Thesis for doctoral degree (Ph.D.) 2008

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Prevalence, risk factors, health effects and suggestions for interventions

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Stockholm 2008

Published by Karolinska University Press and printed by US - AB
Box 200, SE-171 77 Stockholm, Sweden

ISNB 978-91-7409-079-6

ABSTRACT

Background: Vietnam has undergone a rapid transition in the past 20 years, moving towards a more equal situation for men and women. However, Confucian doctrine is still strong and little is known about men's violence against women within the Vietnamese family.

Aim: To improve knowledge of intimate partner violence (IPV) in a Vietnamese context, by focusing on professionals' and trusted community inhabitants' explanations of the violence and their suggestions for preventive activities. Further, to present data on prevalence, risk factors and health effects and to suggest appropriate intervention and prevention activities.

Method: Qualitative and quantitative data were collected in the rural district, Ba Vi in northern Vietnam in 2002. Five focus group discussions were held and face-to-face interviews following a questionnaire developed by WHO for violence research were performed. In the epidemiological part, 883 married/partnered women aged 17–60 were included. Bi- and multivariate analyses were undertaken, with effect modification analyses and calculation of attributable fractions and population attributable fractions.

Main findings: In the explorative qualitative study, intimate partner violence was explained as interplay between individual and family-related factors and socio-cultural norms and practices where Confucian ideology exerted a strong influence (paper I). It further revealed that IPV was rarely discussed openly in the community and women subjected to violence kept silent.

The epidemiological study revealed that out of the 883 married/partnered women, 30.9% had been subjected to physical violence in their lifetime, and 8.3% in the preceding year. For the combined exposure to physical and sexual violence, the corresponding figures were 32.7% and 9.2%. The most commonly occurring form was psychological abuse (lifetime 55.4%; past year 33.7%). Lifetime experience of sexual violence was reported by 6.6% of the women, and by 2.2% for previous year exposure. In the majority of cases, the violence was exerted as repeated acts (paper II).

The risk factors found for lifetime and past year physical/sexual violence were women's low education, husbands' low education, low household income and male polygamy. The pattern of factors associated with psychological abuse alone were husband's low professional status and women's intermediate level of education (paper II). Women who witnessed interparental violence during childhood were significantly more likely to report experience of physical and sexual intimate partner violence in their own relationship at adult age and they also displayed a more tolerant attitude towards violence (paper III). When health effects were investigated, it was found that physical and sexual violence caused chronic pain, injuries and serious mental health problems such as sadness/depression and suicidal thoughts in exposed women (Paper IV).

Conclusions: IPV is commonly occurring in rural Vietnam, more so among the low educated and in poorer households. Violence perpetration is a serious violation of women's human rights that causes long-term suffering in exposed women. These findings call for legal and policy actions. Collaboration between the health sector and other bodies at all levels, and with community leaders as spokesmen would help to improve openness and reduce society's tolerance of violence against women.

Keywords: intimate partner violence, domestic violence, prevalence, women's health, gender equality, witnessing interparental violence, health effects, human rights, Vietnam.

LIST OF ORIGINAL PAPERS

This thesis is based on the following papers:

I. Jonzon R, Vung ND, Ringsberg KC, Krantz G. Violence against women in intimate relationships: Explanations and suggestions for interventions as perceived by healthcare workers, local leaders, and trusted community members in a northern district of Vietnam, *Scandinavian Journal of Public Health* 2007; 35 (6):640–7

II. Vung ND, Östergren P-O, Krantz G. Intimate partner violence against women in rural Vietnam—different socio-demographic factors are associated with different forms of violence: Need for new intervention guidelines? *BMC Public Health* 2008, 8:55 doi:10.1186/1471-2458-8-55

III. Vung ND, Krantz G. Is a history of witnessing interparental violence associated with women's risk of intimate partner violence? A population-based study from rural Vietnam. (Submitted & under revision)

IV. Vung ND, Östergren P-O, Krantz G. The contribution of intimate partner violence to common illnesses and suicidal thoughts. (Submitted & under revision)

