote lasting social change.

5.2 WOMEN WITH LIVED EXPERIENCE OF 'HONOUR-BASED VIOLENCE'

The key findings draw on consultations with seven South Asian women, conducted through individual interviews and focus groups. An additional six women shared insights confidentially off the record; these contributions were not included in the key findings, bringing the total number of participants consulted to 13.

Participants described how cultural expectations around "honour" shape restrictive gender roles, control over their lives, and barriers to accessing support. They discussed the enforcement of restrictive gender roles and control over women's bodies and sexuality. Many expressed pervasive fear of disclosure, citing potential reprisals and social ostracism. Participants also noted the use of coercive measures, including FM, to "restore" family honour. Consultations revealed significant gaps in culturally competent, trauma-informed services, with many participants seeking alternative approaches such as somatic therapy. Barriers in navigating formal support systems highlighted structural limitations and the urgent need for culturally responsive interventions. A thematic analysis follows, illustrated with anonymized participant quotes. **Full details of the guided discussion questions are provided in Appendix D**.

HONOUR, GENDER NORMS, AND THE SOCIAL CONTROL OF WOMEN'S AGENCY

While many survivors were unfamiliar with the term 'honour-based violence' as it is used by frontline workers and service providers, they deeply understood the cultural expectations embedded in the concept of "honour" or *izzat*. For these women, honour was less a term and more a lived code, one that governed their behavior, shaped gender roles, and enforced restrictions through shame, guilt, and surveillance.

The pressure to embody purity, obedience, and restraint began early in life. Many described growing up under rigid double standards that differentiated expectations for boys and girls and restricted women from fully engaging as themselves. Women were often held to higher standards regarding societal engagement—for example, being expected to stay home unless accompanied, return earlier than their male counterparts, or avoid spending extended time alone with friends. These double standards also shaped life trajectories, with girls encouraged to prioritize domestic responsibilities and marriage over education or career. Work and schooling were frequently framed as secondary to their role in managing a household, reinforcing control through social conditioning rather than just overt violence.

> *"From a young age, I was told that I could not do what my brothers or other male members of the family did. I was told that I was different and that I had special rules to protect not only me but also members of our family. That somehow my actions would wrongfully impact everybody at home."*

"I was married off early and told that my career and education were no longer a priority. That my main purpose in life was to procure and to establish and raise a family"

These reflections reveal how HBV is rooted in normative expectations about gender and purity. The concept of honour is used to dictate behavior, restrict women's agency, and pre-emptively frame women as either modest and respectable or dishonourable and disposable. The consequences of defiance or even perceived non-compliance could be devastating.

WOMEN'S HEALTH, SEXUALITY, AND HONOUR

The concept of 'honour' profoundly shapes women's experiences of health, sexuality, and bodily autonomy, influencing how they navigate their relationships and well-being within families and communities. Many survivors described how family and community expectations controlled conversations around menstruation, fertility, and chastity. From a young age, girls were taught that their bodies were sources of both pride and danger—things to be covered and concealed to avoid "shame."

Women were expected to avoid engaging with the opposite gender to prevent premarital sexual activities that could bring shame to the family. Within communities where honour shapes social expectations, fear of losing virginity led to isolation and influenced how women approached sexual health. These pressures also intensified the stigma faced by survivors of sexual violence, who often encountered harsh judgment from their own families, unable to move past the fact that they had "lost their virginity," overshadowing the trauma and care they needed.

"By the time I was 12, I was asked to cover myself in front of the male members of the family as showing parts of my body that accentuated my femininity was considered a distraction and could put me at risk of abuse from others both inside and outside the home."

For some women, the control and restrictions imposed by family and community extended into practices, such as SA. These practices illustrate the broader ways in which cultural norms and HBV perpetuate physical and psychological harm, compounding the multiple layers of vulnerability and trauma women face within their families and communities.

SILENCE, FEAR, AND THE COSTS OF DISCLOSURE

A common thread across many narratives was the profound fear of disclosure. Survivors often remained silent or shared very little, describing calculated silences driven not by shame, but by fear of reprisals or repercussions from their families, extended communities, or even the systems meant to protect them. When survivors did speak out, they often faced social ostracism, emotional abandonment, or were subjected to coercive measures, such as FM, intended to "restore" the family's honour.

These consequences played out in deeply personal ways. One woman was pressured to marry a closeted LGBTQIA2S+ man so her family could appear "respectable." Another was completely cut off by her family to protect her sisters' reputations and marital prospects. A third, abused and abandoned after immigrating to Canada when her partner remarried, was forced into a shelter and worked multiple jobs as a single mother. Her family abroad pressured her to return to her partner to restore the family's honour. These stories reflect how HBV enforces silence and communal control, prioritizing reputation over survivor safety.

> *"My family, after learning about my assault, shunned me for a time. I was no longer considered an honourable woman, and therefore it would impact my family honour if I stayed."*

> *"When I was in my country of origin, as a young person, I was heavily abused by members of my family. But despite this, I was unable to share with even the women closest to me, out of fear of reprisal or the kind of shame it would bring upon my family."*

The fear of losing familial belonging often outweighed the promise of safety. Some women attempted to rebuild ties after leaving abusive relationships, only to be pressured into returning to harmful situations as a way to reclaim family reputation. These dynamics emphasize the need for trauma-informed care that recognizes family-based coercion, especially when it crosses borders.

BARRIERS TO ACCESSING SAFE, CULTURALLY RESPONSIVE SUPPORT

Many survivors cited practical barriers—including long waitlists, limited resources, difficulty accessing services in their preferred language, and gaps in shelter safety measures—but the most significant gap was a lack of cultural, spiritual, and faith-based understanding, which made support and safety planning challenging. While mainstream services often provided physical safety and basic support, they frequently failed to engage meaningfully with these frameworks shaping women's experiences. Survivors reported feeling judged when providers dismissed the importance of religion, misread culturally informed decisions, or questioned why

they stayed in or returned to unsafe situations. This often left women isolated and hesitant to share their experiences, increasing the emotional burden of navigating family and community pressures.

In addition to these gaps, survivors highlighted a critical lack of attention to the emotional complexities they face. Feelings of guilt, shame, and fear, especially in the aftermath of SA, FM, or challenges to gender roles, often went unrecognized by service providers. These struggles often manifest physically, causing tension, numbness, or dissociation that traditional talk-based counseling may not fully address. Many women reported that trauma-specific, HBV-informed mental health supports were rarely available, leaving them without services that truly addressed their needs. Recognizing these gaps, some survivors sought alternative approaches such as somatic healing, which focuses on releasing trauma stored in the body through movement, breathing, and body awareness.

Some women also deliberately avoided culturally specific services out of fear that their privacy would be breached and information might reach their families or communities. Others described how their abuse was embedded within large, interconnected family and community networks, what survivors described as collective violence. This made leaving particularly dangerous and complicated. These women were not just fleeing individuals but entire systems of complicity.

"I wish I had a counselor at the shelter who understood my perspective and point of view. My faith is important to me, but she did not understand why I was afraid to face my family or why I had a fear for God and how that was tied to my abuse."

"Despite going through mainstream services and finding some solace, I also found solace in doing more hands-on healing and body trauma work for which I am very grateful. Today I do my best to inspire other women to do the same."

"I did not feel safe accessing a community-based agency as I was afraid the information may get back to my family."

These accounts highlight the need for services that truly understand and respond to survivors' experiences. Supporting women effectively requires approaches that are trauma-informed, culturally aware, spiritually sensitive, and committed to confidentiality, ensuring they can access help safely and with dignity.

5.3 LGBTQIA2S+ INDIVIDUALS WITH LIVED EXPERIENCE AND PROFESSIONALS SUPPORTING AFFECTED COMMUNITIES

Key findings are based on consultations with six participants. These included an individual interview with a participant who identifies as LGBTQIA2S+, has lived experience of HBV, and remains actively engaged in the community. Additionally, a focus group was held with five other participants, including survivors and supporting professionals.

Participants highlighted the distinct and multifaceted ways HBV affects queer and trans individuals, particularly within cultural contexts where family reputation, obedience, and heteronormativity are tightly interwoven. They discussed the enforced secrecy and silencing surrounding identity, the reinforcement of HBV across migration contexts, and the psychological toll of navigating queerness within familial and cultural structures. Participants also described the emotional labour of holding both professional and survivor identities and engaged in critical discussions on the language of "honour" and the limitations of current service frameworks. Consultations emphasized structural gaps, including the lack of culturally affirming, LGBTQIA2S+-responsive services and insufficient representation. A thematic analysis follows, supported by anonymized direct quotes from participants. **Full details of the guided discussion questions are provided in Appendix D.**

SILENCED TRUTHS OF LGBTQIA2S+ SURVIVORS

One of the most profound themes that surfaced was the intense silencing and concealment many LGBTQIA2S+ individuals are forced into due to threats, both implicit and explicit, of HBV. For several participants, being queer meant a constant risk of discovery, rejection, or violence, particularly from immediate and extended family.

Surveillance began early in life and was often enforced through controlling behaviours such as restricting friendships, isolating individuals from social networks, and applying pressure to marry. Rather than overt physical violence, HBV in these cases often took the form of psychological coercion, denial of autonomy, and the internalization of shame. Some participants had to hide their identity for decades, carrying with them the fear of being outed or harmed if they ever returned to their country of origin.

> *"I was not allowed any females in the house. My father put that in place. I was not allowed to go without somebody escorting me. It became my own shame."*

"I'm queer too but very closeted. My work has been around care work and I do not come out as queer in most settings. And because I love going back to Pakistan. And I have a Muslim family. And I really don't want to be killed in Pakistan. I really, really love home."

"My father said another noose around my neck and he's coming from his traumas. Okay, and in a bit of shame. That we weren't allowed to go once I said I'm separated. None of the family could go in that area where my in-laws lived. And [that] separated the women's supports from each other."

This survival-based secrecy had a long-term impact on participants' mental health and self-perception. Even when participants had physically left abusive environments, many still struggled with feelings of shame and fear conditioned by years of familial policing. The expectation to remain silent, to conform, and to protect the family's public image had left deep emotional scars, contributing to cycles of isolation and delayed healing.

COMPLEX REALITIES OF MIGRATION AND REINFORCEMENT OF 'HONOUR-BASED VIOLENCE'

Participants emphasized that migration does not necessarily offer liberation from HBV; in fact, for many, it can intensify it. In diaspora contexts, the pressure to preserve cultural values in a foreign environment often leads to the reassertion of traditional norms, particularly around gender, family structure, and reputation. Rather than adapting, some families enforce outdated expectations from the time and place of their departure, creating rigid environments that punish deviation and suppress autonomy.

"So there's this whole thing about like, the diasporic lens is also — my parents are inflicting these rules that are from the 80s, not from right now. And if we don't fast-forward to 2025, then we're going to still be in that. Having to deal with people stuck in a time loop — that's hard. They're not going to understand you at all. When I got divorced, I literally had to hide my divorce so that I could have it. I sold my house in secret. My dad didn't talk to me for a year, and my kid was only a year old. His toxicity — he knew what happened, but he also beat me. So he didn't really see the difference."

"It was always told that you keep your mouth shut. Because we don't want our men to be sentenced severely. So here you have immigrant women coming in who don't know anything about the system, who have never worked outside the home… how are they supposed to leave?"

"Back home, there are no resources. But here, my mom says she didn't leave because of us… It's her choice, her life. And it took me a while to understand."

These reflections show that HBV in the context of migration is not a relic of the past or something left behind. It travels with families, often hardens in diaspora, and intersects with structural barriers, generational gaps, and cultural memory. Even when resources exist in a new country, the emotional and cultural obligations tied to honour and motherhood can remain just as binding and emotionally complex. Addressing HBV in diaspora requires a deeper understanding of these layered and often invisible pressures that shape the lives and decisions of racialized women across borders.

HEALING, RESILIENCE, AND THE WEIGHT OF TRADITION IN FAMILY DYNAMICS

Participants shared deeply personal reflections on the complex and evolving family dynamics shaped by HBV. One spoke about her mother's long, difficult journey toward reclaiming autonomy, describing a marriage marked by chaos, emotional distance, and trauma, but also resilience and slow, hard-won healing. Another participant reflected on similar experiences of cultural pressure and the immense difficulty of breaking free from restrictive family expectations that are deeply rooted in tradition.

"It took her 25 years to be able to say that I cannot live with you under the same roof, even if we are culturally going to be married… For the longest time, I was really angry at her—why not leave? But now I understand. Back home, there are no resources. But here, my mom says she didn't leave because of us."

My mom broke free for a bit and went to my grandparents' house, but they sent her back saying, 'We're traditional people. We don't do this.' Years later, I was coerced into a marriage of my own and I became my mother. As much as I was frustrated at her for not breaking free. I couldn't stand up to him. And it's not somebody who I am."

These stories emphasize that healing is rarely a straight path. It is shaped by the delicate and often painful interplay between individual agency, family relationships, and the powerful cultural scripts tied to honour, duty, and belonging. They underscore the critical need for service providers and communities to approach survivors' journeys with empathy and without judgment, respecting that each person's choices reflect their readiness and unique circumstances.