The papers will be referred to by their Roman numerals I–IV

CONTENTS

LIST OF ABBREVIATIONS

AF	Attributable Fraction
AIDS	Acquired Immuno-Deficiency Syndrome
CI	Confidence Intervals
CHC	Commune Health Center
DHC	District Health Center
FGD	Focus Group Discussion
GSO	General Statistical Office
HIV	Human Immuno-deficiency Virus
HSR	Health Systems Research
IHCAR	Division of International Health Care Research at the Department of Public Health Sciences, Karolinska Institutet
IPV	Intimate Partner Violence
MOH	Ministry of Health
SAREC	Department of Research Cooperation at Sida
SES	Socio-economic status
OMCT	World Organization Against Torture
OR	Odds Ratio
PAF	Population Attributable Fraction
Sida	Swedish International Development Cooperation Agency
STD	Sexually Transmitted Diseases
UNFPA	United Nations' Population Fund
WHO	World Health Organization
WTO	World Trade Organization
WU	Women Union

1. INTRODUCTION

The aim of this study was to describe how people who face intimate partner violence against women, either as volunteers or as professionals in their everyday work, explain violence against women in intimate relationships and their suggestions for preventive activities. A further aim was to investigate the magnitude of the problem of violence within an intimate relationship, the risk factors and the health consequences for exposed women. The study took place in rural Vietnam. The overall objective of the study was to contribute to improved knowledge and awareness of violence against women in intimate relationships and thus hopefully contribute to a reduction of such violence in Vietnam and elsewhere.

This study forms part of a larger project on violence against women in northern rural Vietnam. The present study was conducted within the framework of the demographic surveillance site in Ba Vi District, Ha Tay province, in northern rural Vietnam.

The study is based on focus group discussions in which men and woman participated and also on face-to-face structured interviews in which only women participated, following a questionnaire. Part of the collected data has already been published while the remaining data is presented in this thesis and in the attached manuscripts.

My interest in public health issues developed during the 1980s when I spent almost nine years as an undergraduate and postgraduate student specialized in hygiene and epidemiology at Hanoi Medical University. During those years I was engaged in various public health related projects and programmes.

Through the collaboration with Sweden in the Health Systems Research Programme, I was registered as a Doctoral student in Medical Science in 2004 at the Division of International Health (IHCAR), Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden. During my doctoral training my main supervisor was Associate Professor Gunilla Krantz from Department of Community Medicine and Public Health, Sahlgrenska Academy at University of Gothenburg, Gothenburg, and IHCAR, Department of Public Health Sciences; and my second supervisors Professor Vinod Diwan from IHCAR, Department of Public Health Sciences, Karolinska Institutet, Stockholm, Sweden, and Associate Professor Ngo Van Toan from the Faculty of Public Health, Ha Noi Medical University, Hanoi, Vietnam.

During my research training I have continued to work as senior lecturer at the Faculty of Public Health, Hanoi Medical University and senior programme officer at Health Policy Unit, Ministry of Health, Vietnam. The research training that I have gone through during these years has further increased my interest in systematic search for knowledge of the particular public health problem related to women's health, human rights and how it can be improved in the new situation Vietnam is facing as a member of the World Trade Organization (WTO) and being a part of the globalization process. For this, basic technical information and the perceptions and experience of women, communities and various stakeholders are very important to improve the situation and to serve as a good base for effective implementation of law on prevention and control of Intimate Partner Violence in Vietnam. This is reflected in this thesis.

2. BACKGROUND

WOMEN'S RIGHTS AND VIOLENCE TORWARDS WOMEN

Violence against women has shifted over recent decades from being considered a private or family problem to being recognized as a public health concern with serious consequences for the health and wellbeing of the victims (Krantz, 2002). According to the WHO report "World report on violence and health" (Krug et al., 2002), violence is globally the leading cause of death among people aged 15–44 years and hence a global public health issue. Above all, violence against women is one of the most prevailing expressions of gender discrimination worldwide, which violates and invalidates women's human rights and their fundamental freedom.

For centuries women have occupied a position of subordination in relation to men. Only in 1948, in the Universal Declaration of Human Rights adopted by the General Assembly of the United Nations (UN), did the human rights of all people begin to be recognized regardless of sex, race, colour, language, religion or any other factor. However, despite the "Universal Declaration", women have continued to be consigned to a subordinate role and discriminated against in their homes as well as in society as a whole.

In the 1970s, 80s and 90s, women of different cultures, religions and geographical areas organized themselves to demand their rights and to improve their living conditions. Women's Rights Conferences were held in different parts of the world (Mexico 1975, Copenhagen 1980, Nairobi 1985, Beijing 1995 and Hanoi 2008) with the support of the UN organization. Historical milestones were the "Convention on the Elimination of all forms of Discrimination against Women" (CEDAW) approved in 1979 and the "Worldwide Conference of Human Rights in Vienna in 1993" (http://www.un.org/rights/HRToday/declar.htm) along with the recognition of the human rights of women and girls as inalienable (priceless or indispensable), integral (essential) and indivisible. All of these efforts have produced substantial advances, world declarations ratified by governments and commitments by those governments to prioritize the situation of women and include them in their national agendas. However, these advances have not been sufficient, nor have they been implemented equally by all countries.

Profound inequities between women and men persist and are commonly expressed in the feminization of poverty, women's economic dependence, limited possibilities of reaching the locus of power, continued gender violence and limitations in determining their sexual and reproductive lives (UN, 1995).

It is clear in world reports that the rights of millions of women are violated daily, especially in developing countries. The World Health Organization in its World Report on Violence and Health (Krug et al., 2002) provides evidence of how a fundamental right, the right to health, is denied to the majority of women in the world. Women's health includes their emotional, social and physical wellbeing and goes beyond the biological vulnerabilities to be also importantly determined by the socio-cultural, political and economic context of their lives. The reproductive process places discriminated women at major risk.

Violence against women is a universal and complex phenomenon and possibly the most widespread violation of human rights. Everyday, women are beaten, insulted, humiliated, threatened and sexually abused. The violence that women are subjected to most commonly is interpersonal violence committed by an intimate partner (Krantz & Garcia-Moreno, 2005; Tjaden & Thoennes, 2000); (Krug et al., 2002); and this violence is a major explanation to women's poorer health all over the world (WHO, 2005).

TYPOLOGY AND DEFINITIONS

Typology

WHO (2002) have presented a typology of violence, presented below in Figure 1. The main types of violence are divided into self-directed, inter-personal and collective violence. Self-directed violence refers to suicidal behaviour and self-abuse. The former includes suicidal thoughts, attempted suicides-also called "Para suicide" or "deliberate self-injury" in some countries-and completed suicides. Self-abuse includes acts such as self-mutilation.

Interpersonal violence is divided into two subcategories. Firstly, family and intimate partner violence is the violence ongoing between family members and intimate partners, usually taking place in the home including child abuse, intimate partner violence and abuse of the elderly. Secondly, community violence describes the violence between individuals who are unrelated and who may or may not know each other, generally taking place outside the home. It consists of youth violence, random acts of violence, rape or sexual assault by a stranger and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

Collective violence is subdivided into social, political and economic violence. Collective violence that is committed to advance a particular social agenda includes, for example, crimes of hate committed by organized groups, terrorist acts and mob violence. Political violence includes war and related violent conflicts, state violence and similar acts carried out by larger groups. Economic violence includes attacks by larger groups motivated by economic gain-such as attacks carried out with the purpose of disrupting economic activity, denying access to essential services, or creating economic division and fragmentation.

This thesis is only occupied with *interpersonal violence* exercised by the male *partner towards his wife/female partner* (indicated in red in the figure).