THE COMPLEXITIES OF NAVIGATING PROFESSIONAL IDENTITY

Several participants occupied dual roles as both service providers and LGBTQIA2S+ individuals with personal histories of HBV. These participants spoke openly about the emotional toll of working within institutions that often lacked understanding or acknowledgement of the intersectional experiences they carried. Many described the need to carefully manage their professional identities, deciding when, where, and to whom they could safely disclose their queerness. This constant negotiation led to burnout, isolation, and, at times, retraumatization, particularly when working with clients whose stories mirrored their own.

"I'm a therapist and a survivor. Sometimes it feels like I have to choose which version of me gets to show up."

"I used to be much more out in the earlier part of my career, but I was harmed by it. Now I pick and choose."

Participants described feeling tokenized in some spaces and erased in others. Despite their expertise, they were often expected to leave their lived experience at the door, or worse, have it used against them as evidence of bias or instability. The emotional labour required to be "the representation" in predominantly heteronormative, white, or cis-centric institutions often went unacknowledged, deepening feelings of invisibility and disempowerment.

DEBATING THE LANGUAGE AND OWNERSHIP OF 'HONOUR-BASED VIOLENCE'

There was robust discussion around the term 'honour-based violence,' with several participants expressing discomfort with the word "honour" itself. They pointed out that using the term may inadvertently dignify or normalize the violence by connecting it to a concept that is typically seen as positive or virtuous. At the same time, others urged caution in removing the term altogether, particularly because it reflects the language many survivors themselves use to describe their experiences. The deeper concern was not just about the terminology, but about who has the authority to define it, whether it's survivors or professionals removed from the lived experience.

"So how will you make a decision? Even if, let's say you wanted to take a vote on it... is it going to be from the experiences of people or the do-gooders who want to change this? Okay, I'm coming from a good place. The do-gooders. They're privileged. They haven't experienced it."

"When we say 'honour,' we have to remember it's being weaponized. But for some survivors, that word is exactly what they need to name what happened."

"How would you go about talking and discussing about a person who has changed their name and you're not allowed to say the last name or not allowed to say the old name—the dead name—anymore? How would you actually go through that process? Because that's the exact same thing that's happening here. People are getting insulted by this thing that is very... it's a past term."

This analogy to a "dead name" offered a powerful way to understand the emotional and political weight that language carries. Just as a person who changes their gender may no longer use their previous name—their "dead name"—but that name still carries personal and social history, the term "honour-based violence" may feel outdated or painful to some while still being meaningful and recognizable to others. Participants emphasized that language must be rooted in the realities and voices of those most impacted. They also highlighted that suddenly changing or eliminating the term could create confusion, making it harder for people to recognize, discuss, or address these harms. Rather than eliminating the term completely, some suggested using modifiers like "so-called honour-based violence" or tailoring the language based on the preferences of survivors. What mattered most was ensuring that terminology is not imposed from above, but informed by the communities being served.

BARRIERS TO CULTURALLY RESPONSIVE AND LGBTQIA2S+-AFFIRMING SERVICES

Across both consultations, participants reported a striking absence of affirming services for queer South Asians experiencing HBV. They described being caught between mainstream LGBTQIA2S+ services that often lacked relevance to their cultural and lived experiences, and community-focused services, which sometimes upheld heteronormative norms or failed to ensure safety for queer participants. Past experiences of judgment, exclusion, or violence created anxiety and hesitation, even with community services. Participants emphasized the need for trauma-informed, competent, and LGBTQIA2S+-affirming support, mindful of survivors' comfort in shared spaces. As a result, many were left without trustworthy assistance, leading to delayed help-seeking or further marginalization.

"If I'm going to be honest, when I opened the Zoom call, I was a bit hesitant because I saw hijabis on the screen, and it was a bit traumatic because of my experience with the Muslim community being very judgmental and sometimes even violent toward queer people."

"It's not that we don't want help… it's that we don't trust the help that's offered."

"Just because someone is queer doesn't mean they want to leave their family behind. That nuance is always missed."

"If the framework is heterosexual, you're already leaving us out."

Many participants were frustrated by service providers who assumed severing family ties was the only path to safety. While some choose estrangement, others seek healing without abandoning family. They emphasized the need for trauma-informed, culturally competent services that respect both safety and connection, rather than relying on Western individualism, which often assumes that personal liberation requires cutting ties with family. In contrast, many South Asian communities prioritize collectivist values, where identity and well-being are deeply tied to family, interdependence, and community belonging. For these survivors, healing may involve preserving familial relationships while setting boundaries, not severing them entirely.

Participants also called for structural changes, including increased representation of queer and trans South Asians within service systems, more funding for affirming initiatives, and a critical review of heteronormative service frameworks that often fail to reflect the realities of racialized LGBTQIA2S+ communities.

DISCUSSION & ANALYSIS

6.1 CONCEPTUAL FRAMING: 'HONOUR-BASED VIOLENCE' WITHIN THE CONTEXT OF GENDER-BASED VIOLENCE

HBV is best understood within the broader framework of GBV, yet it is distinct in its scope, motivations, and mechanisms. While GBV typically involves an individual exerting control over an intimate partner, HBV is characterized by its collective enforcement, where entire families and sometimes wider community networks, participate in upholding patriarchal codes of honour and punishing perceived transgressions. This collective dynamic can take many forms, including surveillance by siblings or cousins, restricting friendships and social interactions, imposing curfews, and controlling access to education or employment. Survivors are thus targeted not by a single abuser but by multiple actors, creating unique safety challenges and intensifying feelings of isolation and fear.

The findings highlight how intergenerational dynamics deepen these risks. Second-generation youth in Ontario, particularly young women and LGBTQIA2S+ individuals, often experience heightened surveillance and control as families attempt to preserve “traditional” norms in diasporic contexts. Parents may perceive behaviours such as dating, rejecting arranged marriages, asserting independence, or expressing non-conforming gender or sexual identities as threats to cultural or familial honour. These attempts to maintain control often involve not only verbal pressure but also emotional manipulation, monitoring online activity, and enforcing strict behavioural rules. The tension between cultural preservation and individual autonomy frequently triggers HBV, leaving survivors navigating complex emotional landscapes of fear, loyalty, and identity.

HBV also has transnational dimensions that separate it from other forms of GBV. Families may threaten to send survivors abroad for FM, “re-education,” or punishment, exploiting the difficulty of cross-border protection. Survivors reported fears not only of local retaliation but also of being trapped in foreign jurisdictions where Canadian protections cannot easily reach them. At the same time, public narratives that frame HBV solely as an “imported cultural issue” risk reinforcing racism and Islamophobia, obscuring how patriarchy, racialization, and systemic inequities in Canada also shape survivors’ experiences. Situating HBV as both part of GBV and as a distinct phenomenon ensures that interventions can address the unique risks, collective enforcement, and transnational threats HBV entails, while remaining integrated into broader anti-violence strategies.

6.2 SURVIVOR REALITIES: SILENCE, STIGMA, AND INTERSECTIONAL BARRIERS

The lived realities of survivors underscore the silencing and stigmatization that define HBV. Survivors are often forced into secrecy, pressured by the belief that leaving an abusive home would bring shame not only upon themselves but upon their entire families. Abusers weaponize distorted cultural and religious narratives to instill guilt, convincing survivors that resistance equates to betrayal. Importantly, these narratives are not authentic to any faith or culture but reflect patriarchal reinterpretations designed to maintain power and control.

The impacts of HBV extend far beyond immediate harm. Survivors endure physical violence and forced confinement, but also face profound disruptions to their life trajectories. Many are withdrawn from school or prevented from pursuing higher education, cutting off pathways to independence and limiting career opportunities. Employment is often restricted or tightly controlled, with survivors prevented from working or forced into exploitative arrangements. These constraints hinder financial self-sufficiency, reduce opportunities to build social networks, and limit development of skills necessary for independent living. Over time, these restrictions reinforce dependency, curtail personal growth, and undermine confidence, making it harder for survivors to reclaim agency even after leaving abusive environments.

Beyond structural barriers, survivors experience profound psychological and emotional consequences. Isolation, constant surveillance, and restricted autonomy contribute to chronic stress, with many reporting depression, anxiety, hypervigilance, and symptoms consistent with post-traumatic stress disorder. For many, these impacts are compounded by shame, self-blame, and internalized fear, which can persist long after escaping immediate danger. Yet, culturally safe and trauma-informed mental health supports remain scarce, leaving survivors without accessible avenues for healing, validation, or guidance.

Intersectionality compounds these challenges. Newcomer survivors with precarious immigration status risk deportation if they leave abusive sponsors. LGBTQIA2S+ survivors face risks of outing, disownment, or "corrective" forms of HBV. Many survivors also feared approaching institutions out of concern that disclosures would reinforce negative stereotypes about South Asian or Muslim communities. For these individuals, the double burden of choosing between personal safety and community reputation forces prolonged silence and isolation.

Despite these barriers, survivors also demonstrate resilience. Some seek discreet support online or through trusted peers, others escape and establish new lives, often at great personal risk. These acts of resistance illustrate both survivors' agency and the urgent need for services that validate their strategies, protect their safety, and provide trauma-informed, culturally grounded support.

6.3 CRACKS IN THE SYSTEM: GAPS IN SERVICES AND INSTITUTIONAL RESPONSES

The background and findings from this study revealed systemic shortcomings that exacerbate survivors' vulnerability. Although survivors may access mainstream GBV services, the absence of HBV-specific approaches leaves critical risks unaddressed. Survivors are forced to navigate systems ill-equipped to account for the collective, cultural, and transnational nature of HBV.

Several gaps emerged:

Inadequate Culturally Responsive Knowledge and Training: Frontline workers across agencies, shelters, and law enforcement often lack understanding of the cultural or religious values that abusers exploit to control survivors. These values, though framed as cultural or religious, are frequently rooted in misogyny and create guilt, shame, or fear that trap women in cycles of violence. To address these challenges, HBV-specific training must consider local and immigrant experiences, as well as transnational and culturally nuanced contexts, enabling staff to build trust, develop effective safety plans, and provide interventions tailored to each survivor's situation.

Funding and Sustainability Challenges: Organizations that provide services tailored to specific cultural communities are often underfunded and rely on short-term grants. This leaves survivors without stable, long-term support and creates gaps in case management, staff retention, and specialized training. Limited funding also constrains outreach, mental health supports, and prevention initiatives, perpetuating systemic inequities for women experiencing HBV.

Lack of HBV-Specific Risk Assessment Tools: Current GBV assessment tools used by frontline workers, legal advocates, and social service providers often fail to capture risks unique to HBV, such as family involvement, community surveillance, and threats of being taken abroad. Without HBV-specific indicators, authorities and service providers may misjudge danger levels, and safety plans may fall short of addressing the complex collective, cultural, and transnational realities survivors face. This gap underscores the critical need for tailored, context-sensitive tools that guide service actors in developing effective, survivor-centered responses.

Weak Interagency Collaboration: Survivors often must retell their stories multiple times to different agencies, compounding trauma and creating opportunities for risk to be overlooked. Fragmented communication and a lack of coordinated protocols between shelters, law enforcement, and community agencies hinder timely and effective responses. Weak collaboration also undermines safety planning, case monitoring, and accountability across sectors.

Reporting and Law Enforcement Limitations: Many survivors delay seeking help due to fear of family retaliation, social stigma, or immigration concerns, as well as mistrust of authorities. Police frequently interpret HBV as ordinary DV, failing to account for collective, community, or transnational dimensions of risk. Missing persons reports are sometimes weaponized by families, yet authorities may treat them without context. These barriers can prevent timely intervention, leaving survivors isolated during critical moments and increasing the risk that they will be misunderstood, retraumatized, or further harmed.

Service Access and Safety Challenges: Survivors face barriers that compromise both access and safety, including practical obstacles such as long waitlists and language challenges, alongside logistical issues in intake, shelter placement, safety planning, and confidentiality, all of which hinder timely and secure support. These challenges are further compounded by a lack of trauma-specific, HBV-informed, culturally sensitive, and LGBTQIA2S+-inclusive care. Together, these barriers leave survivors isolated and at greater risk, limiting their ability to navigate services safely and rebuild autonomy.

Limited Prevention and Public Awareness Efforts: The absence of targeted prevention and public awareness leaves survivors without access to resources and communities without opportunities to challenge harmful norms. Survivors emphasized the importance of educating men about healthy gender norms and women about their rights and healthy relationships, noting that greater awareness could prevent abuse, support early intervention, and disrupt cycles of harm.

Two cases documented during this study illustrate these gaps in practice:

- **Case 1:** A woman seeking safety was moved to a shelter outside her neighbourhood, yet staff allowed her to remain in contact with community members still connected to her abuser. Due to language barriers and delayed intake, she was persuaded to leave the shelter and ultimately returned to her abuser, where the abuse escalated. This underscores the dangers of failing to recognize how community ties can compromise safety in HBV cases.
- **Case 2:** A young woman forced into a marriage fled after being held at home for several days without access to technology, as her family viewed her relationship outside the community and rejection of an arranged marriage as shameful. She was rehoused in another city with support from a worker. A few days later, police interrogated the worker after the family filed a missing persons report, without understanding the HBV context. Fortunately, the survivor was able to remain safely with her partner, living independently from her family and community. But this case highlights law enforcement's lack of HBV-specific awareness and the risks of misinterpreting survivor actions.