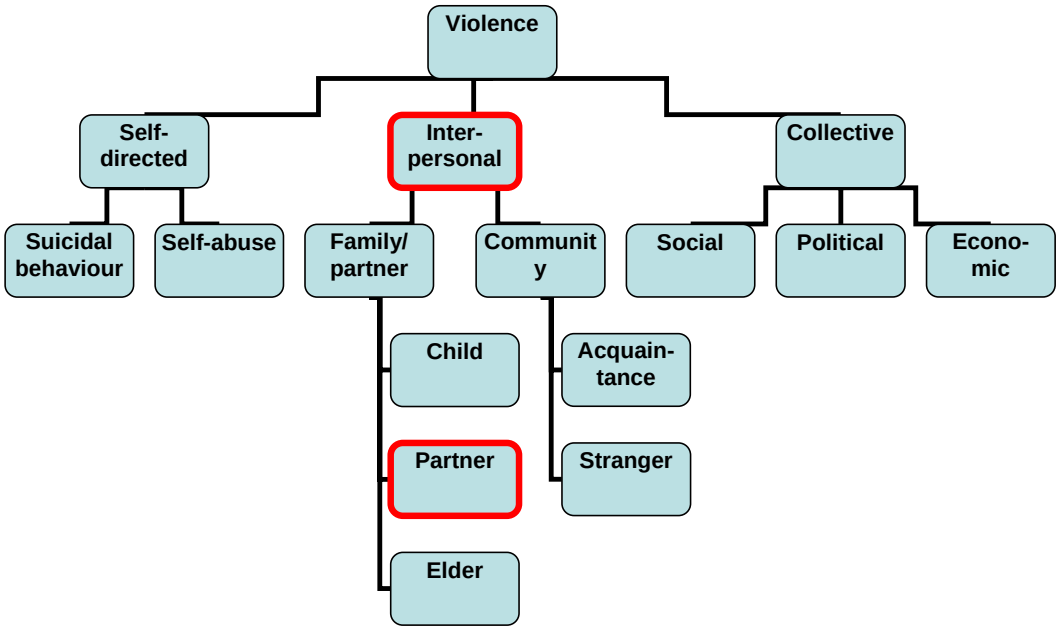

Figure 1. WHO Typology from the World Report on Violence and Health, 2002

The UN declaration and WHO also state that violence against women encompasses but is not limited to three forms of violence: psychological/emotional, physical and sexual acts of violence (UN, 1995; WHO, 2002). Psychological/emotional violence is defined by acts or threats of acts, such as shouting, controlling, intimidating, humiliating and threatening the victim. This may include coercive tactics. Physical violence as defined as one or more intentional acts of physical aggression such as (but not limited to) pushing, slapping, throwing, hair pulling, punching, hitting, kicking or burning, perpetrated with the potential to cause harm, injury or death. Sexual violence is defined as the use of force, coercion or psychological intimidation to force the woman to engage in a sexual act against her will, whether or not it is completed.

Definitions

The UN Declaration on the Elimination of Violence against Women (1993) has defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such act, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (Valladares, 2005). Violence against women is linked to a web of attitudinal, structural and systemic inequalities that are 'gender based' as they are associated with women's subordinate position in relation to men's in society (Krantz & Garcia-Moreno, 2005). The nature and span of violence against women reflect the pre-existing social, cultural and economic disparities between the sexes. The relationship between victims and the perpetrator highlights clear differences of power or the fight to obtain it.

Intimate partner violence (IPV) is the actual or threatened physical or sexual violence or psychological/emotional abuse directed towards a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner (Krug et al., 2002). IPV includes physical, sexual and psychological/emotional abuse and is used by one person in a relationship as a means to harm and take power and control over the other (Krantz & Garcia-Moreno, 2005; Romedenne & Loi, 2006). Intimate partner violence can also be described as 'the kind of violence that occurs in the private sphere between people related through kinship, intimacy or law' (Heise et al., 1999).

Intimate partners are the most frequent perpetrators of domestic violence against women (WHO, 1997). Intimate partners may or may not be cohabiting. The woman is often emotionally involved with and/or is economically dependent on the aggressor, which affects the dynamic of the abuse and places the woman in a position of disadvantage in being able to deal with the violent situation. The overwhelming burden of partner violence is shouldered by women, although men also have to face violence in relationships and it also occurs in same-sex relationships (Heise et al., 1999).

Domestic violence or family violence is a broader concept, reflecting various forms of violence perpetrated by a family member or a group of family members against another family member or another group of family members (husband-wife, parents-children, violence from in-laws or violence against the elderly) (Romedenne & Loi, 2006). However, the most common type of family violence is violence against women committed by an intimate partner (intimate-partner violence), also referred to as "wife-beating" or "battering". Most often domestic violence and intimate partner violence are used interchangeably (Krantz & Garcia-Moreno, 2005). In this thesis, intimate partner violence, IPV, is used.