These examples demonstrate how systemic blind spots, ranging from insufficient training to weak protocols, can place survivors at greater risk rather than offering protection. Without HBV-specific frameworks, survivors face not only familial violence but also institutional failures that perpetuate cycles of harm.

RECOMMENDATIONS

HBV is a complex form of GBV that intersects with family, cultural, and community dynamics, often making it difficult for survivors to seek help safely. Effective responses require a comprehensive, multi-sectoral approach that centers survivor needs, ensures safety, and addresses the underlying social and cultural factors that contribute to abuse. Culturally informed practices, trauma-sensitive interventions, and coordinated systems-level responses are essential to prevent harm, support survivors' well-being, and hold perpetrators accountable, while fostering trust and engagement within diverse communities.

Responding to HBV also requires strong collaboration among government, law enforcement, justice, research, education, and community service sectors. Sustainable solutions depend on culturally specific programming, consistent legal frameworks, and stable, long-term funding that prioritize marginalized populations, including racialized communities, newcomers, LGBTQIA2S+ individuals, and those with disabilities. Within the GTA, this coordination is particularly critical given the region's diversity and the unique needs of South Asian, Muslim, and other racialized populations.

The following recommendations outline a comprehensive approach to implementing these strategies, identifying lead actors and GTA-specific considerations for each area of action.

Government & Policymakers

Coordinated Systems-Level Response: A systems-level approach ensures HBV interventions are consistent, timely, and effective across sectors. This includes establishing regional protocols and joint community intervention tables that allow agencies to meet regularly, prioritize high-risk cases, and collaboratively address survivors' legal, social, educational, and health-related needs. Clear communication, ongoing evaluation, and flexibility are critical to adapting these mechanisms to evolving community and survivor needs. Building on this, GTA municipalities—including Toronto, Peel, and York—should embed culturally specific services for South Asian, Muslim, and other racialized communities within broader GBV frameworks. Central to effective coordination is the collection and use of disaggregated data on race, ethnicity, immigration status, and other relevant factors, enabling agencies to identify disparities, monitor service gaps, and target interventions effectively. Successful models such as Peel's Community Response Table illustrate how inter-agency coordination,

culturally responsive interventions, continuous learning, and data-driven decision-making can be integrated in practice.

Lead Actors: Ontario provincial and municipal governments, Ministry of Health, GBV service agencies in the GTA, public health units.
GTA Consideration: Coordinate services across multiple municipalities; ensure suburbs with high newcomer populations are included; prioritize GTA high-need neighborhoods; establish shared local data systems for tracking and referrals.

Legal Recognition of HBV and National Action Plan Integration: HBV should be explicitly defined in the Criminal Code to provide clear guidance for law enforcement, prosecutors, and courts, ensuring accountability, enforceable penalties, and stronger protections for survivors. Legal recognition also supports the implementation of Canada's 2022 National Action Plan to End Gender-Based Violence (NAP) by giving agencies and service providers a concrete legal foundation, enabling the Plan to reference enforceable offenses, risk assessments, and reporting standards. The NAP explicitly supports disaggregated data collection by gender identity or expression, indigeneity, sexual orientation, age, race, status, disability, geography, and other identity factors. Despite this, it does not explicitly reference HBV or provide guidance tailored to its unique dynamics. We recommend that HBV be explicitly included in the NAP with clear implementation guidance for frontline workers, law enforcement, and community agencies. Integrating HBV into this national framework ensures alignment between legal reforms, GBV policies, monitoring systems, and data frameworks — enhancing culturally informed and intersectional survivor protections.

Lead Actors: Government of Canada, Ministry for Women and Gender Equality, Ontario provincial and municipal governments, legislative bodies.
GTA Consideration: Ensure HBV policies are applied in ways that reflect GTA's diverse cultural, religious, and linguistic communities, providing culturally informed, survivor-centered guidance for local agencies and service providers.

Funding and Sector Support: Long-term, stable funding is critical to addressing chronic underfunding in shelters, transitional housing, counseling, legal aid, and community programs serving HBV survivors. To ensure equity, resources must prioritize underserved populations, including LGBTQIA2S+ survivors, individuals with disabilities, newcomers, youth, older adults, and racialized communities. Strengthened investments in culturally specific organizations, inter-agency coordination, staff training, program evaluation, and culturally appropriate service design will improve service quality and accessibility. Sustained, multi-year operational funding is essential for consistency, survivor-centered approaches, and preventing service gaps, while supporting ongoing community engagement in prevention, rehabilitation, and outreach initiatives.

Lead Actors: Ontario provincial and municipal governments, funders and foundations, grant agencies, philanthropic organizations.
GTA Consideration: Address funding gaps in suburban shelters and community programs; target neighborhoods with large South Asian, Muslim, and immigrant populations; ensure multi-year funding for GTA-specific services.

Law Enforcement & Justice System

Culturally Competent Support and Frontline Capacity Building: Law enforcement, crown attorneys, and frontline GBV agencies require specialized training to identify and respond to HBV effectively. Training should address coercive control, FM, digital surveillance, and intersectional considerations for LGBTQIA2S+ individuals, people with disabilities, older adults, and newcomers. Complementing this, agencies should employ staff reflective of the communities they serve and offer multilingual resources to improve accessibility and trust. Confidentiality and secure communication protocols are also essential to protect survivors from retaliation. Embedding HBV response within broader GBV frameworks strengthens referral pathways, risk assessment processes, and coordinated survivor support. Consistent standards and culturally informed risk assessment tools adopted by GTA municipalities can help ensure safety, trust, and accountability across legal and social service sectors.

Lead Actors: Police services, crown attorneys, frontline GBV agencies, specialized HBV units, legal aid services, immigration and family lawyers.
GTA Consideration: Standardize training across GTA municipalities; recruit staff reflecting local diversity; provide multilingual resources for GTA's immigrant communities; implement consistent risk assessment tools locally.

Perpetrator-Focused and Rehabilitation Interventions: Effective HBV prevention requires interventions that address perpetrators' behaviors through culturally informed rehabilitation, counseling, and accountability measures. These programs should directly confront harmful gender norms, family pressures, and underlying beliefs that contribute to abuse, while promoting long-term behavioral change. Legal accountability must be integrated with rehabilitative approaches, including court-mandated counseling, diversion programs, and educational initiatives that reinforce responsibility and safety. Collaboration with community leaders and culturally specific organizations enhances program credibility and increases engagement. Pilot programs in GTA neighborhoods with higher HBV prevalence can tailor interventions to local cultural dynamics. Ongoing monitoring of recidivism, survivor feedback, and community acceptance ensures sustainable outcomes and reduced risk of repeat offenses.

Lead Actors: Courts, probation services, rehabilitation programs, community organizations, faith/community leaders.
GTA Consideration: Pilot programs in GTA neighborhoods with higher HBV prevalence; tailor interventions to local cultural norms; monitor feedback from specific GTA communities.

Survivor Safety and Legal Measures: Survivor safety must be the highest priority, recognizing that a disclosure may be a survivor's only opportunity for protection ("one chance rule"). Authorities should implement comprehensive measures such as relocation, safe housing, confidentiality protections, and anonymity in legal proceedings to prevent family or community retaliation. Explicitly recognizing HBV

motives during prosecutions and sentencing ensures the justice system reflects the unique dynamics of HBV. Consistent application of these measures across GTA municipalities, supported by clear guidance for law enforcement, legal professionals, and service providers, strengthens coordinated protective interventions and prioritizes survivors' long-term security.

Lead Actors: Police services, crown attorneys, courts, probation services, shelters.
GTA Consideration: Apply survivor protection measures consistently across Toronto, Peel, and York; provide relocation and shelter options in GTA suburbs; ensure confidentiality and safe access in culturally diverse communities.

Researchers & Educational Institutions

Data Collection, Monitoring, and Participatory Research: Researchers should lead ongoing, disaggregated data collection to better understand HBV prevalence, patterns, and risk factors. Studies must account for race, immigration status, gender identity, age, disability, and socioeconomic status to reflect the lived realities of affected communities. Engaging survivors as co-researchers ensures culturally grounded, ethical insights and strengthens the relevance of findings. Partnerships with community organizations, service providers, and policymakers are essential for evaluating program effectiveness and identifying best practices. Longitudinal and intersectional studies will help track trends over time, assess intervention outcomes, and inform future policy and service delivery. GTA-focused research should prioritize neighborhoods and populations most affected, producing evidence that translates into practical, culturally responsive tools for frontline agencies.

Lead Actors: Universities, colleges, research institutes, government research bodies, community organizations
GTA Considerations: Focus research on neighborhoods with high HBV prevalence; ensure studies include GTA's multicultural and immigrant populations; translate findings into locally relevant tools for service providers.

Education, Teacher Training, and Safe Reporting: Educational institutions should integrate HBV and broader GBV awareness into health and sex education curricula, ensuring students understand healthy relationships, consent, and their rights. Teachers and school staff must receive specialized training to recognize coercion, FM family-based abuse, and digital surveillance, using culturally informed and trauma-sensitive approaches. Confidential school-based reporting channels should be connected to culturally safe community services, shelters, and counseling programs to support at-risk youth. Collaboration with local service providers and community leaders strengthens referral pathways and ensures timely interventions. By preparing educators and students, schools become proactive environments for prevention, early disclosure, and survivor support, helping youth navigate complex cultural and social pressures with confidence.

Lead Actors: High schools, colleges, universities, community organizations
GTA Considerations: Implement training in schools with high concentrations of South Asian, Muslim, and immigrant students; establish confidential reporting pathways connected to local GTA services; tailor awareness materials to local communities.

Community & Service Providers

Survivor-Centered Services and Targeted Support: Services must address both immediate and long-term survivor needs, including counseling, peer support, mentorship, and life-skills programs covering digital literacy, financial literacy, employment preparation, and language development. Holistic approaches that support survivors' mental, physical, and emotional well-being promote recovery and strengthen resilience. Emergency financial support, legal aid, and guidance on immigration or custody issues are also critical for rebuilding autonomy. Programs must remain culturally and linguistically accessible and coordinated within broader GBV service networks to avoid duplication and confusion. Collaboration across Toronto, Peel, and York enhances continuity and ensures survivors can navigate multiple systems safely. Survivor-centered, culturally responsive interventions help improve safety, empowerment, and long-term well-being.

Lead Actors: Shelters, counseling centers, social service agencies, cultural organizations, mental health professionals.
GTA Consideration: Expand services in high-need GTA neighborhoods and suburbs; ensure cultural and linguistic accessibility; address intersectional needs of local populations (LGBTQIA2S+, newcomers, older adults, youth, persons with disabilities).

Expanding Safe and Secure Spaces: Safe, culturally responsive shelters are essential to protect survivors and provide holistic support. These spaces must maintain confidentiality and physical security, including controlled entry, secure locks, alarm systems, and safe building design, while also offering mentorship, skill-building, and access to supportive networks. Staff must be trained in trauma-informed, culturally competent care to address the diverse needs of South Asian, Muslim, and other racialized communities. Integrating safe spaces within broader GBV frameworks ensures coordination with law enforcement and social services. Expansion efforts in the GTA should focus on suburbs and high-density neighborhoods where survivors may be isolated, ensuring equitable access to secure housing, resources, and community support networks.

Lead Actors: Shelters, cultural organizations, social agencies, municipal housing authorities.
GTA Consideration: Develop shelters in suburban and isolated neighborhoods; integrate with GTA GBV service networks; ensure culturally sensitive and physically secure spaces for diverse communities.

Community-Led Awareness and Education Programs: Community-led initiatives play a crucial role in raising awareness, reducing stigma, and complementing formal service provision. Faith and cultural leaders can facilitate dialogues that redefine “honour” in non-violent ways, publicly denounce harmful HBV practices, mentor survivors, and model healthy gender norms. Programs targeting youth and men can promote healthy relationships, gender equity, and non-violence, working alongside schools and service providers to reach younger generations. Coordinated educational campaigns across GTA

neighborhoods with large South Asian, Muslim, and immigrant populations strengthen community engagement and increase survivor outreach. Integrating these initiatives with established service networks ensures that prevention strategies link directly to support resources, enhancing community-level responsiveness and systemic HBV interventions.

Lead Actors: Community organizations, faith-based institutions, cultural centers, shelters, social service agencies, media partners, local leaders.
GTA Consideration: Target youth and men in GTA neighborhoods with large South Asian, Muslim, and immigrant populations; coordinate campaigns with local schools and community networks; focus on culturally relevant messaging.

CONCLUSION

The examination of HBV within Ontario's South Asian communities underscores the urgency of addressing it as a distinct yet interconnected aspect of GBV. The background context revealed HBV as rooted in patriarchal norms, collective family structures, and cultural expectations of honour, while the findings highlighted the lived realities survivors face, including stigma, fear, and systemic barriers to support. Together, these insights show that HBV is a multidimensional problem requiring equally multidimensional solutions.

Findings demonstrate that survivors are caught at the intersection of cultural, familial, and systemic forces that severely restrict their autonomy and safety. Their silence is not a reflection of weakness but rather a strategic response to layered risks, ranging from family retaliation to community ostracization and systemic discrimination in Canadian institutions. Effective responses must therefore prioritize immediate protection while addressing the deeper power structures that sustain HBV.

At the systemic level, this study highlights the pressing need for specialized training across sectors, including healthcare, education, law enforcement, and social services. Without an informed and coordinated approach, survivors will continue to fall through the cracks of existing GBV frameworks. Policymakers must ensure that HBV is explicitly named and addressed in provincial and national strategies on GBV, accompanied by robust funding and accountability mechanisms.

Community engagement is equally vital. Preventing and addressing HBV requires collaborative work with South Asian communities, religious leaders, women's groups, and youth networks to challenge harmful honour-based norms while also fostering culturally affirming pathways of support. Survivor-led advocacy, when supported and resourced, has the potential to shift narratives, dismantle stigma, and empower others to come forward.

Addressing HBV also demands attention to broader societal dynamics. Survivors' hesitation to disclose HBV due to fears of racism and cultural stereotyping calls for a careful balance: interventions must confront HBV without vilifying South Asian communities. This means adopting anti-racist, intersectional approaches that center survivors' dignity and human rights.

Ultimately, HBV cannot be addressed in isolation. It is both a personal and systemic issue that affects individuals, families, and communities while challenging institutions to strengthen how they uphold safety, equality, and justice. Tackling HBV requires immediate protective measures alongside long-term systemic change, embedded within broader commitments to gender equality, immigrant integration, anti-racism, and community empowerment.

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APPENDICES

APPENDIX A — KEY DEFINITIONS

Child Abuse: Child abuse refers to any form of physical, emotional, sexual, or psychological harm, or neglect, inflicted on a child (anyone under 18) by a caregiver, family member, or other responsible adult. It includes behaviours that endanger a child's health, development, or well-being, and may involve physical violence, emotional manipulation, sexual exploitation, or withholding basic necessities such as food, shelter, or education.

Child Marriage: Child marriage is a marital union where at least one party is under the age of 18. It is often justified as protecting family honour, securing economic stability, or reinforcing community ties. The practice disproportionately affects girls, depriving them of autonomy, education, and safety.

Collective/ Community-Enforced Violence: Collective or community-enforced violence refers to abuse involving not only immediate family but also extended relatives or community members. Responsibility and punishment are distributed across the group, which dilutes individual accountability. Survivors face increased vulnerability due to communal surveillance, pressure, and retaliation.

Domestic Violence (DV): Domestic violence is abuse that occurs within intimate or familial relationships, motivated by power and control. It can include physical, emotional, psychological, financial, or sexual harm. Unlike 'honour-based violence', which often involves multiple perpetrators, DV is typically committed by a single individual, usually a current or former partner.

Dowry-Related Violence: Dowry-related violence refers to the harassment, abuse, or murder connected to disputes or dissatisfaction over dowry payments. Women may be mistreated by husbands or in-laws if demands are unmet. It transforms economic bargaining into a form of coercion and gendered violence.

Economic Abuse: Economic abuse is the control or restriction of money, employment, or resources to increase dependency. Survivors may be denied education, job opportunities, or basic necessities. This form of abuse traps individuals in unsafe relationships by limiting their autonomy.

Elder Abuse: Elder abuse is any action or inaction that causes harm, distress, or loss to an older adult, typically by a family member, caregiver, or other trusted individual. It can include physical, emotional, or sexual abuse; financial exploitation; neglect; or social isolation, and often occurs in situations where the elder depends on others for care or support.

Emotional & Psychological Abuse: Emotional and psychological abuse refers to patterns of manipulation that undermine self-worth and independence. It can involve threats, intimidation, humiliation, gaslighting, or guilt. Though often invisible, it causes long-term trauma and reinforces other forms of violence.

Female Genital Mutilation (FGM): Female genital mutilation is the partial or total removal of female genitalia for non-medical reasons. It is often justified as preserving purity or ensuring marriageability. The practice causes severe physical and psychological harm and is internationally recognized as a human rights violation.

Female Infanticide & Sex-Selective Abortion: Female infanticide and sex-selective abortion involve killing newborn girls or terminating pregnancies based on fetal sex. These practices are rooted in son preference and beliefs that daughters are burdensome or dishonourable. They contribute to distorted sex ratios and reinforce systemic gender inequality.

Forced Marriage (FM): Forced marriage is a union where one or both parties do not give free and informed consent. Coercion may include threats, deception, or physical violence, and victims are sometimes taken abroad under false pretences. It is often linked to family honour, immigration control, or economic gain.

Gang Violence: Gang violence is organized collective violence used to assert dominance over territory, illicit markets, or rival groups. It often involves extortion, intimidation, assault, and murder. This form of violence thrives in contexts of poverty, inequality, and weak state presence.

Gender-Based Violence (GBV): Gender-based violence refers to harmful acts directed at individuals because of their gender, gender identity, or perceived gender roles. It includes physical, sexual, emotional, psychological, spiritual, and economic forms of abuse, as well as practices like HBV, FM, and FGM. GBV is rooted in patriarchal power structures and recognized as a violation of human rights.

'**Honour-Based Violence' (HBV):** 'Honour-based violence' is abuse carried out to protect or restore family or community honour. It often involves multiple perpetrators, including relatives or community members, and disproportionately affects women and girls, though others may be targeted. HBV can take the form of forced marriage, confinement, ostracism, physical assaults, or 'honour' killings.

'**Honour Killings' / Femicide: '**Honour killings' are the intentional killing of individuals, mostly women and girls, perceived to have brought shame to their families. Femicide more broadly refers to the killing of women because of their gender. These acts are often triggered by behaviors considered transgressive, such as rejecting FM, seeking divorce, engaging in pre-marital relationships, surviving SA, or challenging traditional gender roles.

Mob Violence: Mob violence is spontaneous, emotionally charged group violence carried out by crowds. It can involve assault, intimidation, or vandalism, often fueled by shared grievances or desires for retribution. The group typically lacks centralized leadership or formal coordination, and responsibility is diffused among participants, making accountability difficult.

Physical Abuse: Physical abuse refers to direct acts of violence that cause bodily harm. This includes hitting, slapping, choking, burning, or assault with weapons. In HBV, it may escalate to mutilation or 'honour killings'; in DV, it often follows a recurring cycle of escalation and reconciliation.

Religious Extremism: Religious extremism involves violent acts committed in the name of religion or ideology, often supported by group participation or endorsement. This can include terrorist attacks, hate crimes, or communal violence. It typically arises from the manipulation of faith or doctrine to justify violence against perceived enemies, non-believers, or rival sects.

South Asian: South Asian refers to people with origins to South Asian or the Indian subcontinent, including countries like India, Pakistan, Bangladesh, Afghanistan, and Sri Lanka.

Sexual Assault (SA) or Violence: Sexual assault or violence refers to any sexual act committed without consent. It may involve coercion, intimidation, exploitation, or force. In HBV contexts, survivors may face additional punishment or rejection from families who perceive them as dishonourable.

Social Ostracism: Social ostracism is the deliberate exclusion, shaming, or rejection of an individual by their family, community, or social group. It is often used to enforce social, cultural, or moral norms, punish perceived transgressions, or maintain communal control.

Social Violence (Culturally Sanctioned / Tradition-Based Violence): Social violence refers to harmful practices justified or legitimized by cultural or traditional customs. Examples include HBV, FGM, and child marriage. These acts disproportionately affect women, girls, and gender-diverse people, and are often upheld by the community.

Spiritual Abuse: Spiritual abuse is the misuse of religious or spiritual beliefs to control, shame, or silence individuals. Survivors may be pressured to remain in abusive situations by appeals to faith, threatened with divine punishment, or dismissed when seeking religious support.

State-Sanctioned Violence: State-sanctioned violence refers to harm carried out or endorsed by governments or authorities to maintain control, suppress dissent, or enforce policy. It includes police brutality, military crackdowns, genocides, and state-sponsored terrorism. Such violence is often institutionalized, with perpetrators shielded from accountability and justified under the guise of national security or law and order.

Tribal or Ethnic Conflict: Tribal or ethnic conflict is violence between groups rooted in historical grievances, competition for resources, or political tensions. It may involve massacres, displacement, or targeted attacks. These conflicts are often intensified by colonial histories and elite exploitation of divisions. They are frequently exacerbated by colonial legacies, territorial disputes, and elites who exploit ethnic divisions for power.

Violence Against Women and Girls (VAWG): Violence against women and girls is a category of GBV that disproportionately impacts women and girls. It includes physical, sexual, psychological, and economic harm, as well as harmful practices like HBV, FM, and FGM. VAWG is rooted in gender inequality and recognized globally as a barrier to equity and human rights.

APPENDIX B — COMPREHENSIVE OVERVIEW OF CANADIAN HBV RESOURCES AND TOOLKITS

CANADIAN COUNCIL OF MUSLIM WOMEN (CCMW) – "VIOLENCE AGAINST WOMEN" (2013)

Addressing the critical need for culturally and faith-sensitive resources on violence against Muslim women in Canada, CCMW developed the toolkit *Violence against Women: Health and Justice for Canadian Muslim Women*. Funded by Status of Women Canada, this comprehensive resource was created through consultations with experts, survivors, community leaders, and service providers to offer a nuanced understanding of violence within Muslim communities, while supporting frontline workers in delivering culturally competent care.

The toolkit covers a wide spectrum of violence, including domestic abuse, FM, HBV, FGM, and femicide, situating these issues within the context of faith, culture, and migration experiences. CCMW explicitly rejects framing HBV as a cultural or religious practice, instead positioning it as a form of patriarchal control and abuse that violates Islamic principles and human rights. The resource highlights the importance of addressing HBV through community education and survivor-centered interventions that challenge harmful norms without stigmatizing Muslim communities.

Key components of the toolkit include:

- **Comprehensive Overview:** The publication outlines various forms of violence experienced by Muslim women, detailing their prevalence and challenging harmful stereotypes tied to culture or religion. It also highlights intersecting factors like immigration status, language barriers, and social isolation that impact access to support and services.
- **Legal and Social Frameworks:** CCMW reviews Canadian laws related to family violence, FM, and trafficking, emphasizing the need for culturally sensitive legal responses to avoid retraumatizing survivors. It also identifies challenges faced by service providers and calls for better coordination of social support.
- **Community and Faith-Based Perspectives:** The resource emphasizes the important role of Muslim community leaders, imams, and faith organizations in violence prevention and response. It encourages open dialogue about gender equity and engages men and youth as allies in promoting change.
- **Practical Resources:** CCMW provides guidance for service providers on culturally sensitive communication, trauma-informed care, and safety planning. It offers strategies to overcome barriers like mistrust, fear of community backlash, and immigration concerns, along with sample intake questions, referral protocols, and culturally specific support contacts.

This publication remains an essential resource for agencies and professionals working with Muslim women affected by violence, advancing culturally grounded and survivor-centered approaches that honor faith identities while promoting safety, dignity, and justice. (Cross, 2013)

SOUTH ASIAN WOMEN'S CENTRE (SAWC) – "THERE IS NO HONOUR IN VIOLENCE AGAINST WOMEN AND GIRLS" (2013–2015)

In response to growing concerns around family and community violence in South Asian communities, the South Asian Women's Centre (SAWC) developed a comprehensive, community-informed Inter-Agency Strategy (IAS) titled *There Is No "Honour" in Violence Against Women and Girls*. Funded by Status of Women Canada and developed over two years, the IAS was the result of extensive community consultations, a literature review, and a needs assessment that engaged over 3,000 participants, including survivors, service providers, and community stakeholders.

The IAS addresses HBV by contextualizing it within broader GBV, while acknowledging the unique cultural, systemic, and familial dynamics South Asian women face. SAWC's approach rejects the framing of HBV as an "exotic" or "cultural" issue and instead roots it in patriarchal power structures, coercive control, and gaps in mainstream service accessibility.

Key components of the strategy include:

- **Three-Pillar Framework:** The IAS is built on Advocacy, Education, and Implementation. These pillars guide community mobilization, public awareness, and institutional partnerships that are culturally competent and trauma-informed.
- **Client-Centered and Intersectional Approach:** SAWC prioritizes survivors' lived experiences and social locations (including immigration status, language barriers, and intergenerational family dynamics) in designing supports. The strategy includes tools for risk assessment, safety planning, and coordinated service delivery across sectors.
- **Community Strategy and Engagement:** The IAS emphasizes the need to involve men and boys, faith leaders, and youth in HBV prevention efforts through dialogue, education, and gender equity training.
- **Service Provider Tools:** The strategy includes frontline guidance, sample disclosure responses, safety protocols, and organizational training modules for working with HBV survivors.
- **Case Studies and Practical Scenarios:** The IAS presents anonymized client cases that reflect the nuanced experiences of South Asian women facing conditional sponsorship abuse, FM, technological surveillance, and extended family control.

This model, unique in its cultural specificity and systems-level thinking, continues to serve as a resource for other agencies seeking to build cross-sectoral responses to HBV that are embedded in community voice and leadership. (Kanagasabapathy, 2016)

SOUTH ASIAN LEGAL CLINIC OF ONTARIO (SALCO) – FORCED MARRIAGE TOOLKIT (2016)

Recognizing that FM is a severe and often hidden form of HBV, the South Asian Legal Clinic of Ontario (SALCO) developed *Forced/Non-Consensual Marriages: A Toolkit for Service Providers* as part of the broader project *Who/If and When to Marry: It's a Choice: Forced Marriage is a Form of Violence*, funded by the Ontario Trillium Foundation. The toolkit aims to equip service providers in Ontario with the tools and knowledge needed to identify, prevent, and intervene in cases of forced and non-consensual marriages.

The project emerged in response to an increasing number of clients, particularly racialized and immigrant youth, seeking legal and emotional support in situations involving coercion, family pressure, and threats of being sent abroad for marriage. SALCO, which provides legal advocacy for low-income South Asians in the GTA, partnered with multiple community-based organizations including the Forced Marriage Project Advisory Community and the Network of Agencies Against Forced Marriages (NAAFM) to guide the toolkit's development.

Key features of the toolkit include:

- **Comprehensive Identification Tools:** The toolkit outlines emotional, behavioural, and situational indicators of FM, including frequent absences from school, work, or medical appointments; signs of emotional distress such as anxiety or depression; and controlling or coercive behaviour by a partner or family member.
- **Step-by-Step Intervention Protocols:** A detailed response flowchart helps service providers assess urgency, create safety plans, refer clients to appropriate agencies, and document disclosures—all while centering client safety and autonomy.
- **Safety and Legal Guidance:** The toolkit includes legal overviews of Canadian criminal, family, and immigration law as they apply to FM. It also offers guidance for professionals working with clients at risk of being removed from Canada or coerced into marriage through conditional sponsorship.
- **Prevention Strategies:** It encourages youth- and parent-focused workshops, school-based education, and culturally responsive public awareness campaigns that address the root causes of FM, such as community stigma, gender inequality, and immigration-related vulnerabilities.
- **Anti-Oppressive and Anti-Racist Framework:** A foundational component of the toolkit is its rejection of cultural essentialism. SALCO emphasizes that FM is not unique to any one religion or ethnicity and must be addressed through rights-based, anti-racist, and survivor-centered approaches.
- **Case Studies and Training Activities:** Real-life scenarios and reflection exercises help service providers understand the emotional toll and complexity of FM, while improving their ability to offer culturally sensitive, legally informed responses.

This toolkit remains a landmark resource in Canada's response to HBV and continues to be adapted by frontline organizations and legal clinics across the country. (Chokshi, Khanna, & Silim, 2016)

BARBRA SCHLIFER COMMEMORATIVE CLINIC – "INTIMATE PARTNER VIOLENCE RISK IDENTIFICATION AND ASSESSMENT (IPV RIA) USER GUIDE" (2020)

As part of the Enhanced Safety – Risk Assessment Tool in Family Courts initiative, the Barbra Schlifer Commemorative Clinic developed the *Intimate Partner Violence Risk Identification and Assessment (IPV RIA) User Guide*, a comprehensive tool designed to support service providers and legal advocates in identifying, assessing, and responding to IPV in the context of family law. Funded by the Law Foundation of Ontario, the guide centers survivors' experiences within an intersectional, trauma-informed, and anti-oppressive framework, recognizing the many forms of abuse, including those linked to cultural and systemic power dynamics.

The IPV RIA guide acknowledges HBV as a serious and often misunderstood form of coercive control. It includes HBV, such as FM, reputational policing, and multigenerational family involvement, as part of its broader IPV framework, situating these experiences within systemic issues like immigration precarity, racialization, and social isolation. The guide explicitly cautions against cultural essentialism, urging professionals to avoid framing HBV as culturally inherent and instead recognize it as rooted in patriarchal power and control.

Key components of the guide include:

- **Three-Part Risk Assessment Tool:** Screens for high-risk IPV (e.g., threats, strangulation, coercive control), identifies deeper factors like family involvement, HBV, and cultural dynamics, and offers tailored safety planning and legal referrals based on the survivor's needs.
- **Recognition of HBV and Extended Family Control:** The guide highlights that abuse can come from multiple people, not just partners but also family or community members enforcing honour, shame, or obedience. It offers guidance on navigating complex family and cultural dynamics, especially when survivors fear ostracism, being sent abroad, or punishment for perceived dishonour.
- **Legal and Court-Based Application:** Designed for family law, the guide helps legal professionals integrate risk assessment in custody and protection order cases. It focuses on survivor safety during court processes, providing strategies to address IPV, including HBV, with sensitivity and consistency.
- **Survivor-Centered and Intersectional Lens:** Created with survivors and experts, the guide acknowledges how racism, colonization, immigration status, and gender norms affect survivor risks and access to safety. It centers survivor autonomy and informed consent throughout the assessment.
- **Practical Tools and Training Materials:** The guide offers worksheets, trauma-informed intake tips, documentation templates, and sample questions to help frontline workers provide culturally safe, consistent risk assessments, especially in cases involving family control or HBV.

This resource is a landmark contribution to the integration of GBV-informed practice into family courts. It provides service providers with the tools to recognize and respond to both visible and invisible forms of violence, including HBV, in ways that center safety, justice, and dignity. (Coelho, Dewolf, Brockie, & Keren, 2020)

APPENDIX C — COMPREHENSIVE OVERVIEW OF GLOBAL HBV RESPONSES AND FRAMEWORKS

UNITED KINGDOM

HBV in the UK is framed legally as So-Called Honour Based Abuse (SCHBA), emphasizing that these harmful acts are abusive behaviors disguised as protecting cultural or religious "honour." SCHBA is recognized not only as a form of domestic and sexual violence but as a collective abuse often perpetrated by family or community members to enforce conformity and control. The UK's legislative framework criminalizes key practices such as FM under the Anti-Social Behaviour, Crime and Policing Act 2014, with protections including lifelong victim anonymity and Forced Marriage Protection Orders (FMPOs). Comprehensive training and risk assessment tools like the DASH model support early identification and coordinated multi-agency responses. A network of specialist support agencies provides culturally sensitive advocacy, helplines, and safe housing for survivors. However, critics highlight that UK policies often prioritize cultural sensitivity at the expense of fully addressing the patriarchal and gendered nature of HBV, which can limit effective protection and support for female victims in affected communities.

Legislative Framework: Known in the UK as So-Called Honour Based Abuse (SCHBA)

In the UK, what is commonly referred to as HBV is officially described in legal and prosecutorial guidance as So-Called Honour Based Abuse (SCHBA). This term emphasizes that these harmful practices are not truly about honour but are abusive behaviors disguised as protecting cultural or religious "honour." Perpetrators may justify SCHBA on various grounds, such as a person wearing unapproved clothing or makeup, having an unapproved relationship (including same-sex relationships), engaging in intimacy in public, rejecting a FM, being pregnant outside of marriage, being a victim of rape, entering an inter-faith relationship, or leaving a spouse or seeking divorce. While there is no specific criminal offence titled SCHBA, the law addresses these abuses through a range of existing offences, including physical assault, coercion, dowry abuse FM, FGM, and murder. SCHBA functions as an umbrella term for various forms of abuse motivated by cultural or social norms rather than legitimate honour. (Crown Prosecution Services [CPS], 2023; Leeds City Council, 2024)

FM, one of the key forms of SCHBA, is explicitly criminalized under section 121 of the Anti-Social Behaviour, Crime and Policing Act 2014. This legislation prohibits coercion, deception, or any conduct aimed at forcing a person into marriage without their full and free consent. It covers FMs involving minors or individuals lacking the mental capacity to consent. The maximum penalty for FM offences is seven years imprisonment. Victims are also protected by lifelong anonymity and civil remedies such as FMPOs, which aim to prevent FM and related harm. (CPS, 2023)

Both CPS guidance and Leeds City Council highlight that SCHBA often overlaps with DV and abuse, with victims suffering physical, psychological, sexual, financial, and emotional harm. A distinctive feature of SCHBA is the involvement of multiple perpetrators acting collectively, usually family or community members, to control the victim and enforce conformity. This collective nature differentiates SCHBA from other forms of DV and requires culturally informed, sensitive approaches from prosecutors and practitioners, who must also be aware of the risks posed by retaliation within the victim's social environment. (CPS, 2023; Leeds City Council, 2024)

The UK legislative framework prioritizes victim safety and dignity through early identification and flagging of SCHBA cases to ensure proper management and support. It incorporates both criminal prosecution and civil protections, reflecting an understanding of the complex social dynamics involved in SCHBA and the need for coordinated responses from law enforcement, legal professionals, and support services. (CPS, 2023)

Professional Capacity: Police Training and Response to SCHBA

In the UK, the police response to SCHBA involves multiple layers of intervention designed to ensure timely recognition and protection of survivors. At the frontline, emergency call-takers play a crucial role in detecting indicators of SCHBA and prioritizing the urgency of the response. Official protocols mandate a minimum response time of 45 minutes for cases flagged as SCHBA or FM, reflecting the high-risk nature of these incidents. A key operational principle is the "one chance rule," which stresses the importance of identifying SCHBA at the earliest contact to avoid missed opportunities that could jeopardize victim safety. Once cases progress, frontline officers are expected to conduct comprehensive risk assessments tailored to the complexity of SCHBA, which often involves multiple perpetrators from extended family or community networks. Officers are instructed to avoid mediation, recognize language barriers, and conduct interviews confidentially to protect survivors from further harm. (Hosey, 2020)

A specialized team within the domestic abuse and stalking unit manages high-risk HBA cases, focusing first and foremost on safeguarding victims before pursuing legal action against perpetrators. This unit's mandate includes navigating the intricate social dynamics that characterize SCHBA, where threats often extend beyond individual offenders to wider familial or communal actors. Additionally, official guidance on SCHBA is developed collaboratively with professionals, charities, and survivors, providing a framework for law enforcement responses that is intended to be informed by lived experience and expert knowledge. (Hosey, 2020)

Despite these structured elements, the UK police response to SCHBA faces significant challenges and limitations. Training for emergency call-takers is minimal, with many receiving only one hour of instruction on identifying and responding to SCHBA, which is grossly insufficient given the nuanced and sensitive nature of these cases. Similarly, frontline officers are often limited to a single day of training, despite the complex and multifaceted risks

inherent in SCHBA scenarios. While specialized teams exist, many officers within these units lack practical experience with SCHBA cases, and the existing two-day training programs do not provide adequate depth or ongoing skill reinforcement. The recommendation for annual refresher training highlights a critical gap in maintaining expertise. (Hosey, 2020)

Moreover, the guidance used by police officers, though developed with input from various stakeholders, is authored by an individual with limited direct experience of SCHBA, raising concerns about its practical applicability and sensitivity. The prevalent narrative among officers that victims, especially young women under 25, are "too Westernized" reflects a reductive and problematic framing that risks pathologizing survivors rather than contextualizing the violence within broader systems of patriarchal control and social pressure. This stereotype can undermine trust and reduce the effectiveness of police interventions. Additionally, while women remain the primary targets of SCHBA, the recognition that men, such as boyfriends of female victims, also suffer abuse is insufficiently integrated into training and response protocols. (Hosey, 2020)

Risk Identification and Management: The DASH Assessment Model

In the UK, the Domestic Abuse, Stalking, and Honour-Based Violence (DASH) Risk Identification, Assessment, and Management Model serves as a critical framework for identifying and managing high-risk cases of domestic abuse, stalking, and HBV. Developed by Laura Richards on behalf of the Association of Chief Police Officers (ACPO) and in partnership with Coordinated Action Against Domestic Abuse (CAADA), now known as SafeLives, the DASH model was implemented across all police services in the UK from March 2009 and has since been updated to the 2025 version. (Richards, 2025)

The DASH model comprises a comprehensive risk checklist that enables frontline professionals to assess the level of risk faced by victims. The checklist includes 24 questions covering various aspects of abuse, such as physical violence, coercive control, stalking, and HBV-related behaviours. A score of 14 or more affirmative responses typically indicates a high-risk case warranting referral to a Multi-Agency Risk Assessment Conference (MARAC) for coordinated intervention. (Richards, 2025)

A distinctive feature of the DASH model is its emphasis on coercive control and HBV. Approximately half of the checklist's questions focus on these elements, recognising that such dynamics are prevalent in cases where women and children are at heightened risk of harm or homicide. The inclusion of questions addressing HBV ensures that professionals consider cultural and familial pressures that may influence the victim's situation. (Richards, 2025)

The DASH model is designed as a multi-agency tool, promoting a shared language and approach among various agencies involved in safeguarding and support. It facilitates

information sharing and collaborative decision-making, ensuring that victims receive comprehensive support tailored to their specific needs. Professionals using the DASH model are required to undergo accredited training to ensure consistent and effective application of the risk assessment. (Richards, 2025)

Victim Support: Confidential Helplines, Safe Housing, and Culturally Sensitive Advocacy

In the UK, a network of specialist agencies offers vital support to victims and survivors of HBV, FM, and related abuses. These organisations provide emotional, practical, and legal assistance tailored to the needs of affected individuals, including both women and men from diverse backgrounds. (CPS, 2023)

The Honour Network (Karma Nirvana) operates a dedicated helpline (0800 5999 247) providing confidential emotional and practical support for victims and survivors of FM and HBV. It offers advice to potential victims, those in crisis, and professionals working in the field. The network ensures access to culturally sensitive guidance tailored to the complexities of honour-related abuse. (CPS, 2023)

The Henna Foundation stands out with its “one stop” service focusing on the needs of Asian and Muslim children and families, while also supporting voluntary and government sectors to enhance mainstream service delivery. By hosting a national multidisciplinary online directory and knowledge center, it plays a key role in improving awareness and coordination of HBV-related support across the UK. Similarly, BAWSO Women's Aid serves Black and Minority Ethnic women and children in Wales, offering refuge and 24-hour emotional and practical support for those fleeing DV, including those impacted by HBV. (CPS, 2023)

Men also have specialized support through the Men’s Advice Line (0808 801 0327), a confidential helpline designed for men experiencing DV, regardless of sexual orientation. This service provides a safe space to discuss abuse, along with practical advice on legal, housing, and mental health concerns. Southall Black Sisters (SBS) is another critical agency, providing comprehensive services including advice, advocacy, and support to minority women facing various forms of gender-related violence such as HBV, FM, and 'honour killings'. Their services encompass immigration, asylum, health, welfare rights, and homelessness support, alongside campaigning and counselling initiatives that empower women to assert their rights and live independently. (CPS, 2023)

National projects like the Halo Project and Freedom Charity further complement these efforts by offering specialized advice and interventions to protect victims and raise public awareness. The Halo Project focuses on support and safety for victims of HBV, FM, and FGM, collaborating with partners to provide timely interventions. Freedom Charity actively targets schools with awareness sessions for students and training for teachers, alongside a 24/7 helpline and text

service, ensuring that prevention and education are integral to tackling HBV. Together, these specialist organisations form a comprehensive support system across the UK, addressing the complex and culturally sensitive needs of HBV victims, promoting their safety, well-being, and empowerment. (CPS, 2023)

Policy Gaps: The Challenge of Cultural Framing and Gender Neutrality

While the UK has established comprehensive legislative and multi-agency frameworks to address HBV, critical gaps remain, especially in how HBV is framed within policy and law enforcement responses. Hosey (2020) highlights that by emphasizing cultural explanations and maintaining a gender-neutral stance, UK policies risk obscuring the deeply gendered nature of HBV. Although men are predominantly perpetrators and women the primary victims, policies often fail to foreground this power imbalance, limiting the effectiveness of interventions tailored to women's specific vulnerabilities.

Hosey (2020) further argues that framing HBV primarily as a cultural or community issue can inadvertently reinforce harmful stereotypes and stigmatize Black and Minority Ethnic (BME) groups, while also enabling "cultural privacy" that keeps violence hidden within communities. his approach risks marginalizing victims by prioritizing community mediation over listening to women's voices and safeguarding their rights. Additionally, inadequate and superficial police training combined with institutional biases contribute to mistrust between BME communities and authorities, further complicating victim support and protection. Consequently, the UK model's reliance on multiculturalism without sufficiently addressing patriarchy and gendered violence leads to diluted policy responses that do not fully challenge the systemic roots of HBV.

SWEDEN

HBV in Sweden is addressed through a comprehensive and coordinated approach that integrates legal reforms, national expertise, and accessible victim support. HBV is recognized not only as a form of DV but as a distinct systemic oppression rooted in controlling women's sexuality and preserving family or community honour. The government has enacted landmark legislation to enhance sentencing in HBV cases and established specialized knowledge centres to guide prevention and intervention efforts. Extensive training programs equip professionals across sectors to identify and respond effectively, while a robust network of shelters and multilingual resources ensure survivors receive culturally sensitive support. Despite these advances, Sweden continues to explore ways to improve perpetrator rehabilitation and address the complex social dynamics underlying HBV.

Legislative Framework: Recognizing Honour as an Aggravating Factor

Sweden introduced a landmark legal reform on July 1, 2020, when "honour" was formally recognized as an aggravating factor in sentencing under Chapter 29, Section 2 of the Swedish Penal Code. This legal reform means that if a criminal act—such as assault, coercion, threats, or homicide—is committed with the motive of preserving or restoring family or group honour, the offender may receive a harsher sentence. It marks an important legal distinction: HBV is not merely DV, but a form of oppression rooted in controlling female sexuality and upholding familial or community "honour" (Cinthio, Staaf, & Ouis, 2022).

Building on this legal milestone, the Swedish Gender Equality Agency (*Jämställdhetsmyndigheten*, SGEA) has become central to advancing these reforms (SGEA, n.d.). In August 2023, the government introduced a dedicated sub-goal within the national gender equality policy focused specifically on honour-related violence and oppression, signaling a stronger, more targeted commitment to tackling this issue (SGEA, 2025a). Entrusted with coordinating national efforts, the agency leads in policy development, research, and training to combat honour-related violence and oppression. It has undertaken initiatives to map the prevalence of forced and child marriages and is preparing to manage the National Competence Centre for Honour-Related Violence and Oppression starting in 2026 (SGEA, 2025a). Through these efforts, the agency plays a vital role in translating legal reforms into effective prevention, victim support, and coordinated action across healthcare, social services, law enforcement, and education sectors (SGEA, n.d.).

Expanding on these foundations, Sweden's 2024–2026 Action Programme presents a comprehensive strategy to tackle men's VAWG, IPV, and HBV and oppression. Comprising 132 targeted measures, the programme emphasizes six strategic goals—including sustainable support structures, early prevention, reducing repeat offenses, and enhancing law enforcement—and prioritizes critical areas such as accessible exit pathways for victims, intensified action against HBV, protection for children and youth, and addressing digital forms of violence. This robust plan reflects the government's commitment to addressing GBV with the seriousness it demands, fostering collaboration across sectors to create safer and more equitable communities. (Government of Sweden, 2024)

Knowledge Infrastructure: Coordination, Expertise, and National Centres

Sweden's HBV strategy is integrated into its broader national framework to combat men's VAWG, which includes action on IPV, sexual violence, prostitution, and trafficking. HBV is explicitly referenced as a distinct form of structural GBV in the 2024–2026 Action Programme, which outlines 132 measures targeting prevention, protection, prosecution, and knowledge building. The implementation of evidence-based, coordinated response is reinforced through the creation of specialized knowledge centres. (Government of Sweden, 2024)

The National Centre against Honour-based Violence and Oppression (*Nationellt centrum mot hedersrelaterat våld och förtryck,* NCH), established in 2022 under Sweden's County Administrative Board of Östergötland, coordinates strategic, preventive, and knowledge-based efforts to combat HBV across national, regional, and local levels. It supports authorities by facilitating information exchange, evaluating interventions, mapping HBV prevalence, and providing guidance to professionals handling related cases. The Centre also operates a national helpline for professionals dealing with risks such as HBV, forced and child marriages, and FGM. Through research, reporting, and collaboration, it strengthens Sweden's comprehensive approach to preventing HBV and supporting victims. (County Administrative Board of Östergötland, n.d.)

Complementing the NCH, the National Centre for Knowledge on Men's Violence Against Women (Nationellt centrum för kunskap om mäns våld mot kvinnor, NCK) at Uppsala University and Uppsala University Hospital is a government-commissioned institution dedicated to raising national awareness of men's VAWG, including HBV and oppression, as well as violence in same-sex relationships. NCK provides support to victims through services such as national helplines and Sweden's first specialized outpatient clinic for women subjected to violence. The Centre also trains professionals and students, develops care methods, and conducts research and knowledge compilation to inform policy and practice. (Uppsala University & Uppsala University Hospital, 2025)

Professional Capacity: Training, Awareness, and Development

Sweden invests heavily in training and professional development to ensure that public sector staff and civil society actors are equipped to identify and respond to HBV. SGEA and the National Board of Health and Welfare (*Socialstyrelsen*) offer sector-specific guidelines and e-learning modules tailored to various frontline professions, including health care providers, teachers, social workers, youth counsellors, and police officers. These training programmes cover key topics such as cultural sensitivity, trauma-informed care, legal rights of victims, child protection in HBV contexts, and strategies for building trust with clients who may be reluctant to disclose abuse. They also include tools for early identification, screening questions, and risk assessment models tailored for HBV, recognizing that victims are often subjected to layered forms of control involving surveillance, isolation, FM, or threats of being sent abroad. (SGEA, 2025b; National Board of Health and Welfare, 2024)

In parallel, the Swedish government commissioned the Swedish Agency for Youth and Civil Society (*Myndigheten för ungdoms- och civilsamhällesfrågor*, MUCF) to develop and share knowledge on honour-related violence and oppression, aiming to improve professionals' competence in supporting young people affected by these issues. Given that many vulnerable youth spend significant time in leisure settings, such as youth clubs, sports teams, arts programs, and community centres, MUCF emphasized the importance of equipping youth workers and staff in these environments with the skills to recognize and respond to signs of HBV. (European Commission, 2024)

Victim Support: Helplines, Shelters, and Multilingual Access

Sweden's support ecosystem is intentionally anonymous, accessible, and multi-tiered, recognizing that survivors of HBV often face extreme isolation and fear from both family and community. A key pillar of this system is the nationwide network of women's shelters (*kvinnojourer*) and girls' support centres (*tjejjourer*), which offer safe housing, psychosocial counselling, legal advice, accompaniment to court or medical appointments, and help with protection orders. Many of these organizations are operated by civil society and are trained specifically in handling HBV-related dynamics such as family complicity, shame, and threats of deportation or violence abroad. (Informationsverige, 2025)

The national information portal Informationsverige.se plays a critical role in providing centralized, multilingual access to resources for victims and practitioners alike. It maintains updated directories of shelters, local social services, emergency contacts, non-governmental organizations (NGO), and helplines—all searchable by location and available in multiple languages. The portal also includes information for people applying for asylum or residence in Sweden, including how to seek help without disclosing one's identity.

Specialist NGOs further enhance accessibility for specific linguistic and cultural groups. For example, Terrafem provides legal and social support for women in over 50 languages. TRIS focuses on youth exposed to honour norms, including those threatened with FM or control. Fempowerment supports immigrant and racialized women through multilingual counselling and advocacy. Bris offers services tailored to children and youth, including online chat and crisis support. These organizations fill crucial service gaps, especially for racialized, migrant, LGBTQIA2S+, and undocumented individuals. (Informationsverige, 2025)

Sweden's layered model, combining government services, civil society support, and specialized NGOs ensures that survivors of HBV have multiple points of access to safety and justice, regardless of language, status, or background.

Perpetrator Perspectives: Honour, Coercion, and Marginalization

Despite Sweden's investments in survivor support, relatively little attention has been paid to rehabilitating or understanding perpetrators. A qualitative study by Cinthio, Staaf, and Ouis (2022) used 12 court verdicts and interviews with 13 convicted perpetrators to explore the socialization, beliefs, and motivations behind HBV-related offences. The study found that most offenders came from patriarchal and collectivist backgrounds where honour was defined relationally and enforced through gendered control. Male family members were often expected to act as "guardians" of female relatives' sexuality, sometimes from early childhood, and viewed violent enforcement of these norms as part of their masculine identity.

Some interviewees described being pressured by transnational family networks, including phone calls from relatives abroad, reinforcing expectations to retaliate in the name of honour. One man described being told by cousins that his family's reputation was "humiliated" and that failure to act would bring shame not only on him but on his deceased father's memory. (Cinthio et al., 2022)

Importantly, the study challenges simplistic victim–perpetrator binaries. Several perpetrators framed themselves as "sacrificial agents," pressured to carry out acts of violence on behalf of a larger family system. Others felt abandoned by their families after conviction, receiving no support despite acting "on the family's behalf." Many expressed regret and said they underwent personal transformation during incarceration, but almost none had access to culturally relevant psychological services or offender rehabilitation programs. (Cinthio et al., 2022)

NETHERLANDS

HBV in the Netherlands is addressed through a multifaceted strategy that combines legal protections, institutional coordination, and frontline service provision. While HBV is not prosecuted as a standalone offense, it is treated seriously under DV laws, with additional safeguards embedded in immigration policy for victims at risk. The Dutch government has invested in a strong knowledge infrastructure to support early detection and intervention, alongside specialised services like shelters, helplines, and culturally competent care. Training programs aimed at strengthening professional capacity further support this ecosystem. However, the country's continued reliance on gender-neutral policy frameworks has drawn criticism for overlooking the structural and gendered dimensions of HBV, raising concerns about the effectiveness and equity of current approaches.

Legislative Framework: Criminalizing 'Honour-Based Violence' within Domestic Abuse Law

In the Netherlands, HBV is not legislated as a separate criminal offense. Instead, it is prosecuted under the existing criminal law framework that addresses DV and related serious crimes. This includes acts such as FM, FGM, and other forms of violence linked to family honour. The law recognizes these acts as forms of DV when they occur within the family or domestic context. Dutch law also provides for enhanced penalties when the perpetrator is a family member, reflecting the seriousness of violence committed in domestic settings. This approach allows for the prosecution of HBV under general criminal provisions related to assault, coercion, and abuse. (European Institute for Gender Equality, 2020)

In addition to criminal provisions, Dutch immigration law also provides protective measures for victims of HBV or DV. The Immigration and Naturalisation Service (IND) grants residence permits to individuals who are victims or at risk of HBV or DV and who do not yet have a residence permit. These permits enable victims to reside legally in the Netherlands independent of their abuser, thus enhancing their safety and access to support services. This residence permit is legally grounded in the Dutch Aliens Act and related regulations, reflecting the state's commitment to protecting vulnerable individuals from HBV or DV (IND, n.d.).

Knowledge Infrastructure: Dissemination and Resource Support for 'Honour-Based Violence'
Addressing HBV in the Netherlands relies heavily on a strong knowledge infrastructure that ensures the widespread dissemination of critical information and the provision of practical resources. The Dutch government plays a central role by publishing accessible fact sheets—such as those found on huiselijkgeweld.nl—which outline the nature of HBV, identify common signs, and provide clear guidelines for professionals across sectors. These fact sheets help standardize understanding and response protocols among police, social workers, healthcare providers, and educators, facilitating early detection and coordinated intervention. Importantly, they include instructions for using specialised reporting codes for harmful practices, such as HBV, FM, FGM, and hidden women, ensuring that cases are reported and addressed through appropriate and legally informed channels. (Government of Netherlands, 2020)

Complementing these governmental efforts, Atria, the Dutch Institute on Gender Equality and Women's History, enhances the knowledge base by conducting research, documenting women's experiences, and providing policy advice and public education. While not directly involved in frontline services, Atria's work supports evidence-based policymaking and raises awareness through publications, exhibitions, and events. This amplifies understanding of HBV within broader gender equality and social justice frameworks and equips policymakers, practitioners, and the public with nuanced perspectives essential for effective prevention and support. (Atria, n.d.)

Together, these initiatives form a foundational knowledge infrastructure that empowers professionals and communities alike with the tools, understanding, and resources necessary to recognize, prevent, and respond to HBVin a culturally sensitive and effective manner.

Professional Capacity: Equipping Front-Line Workers to Detect and Respond

In the Netherlands, enhancing the professional capacity of those working in public service is central to the prevention of HBV. The Ministry of Justice and Security leads efforts to train police officers, youth welfare workers, and other front-line professionals to recognise the warning signs of HBV. Since these signs can be subtle or mistaken for other forms of violence, such as domestic abuse or child maltreatment, specialised training is essential to ensure early detection. Resources such as a list of common indicators, detailed protocols, and reporting procedures are available through platforms like huiselijkgeweld.nl, which provides tools and guidance in Dutch for responding to suspected cases (Government of the Netherlands, n.d.).

A key component of professional training is the practice-based course Domestic Violence and Child Abuse, offered annually by the Netherlands Police Academy. Each year, nearly 1,000 students and professionals are trained to handle cases involving DV, child abuse, stalking, and HBV. The course is delivered in collaboration with partner organisations such as Veilig Thuis, the national advice and reporting centre. Through real-life case examples, participants are introduced to the complexities of abuse dynamics and encouraged to reflect on how professional judgment can be influenced by personal assumptions or cultural bias. Discussions and exercises challenge participants to interpret potential signs of violence more critically and to ask questions such as "What do you think is going on here?" and "Is this safe?" (Netherlands Police Academy, 2024)

These training efforts contribute to a trauma-informed and coordinated response across police and social services, reducing the likelihood that HBV cases are missed or mishandled. By strengthening professional capacity nationwide, the Dutch government improves the chances of early intervention and long-term safety for victims.

Victim Support: Confidential Help, Safe Housing, and Culturally Sensitive Care

Victims of HBV in the Netherlands have access to comprehensive support services aimed at

ensuring their safety, well-being, and recovery. One of the primary points of contact is Safe at Home (*Veilig Thuis*), the national advice and reporting centre for DV, child abuse, and HBV. Safe at Home provides a confidential helpline available 24/7, where victims or concerned individuals can seek advice, support, and intervention. This organisation collaborates closely with police and social services to offer coordinated protection and follow-up care (Veilig Thuis, n.d.).

Specialised organisations like Fier provide tailored support for victims of HBV, FM, and related forms of abuse. Fier offers psychological counseling, legal assistance, and safe accommodation, with a special focus on young people through dedicated programs designed to address their unique needs (Girls Not Brides, n.d.). Similarly, Blijf Groep offers crisis shelters and outreach services, providing safe housing and ongoing support for women, children, and families affected by HBV and DV. These organisations work to create secure environments where victims can regain control over their lives (Blijf Groep, n.d.).

In addition to shelter and counseling, victims may be eligible for legal aid, protection orders, and, if they lack legal status, humanitarian residence permits in cases of HBV or DV (IND, n.d.). Multilingual and culturally sensitive services are also available, particularly through coordinated efforts involving trained police officers, social workers, and frontline organisations (Government of the Netherlands, n.d.). These measures help ensure that victims receive a compassionate and inclusive response throughout their recovery journey.

Policy Gaps: The Limits of Gender-Neutral Approaches

Despite the Netherlands' robust policy frameworks and coordinated responses to HBV, notable challenges persist, particularly in the framing of violence prevention strategies. Van Wijk (2020) critiques the Dutch government's reliance on gender-neutral approaches, which, although intended to promote equality, often fail to account for the gendered nature of HBV. This form of violence is deeply embedded in patriarchal structures and disproportionately affects women and girls. However, by treating victims as a homogenous group without reference to gender, interventions risk overlooking the specific power dynamics, social pressures, and cultural contexts that shape women's experiences of HBV.

As Van Wijk (2020) argues, the absence of a gender-sensitive lens can result in depoliticized and diluted responses that inadequately address the root causes of violence. Without explicitly naming and targeting the structural inequalities that underlie HBV, professionals may be less equipped to recognize patterns, assess risk accurately, or provide tailored support. In effect, gender neutrality may reinforce the invisibility of women's unique vulnerabilities, undermining the very protections that policy frameworks aim to deliver.

GERMANY

Germany combats HBV through a comprehensive approach combining legal protections, coordinated action plans, professional training, and civil society involvement. Though not

defined separately, HBV is prosecuted under broader DV and GBV laws, with civil protection measures in place. Federal and state governments work together through national and regional plans and a dedicated working group to ensure consistent implementation. Training emphasizes culturally sensitive, victim-centered responses, while NGOs provide crucial frontline services, especially for immigrant communities. However, public discourse often frames HBV as a "foreign" issue tied to immigrant cultures, leading to policies focused more on criminalization and integration than on systemic prevention and inclusion.

Legislative Framework: Legal Protections and Approach to 'Honour-Based Violence'

Germany addresses violence within families primarily through provisions in its Criminal Code (*Strafgesetzbuch*), which criminalizes various forms of DV, including physical assault, threats, coercion, and stalking. The Act on Protection against Violence (*Gewaltschutzgesetz*) further enables victims to obtain civil protection orders and emergency interventions to ensure their safety. These laws provide a comprehensive legal basis for protecting victims of intimate and family violence. (Germany, 2020)

These legal protections operate within a broader national framework established by Germany's two national action plans on combating violence against women, adopted in 1999 and 2007. Together, these plans set out over 130 coordinated measures encompassing prevention, legislation, victim support, perpetrator work, training, awareness-raising, and international cooperation. Complementing federal efforts, Germany's 16 federal states (*Länder*) have developed their own tailored action and master plans to address regional needs, reinforcing a multi-level, comprehensive approach. (Germany, 2020)

To ensure consistent implementation across its federal system, Germany established the Federal-Länder Working Group on Domestic Violence in 2000. This platform facilitates interdisciplinary cooperation between federal and state authorities and includes the participation of NGOs, whose frontline experience and practical expertise contribute significantly to policy and operational effectiveness. (Germany, 2020)

Although 'honour-based violence' is not explicitly defined in German law, acts associated with HBV, such as 'honour killings', FGM, FM, and coercive control, are prosecuted within this general legal framework for DV and related criminal offences. Germany adopts an integrated approach by treating HBV as part of the broader category of GBV and DV rather than through separate legislation. This strategy seeks to ensure consistent application of the law while addressing the specific cultural contexts of HBV through targeted prevention and professional training measures. (Germany, 2020)

Importantly, the Federal Court of Justice (*Bundesgerichtshof*, BGH) has made clear rulings on the inadmissibility of cultural justifications in honour-related crimes. In a landmark 2010 decision,

the court ruled that so-called "archaic values," including notions of family honour sometimes cited to excuse violence, cannot negate the classification of murder as motivated by "base motives" (*niederträchtig*). This leads to significantly stricter punishment under German criminal law. The court explicitly rejected cultural or traditional motives as mitigating factors, reinforcing that honour-based killings are criminal acts deserving the full weight of the law (Germany, 2020).

This firm legal position reflects Germany's zero-tolerance policy toward HBV and underscores the country's commitment to protecting victims regardless of cultural context. By rejecting any cultural defense in court and applying comprehensive DV laws, Germany seeks to dismantle harmful honour-related practices and ensure justice for victims through effective prosecution and sentencing (Germany, 2020).

Professional Capacity: Training and Awareness for Effective Response

Germany recognizes that combating DV and HBV requires a well-trained professional workforce across sectors. Education and training are integrated into initial professional programs and ongoing development for police, judges, social workers, healthcare providers, and educators. These efforts focus on identifying abuse, assessing risks, applying protective measures, and providing victim-centered support within an interdisciplinary and legally informed framework. (Germany, 2020)

DV and HBV topics are increasingly included in university and vocational curricula, particularly in social work, psychology, law, and medicine, preparing graduates with foundational knowledge on GBV and trauma-informed care. Continuous training by federal states and NGOs keeps professionals updated on best practices and culturally sensitive interventions, often using practical case studies. (Germany, 2020)

Training programs emphasize cultural competence to address the complexities of HBV, enabling professionals to apply victim-centered and culturally sensitive approaches within complex social contexts. National guidelines standardize procedures for risk assessment, victim interviewing, and inter-agency cooperation. The Federal Ministry for Family Affairs, Senior Citizens, Women and Youth coordinates these initiatives in collaboration with NGOs to integrate frontline and survivor insights. These combined efforts ensure a consistent, informed, and sensitive response to DV and HBV throughout Germany. (Germany, 2020)

Victim Support: Civil Society and Advocacy Efforts

In Germany, HBV first came to the attention of parliament members through the 2003 campaigns and media engagements of the feminist women's organization, Terre des Femmes (TDF). With over 2,000 members, TDF quickly established itself as a major advocate on issues such as DV, FM, human trafficking, FGM, and 'honour killings'. In the early 2000s, the organization

largely reflected a German feminist voice with limited representation from immigrant communities. By 2015, immigrant women were more visible within the organization, but they were often positioned as "exceptional Muslims"—individuals who distanced themselves from their communities by agreeing with narratives that portrayed Muslim immigrants as inherently prone to GBV, often attributing this to Islam. This framing reinforced a policy emphasis on integration and assimilation. TDF also partnered with regional (Land-level) governments on awareness and prevention campaigns that aligned with the state responsibility to "integrate" those with an immigrant background into German society. For example, in 2014, they produced a theatre play titled "My Life, My Love, My Honor?", performed thirty times by students in Baden-Württemberg schools to challenge honour-related narratives. (End FGM European Network, n.d.; Yurdakul & Korteweg, 2019).

While TDF operates primarily as a high-profile advocacy group, other organizations such as Papatya e.V.have taken a more direct service-based approach. Founded in 1986, Papatya runs an anonymous crisis shelter in Berlin for girls and young women from migrant backgrounds who face violence, FM, or HBV. The organization, led by a team of mostly non-immigrant German women, provides counseling, crisis intervention, and outreach to social actors such as schools and youth services. Papatya also operates SIBEL, Germany's first online crisis counseling platform offering confidential support in multiple languages. Despite its long-standing presence, Papatya has received even less state support than TDF and operates on a smaller scale. Still, its shelter and digital services fill a critical gap, especially for youth facing threats within their family and community contexts (Papatya, n.d.; Yurdakul & Korteweg, 2019).

Discursive Framing: A "Foreign" Problem Rooted in Immigrant Culture

Germany's approach to HBV has been shaped by dominant public discourses that frame it as a problem rooted in immigrant, particularly Muslim, communities, rather than as a broader form of GBV. This framing gained traction following the 2005 murder of Hatun Sürücü in Berlin, which coincided with the publication of Necla Kelek's controversial book condemning Turkish-German communities for perpetuating patriarchal, violent traditions and resisting integration. Together, Sürücü's murder and Kelek's writings catalyzed widespread media debates about HBV and so-called "backward" cultural practices, shaping public and political perceptions of the issue. (Yurdakul & Korteweg, 2019)

Following Sürücü's murder, Germany's legislative response focused on criminalizing HBV and controlling immigration rather than prevention or systemic gender equality. Measures like raising the marriage age for foreign spouses and limiting residency permits were proposed, though some faced constitutional challenges. The 2004–2009 coalition government succeeded in criminalizing FM, seen as linked to HBV, as a prosecutable form of coercion and introduced pre-entry language requirements for immigrant spouses, thereby explicitly linking violence prevention to integration mandates (Yurdakul & Korteweg, 2019).

Mainstream political leaders across the spectrum reinforced this narrative. In 2005, Nicolas Zimmer, President of the Christian Democratic Union faction in the Berlin Parliament, claimed that immigrant communities were forming "parallel societies" and imposing "their own law" through acts like 'honour killings', thus rejecting German legal norms. Such statements linked HBV to failed integration and suggested a conditional model of state protection, where support is extended only to those who adopt dominant German values. (Yurdakul & Korteweg, 2019)

Alternative perspectives existed but were marginalized. Left-leaning politicians, such as Giyasettin Sayan of Die Linke, called for inclusive, intersectional approaches to HBV, framing it as a societal issue rather than a cultural deviation. Similarly, immigrant-led organizations like the Turkish Federation of Berlin-Brandenburg promoted human rights-based frameworks over ethnicized interpretations. However, these efforts lost visibility as political discourse increasingly emphasized securitization and assimilation, especially in the wake of the 2015 refugee crisis. (Yurdakul & Korteweg, 2019)

Civil society actors also struggled to influence state policy. Women's organizations lacked systemic resources and remained largely excluded from decision-making processes. Although funding shortages were widely acknowledged, little structural investment followed. Some states, such as Baden-Württemberg, pledged post-2015 support for anti-HBV initiatives, but the long-term impact of these promises remains unclear. (Yurdakul & Korteweg, 2019)

More recently, legislative efforts have focused on criminalizing HBV and FM, especially after Germany ratified the Istanbul Convention in 2017. Yet these legal reforms often maintain the culturalist framing of HBV as a "foreign" problem, reinforcing the exclusion of immigrant communities from full belonging within the German nation-state. (Yurdakul & Korteweg, 2019).

TÜRKIYE

HBV in Türkiye is addressed through legal protections, specialized institutions, and community-based support. Although Türkiye was the first to ratify the Istanbul Convention, it withdrew in 2021 over concerns about traditional values, while remaining bound by other international laws and domestic legislation like Law No. 6284, which provides broad protections and emergency interventions. Victim support comes from organizations such as the KAMER Foundation, offering emergency aid and education in Eastern Anatolia; Mor Çatı Women's Shelter Foundation, providing feminist shelters and legal help; and Havle Women's Association, which combines feminist and faith-informed advocacy for Muslim women. Together, these form a complex system working to protect survivors and challenge cultural norms sustaining HBV.

Legislative Framework: Türkiye's Withdrawal from the Istanbul Convention

Türkiye's legal response to HBV and GBV has undergone significant shifts, most notably in relation to its commitment to the Council of Europe Convention on Preventing and Combating

Violence Against Women and Domestic Violence, widely known as the Istanbul Convention. This international treaty, signed by 45 countries—including the UK, Sweden, Netherlands, and Germany—and the European Union, is the most comprehensive legal instrument dedicated to preventing VAWG, protecting survivors, and prosecuting perpetrators. The Convention addresses various forms of GBV, including FM, FGM, HBV, psychological violence, stalking, sexual harassment, forced abortion, and forced sterilization (Council of Europe, n.d.-a; Council of Europe, n.d.-b).

The Istanbul Convention explicitly rejects any cultural or traditional justification for violence, including HBV, and recognizes VAWG as a violation of human rights and a form of discrimination. To ensure effective implementation, the treaty established an independent monitoring body, the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO), which evaluates states' compliance and provides recommendations for improvement. (Council of Europe, n.d.-a; Council of Europe, n.d.-b).

Türkiye became the first country to sign and ratify the Istanbul Convention in 2011, symbolizing a strong commitment to international norms of gender equality and protection from violence. However, in March 2021, Türkiye formally withdrew from the Convention. The government cited concerns that the Convention undermined "traditional family values" and was being used to "normalize homosexuality," a stance that drew widespread domestic and international condemnation. Critics argue that this rationale reflected a broader political effort to appeal to conservative constituencies while neglecting the systemic realities of GBV and HBV (Amnesty International, 2021).

Despite the withdrawal from the Istanbul Convention, Türkiye remains bound by international human rights law to combat VAWG such as the UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the European Convention on Human Rights (ECHR). It retains domestic laws, many of which derive from the Istanbul Convention, regarding protection from and prevention of GBV. (UK Home Office, 2025)

National Legislation: Legal Protections against HBV and GBV in Türkiye

Türkiye's core legal instrument for addressing GBV and HBV is Law No. 6284 on the Protection of the Family and Prevention of Violence Against Women, introduced in 2012 (UK Home Office, 2025). The law provides protection not only to married women, but also to children, other family members, and victims of stalking or dating violence, regardless of nationality or legal status (Mor Çatı Women's Shelter Foundation, n.d.; UK Home Office, 2025).

Law No. 6284 adopts a broad definition of violence, encompassing physical, psychological, sexual, and economic harm. Acts such as insults, coercion, humiliation, controlling behavior, isolation, and threats are legally recognized as forms of violence. Crucially, legal protection can

be triggered by the existence of risk alone—physical harm does not need to have occurred for measures to be enacted. (Mor Çatı Women's Shelter Foundation, n.d.)

The law sets out a broad range of protective and preventive measures to safeguard victims and prevent further harm. These include restricting the perpetrator's access to the victim's home or workplace, temporarily removing them if necessary, and prohibiting contact or proximity. It allows for temporary custody of children, provides safe shelter and relocation options, and ensures confidentiality of victims' personal information. Protection officers may be assigned to monitor cases and offer support. Other measures include suspending the perpetrator's right to carry firearms, limiting their control over finances, and providing financial assistance. Victims also have access to psychological, legal, and social support services. These orders, granted by police, courts, or administrative authorities, can last up to six months with possible extensions. In emergencies, law enforcement can act immediately, such as removing perpetrators from the home without prior court approval. (Mor Çatı Women's Shelter Foundation, n.d.; UK Home Office, 2025).

To support implementation, various mechanisms are in place to protect women and enable victims of GBV to access justice, particularly in cases of HBV. These include a nationwide hotline, a dedicated web application for reporting abuse, and specialist police units. In addition, Violence Prevention and Monitoring Centres (ŞÖNİM) operate in all 81 provinces and aid GBV victims. These centres coordinate efforts between social services, law enforcement, and the judiciary, offering services such as shelter, legal assistance, risk assessments, and follow-up support. However, the effectiveness of these centres is often hindered by issues related to coordination, staffing shortages, and limited financial resources. (Mor Çatı Women's Shelter Foundation, n.d.; UK Home Office, 2025)

According to the UK Home Office (2025), HBV is legally recognized as a form of GBV alongside DV, femicide, forced or early marriage, and sexual abuse. However, enforcement of Law No. 6284 remains uneven. While the legal framework is comprehensive, protective measures are not always effectively applied or monitored, and institutional gaps, such as limited training and under-resourced services, often undermine women's safety. (Mor Çatı Women's Shelter Foundation, n.d.; UK Home Office, 2025)

Professional Capacity: Training and Support for Front-Line Responders

The Turkish government has taken steps to combat GBV, including HBV, through various programmes and policies focused on prevention and protection. Key among these initiatives are the establishment of local risk management teams and the implementation of training for professionals directly involved in responding to GBV cases. This training targets law enforcement personnel, health workers, prosecutors, and judges, aiming to enhance their capacity to handle cases of DV and provide better protection for survivors. (UK Home Office, 2025)

While judges primarily deal with case files, police officers interact directly with victims and perpetrators, playing a crucial frontline role in combating DV. Specialist DV police units consist of officers responsible for a range of functions including conducting interviews with victims and perpetrators, preparing reports for the courts and prosecutor's office, completing detailed risk assessments, serving perpetrators with protective or preventive orders, monitoring compliance with these orders, and following up with victims to ensure their safety. (UK Home Office, 2025)

Despite the government's stated zero-tolerance policy on DV and support from senior officials, including President Erdoğan, the implementation of these training programs and protective mechanisms remains uneven. Challenges persist due to limited resources and inconsistent delivery of specialised training, which impacts the quality of responses to GBV. Furthermore, prevailing societal attitudes that consider DV a private matter can inhibit effective action by some law enforcement officers, reducing the overall impact of training efforts. (UK Home Office, 2025)

Victim Support: Community-Led Protection, Feminist Shelters, and Faith-Informed Advocacy

In Türkiye, victims of HBV can turn to a range of organizations that provide targeted support, safety planning, and long-term empowerment grounded in feminist, community-led, and faith-informed approaches. One such organization is the KAMER Foundation, founded in 1997, operates in 23 provinces across Eastern and Southeastern Anatolia. KAMER provides emergency support to women at risk of honour-based killings, including risk assessments, legal aid, and psychological counseling. Their broader programming includes community awareness workshops, house visits, and support for women's entrepreneurship and refugee integration. KAMER takes a holistic, locally rooted approach to ending GBV through education, solidarity, and cultural transformation. (KAMER Foundation, n.d.)

The Mor Çatı Women's Shelter Foundation, established in 1990, offers feminist, survivor-centered support through shelters and solidarity centers. Grounded in the principle that male violence stems from systemic inequality, Mor Çatı helps women reclaim autonomy through safe housing, counseling, and legal assistance. In addition to direct services, the organization monitors national and international policies, advocates for stronger legal protections, and collaborates with civil society to build a coordinated response to violence. (Mor Çatı Women's Shelter Foundation, n.d.)

Founded in 2018, the Havle Women's Association brings a faith-informed feminist approach to combating GBV. As Türkiye's first Muslim feminist organization, Havle challenges patriarchal interpretations of religion and creates inclusive spaces for women to organize, learn, and support one another. Through initiatives like Reçel Blog and the Muslims Initiative Against Violence Against Women, Havle blends cultural sensitivity with feminist advocacy to address the specific needs of Muslim women and reshape conversations around justice and gender in religious communities. (Havle Women's Association, n.d.)

APPENDIX D — DISCUSSION GUIDES

SUBJECT MATTER EXPERTS WORKING ACROSS SECTORS ON 'HONOUR-BASED VIOLENCE'

This guide was used to facilitate semi-structured consultations with subject matter experts as part of the research on HBV and its impact on South Asian women in the GTA and across Canada. The questions aimed to explore participants' professional experiences with HBV, including their understanding of the term, the challenges they have faced in practice, observations of systemic gaps, and recommendations to strengthen prevention and intervention strategies.

1. Could you please start by briefly introducing yourself and your role?
2. What is your understanding of 'honour-based violence,' and how do you feel about the terminology used to describe it—particularly the term "honour"?
3. In your professional experience, have you encountered cases of 'honour-based violence'? If so, could you describe how you have addressed these cases, including prevention and intervention efforts?
4. What are the main challenges you have personally faced in your professional experience addressing 'honour-based violence'?
5. From your perspective, are there any gaps or shortcomings in how 'honour-based violence' is currently addressed in the broader field or system?
6. Based on your experience, what actions do you think are necessary to improve interventions and support for those affected by 'honour-based violence'?

WOMEN WITH LIVED EXPERIENCE OF 'HONOUR-BASED VIOLENCE'

This guide was used to facilitate semi-structured interviews with women with lived experience as part of the research on HBV and its impact on South Asian women in the GTA and across Canada. The questions aimed to explore participants' personal backgrounds, lived experiences of HBV or religion-based violence, the reactions of family and community, access to support systems, and reflections on resilience and advocacy for change.

1. Background & Context
    a. Could you tell me a little about your background and upbringing?
    b. How has your religious or cultural community, including its teachings and beliefs, influenced your life, your views, and the experiences of people around you?
2. Experiences of Violence
    a. Thinking about your personal or community experiences, would you feel comfortable sharing any incidents of honour-based or religion-based violence that you or someone close to you have encountered?
    b. How did your family or community react to these experiences?
    c. How have these experiences affected your mental and physical health or overall well-being?

3. Access to Resources & Support
    a. What kinds of support or services have been helpful to you? (For example, counselling, peer support groups, religious or spiritual guidance, talking to friends or family, online resources, or community programs.)
    b. Were there any times when it was hard to get the help you needed, or when you felt that support was missing?
4. Strength, Resilience, and Advocacy
    a. Despite these challenges, how have you found strength and resilience?
    b. What message would you want to share with others who might be going through similar experiences?
    c. How do you think your story or voice could be best amplified to raise awareness and promote change around 'honour-based violence'?

LGBTQIA2S+ INDIVIDUALS WITH LIVED EXPERIENCE OF 'HONOUR-BASED VIOLENCE'

This guide was used to facilitate semi-structured interviews with LGBTQIA2S+ individuals with lived experience of HBV as well as professionals who work with this community. The aim was to explore participants' understanding of HBV, their personal or professional experiences, the specific challenges faced by LGBTQIA2S+ individuals, gaps in existing services, and recommendations to strengthen prevention, intervention, and support.

1. Could you please start by briefly introducing yourself and your role or connection to the LGBTQIA2S+ community?
2. What is your understanding of 'honour-based violence,' and how do you feel about the terminology used to describe this form of violence—particularly the use of the term "honour"?
3. Based on your personal experience or your professional work, have you encountered situations involving 'honour-based violence' affecting LGBTQIA2S+ individuals? If so, could you share more about these experiences?
4. What are the main challenges you have observed or experienced in relation to 'honour-based violence' within the LGBTQIA2S+ community?
5. From your perspective, are there any gaps or shortcomings in how services currently address 'honour-based violence' among LGBTQIA2S+ individuals?
6. What actions or improvements would you recommend to better support LGBTQIA2S+ individuals affected by 'honour-based violence'?

TAKING THE HONOUR OUT OF 'HONOUR-BASED VIOLENCE'

CASSA Council of Agencies Serving South Asians | SACAC South Asian Community Advisory Council | Women's Mosque of Canada

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