INTIMATE PARTNER VIOLENCE, A GLOBAL PUBLIC HEALTH ISSUE

IPV is the most common form of violence to affect women and it occurs in all countries, irrespective of social, economic, cultural, or religious system (Krug et al., 2002). However, it has been shown to be more common in societies characterized by patriarchal beliefs about the right of the male to exercise power in the family (Yllo & Straus, 1990), as well as in relationships where women challenge gender norms (Hamberger et al., 1997; Jewkes, 2002). While violence against women is widespread, it is however not universal. Anthropologists have documented small-scale societies-such as the Wape of Papua New Guinea—where domestic violence is virtually absent (Counts et al., 1992).

Approximately one in three women in the world have been beaten, coerced into sex or abused in some way (Heise et al., 1999). In 48 population-based surveys carried out in different countries, between 10% and 69% of women reported physical assaults by an intimate male partner at some point in their lives (Krug et al., 2002). In some countries it has been reported to be as high as 70%. These huge variations are due to a number of factors such as differences in definitions of the violence and in the methodologies used to measure the violence, but also in differences between countries in how willing women are to disclose violence experience and as well in cultural and contextual differences. While exact numbers are hard to know due to lack of reporting, available data suggest that nearly one in four women will experience sexual violence by an intimate partner in their lifetime. Most victims of physical

aggression are subjected to multiple acts of violence over extended periods of time. A third, to over half of these cases are accompanied by sexual violence (Krug et al., 2002).

CAUSES OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN

The causes of intimate partner violence have been the subject of intense debate and addressed from different theoretical viewpoints offering divergent explanations of the root causes of violence. Among the most commonly cited are theories focusing on psychopathology such as personality disorders or behavior disorders that predispose individuals to violence; social learning theory holding that aggressive men learnt violence in their families as children (Valladares, 2005). Cunningham et al. (1998) organized the many explanations for family violence into five groups: biological/organic, psychopathological, family systems, social learning, and feminist explanations.

The first approach, *Biological* theories of criminal behaviour, have existed for over a century, cycling in and out of fashion. Where family violence is concerned, two dominant explanations are observed in the recent literature. The first is that head injury in men can or could cause them to be violent to family members. The second approach, a gene-based explanation, focuses on sexual jealousy and male efforts to ensure sexual propriety over their partners. Woman abuse is seen as a "mate retention tactic" which will be used only under the right set of circumstances, such as when a man senses his wife could attract and keep a better partner.

Psychopathology, the second category of explanation for family violence, focuses on individual factors but with greater emphasis given to psychodynamic than organic variables. Many researchers and practitioners who adopt this perspective focus on childhood and other experiential events that have shaped men to become perpetrators. In this view, family violence may co-exist in a constellation of other interpersonal problems and functional deficits could be evident in non-family settings such as the workplace.

In the third approach, *System theories*, the family is a dynamic organization made up of interdependent components. The behaviour of one member and the probability of a reoccurrence of that behaviour are affected by the responses and feedback of other members. Family violence researchers using this perspective look at the communication, relationship and problem solving skills of couples where violence occurs. Both partners play some (not necessarily equal) role.

In the fourth approach, the *Social learning* perspective, children observe the consequences of the behaviour of significant others and learn which behaviours that achieve desired results. When inappropriate behaviours are modeled for young children—especially if reinforced elsewhere such as in the media—these patterns of interaction can become deeply rooted and will be replicated in other social interactions.

In the last but not least, the *Feminist* approach, most theorists in this field look to the power imbalances that create and perpetuate violence against women. These imbalances exist at a societal level in patriarchal societies where structural factors prevent equal participation of women in the social, economic and political systems.

Societal level imbalances are reproduced within the family when men exercise power and control over women, one form of which is violence.

Each theory provides a logical explanation of its proposed determinants of family violence and each one has some empirical support, however least support is given to the biological and gene-based theories. Furthermore, no single theory has emerged as having unequivocal support. Instead, calls were found by researchers for integrative approaches that incorporated aspects of each. We are reminded that human behaviour is a complex phenomenon and there are no quick and easy ways to explain it. Moreover, it is important to also point out that far from all men use violence against their intimate partner, but some do, and the mechanisms to explain this probably consist of complex interactions between many factors.

Above all, the structural and systemic gender inequalities in society are of major importance and are to be considered the foundation for any theory of violence against women. Beside that, it is recognized that there is no single factor that can explain why some individuals behave violently and others do not (Heise, 1998; Krug et al., 2002).

From a public health perspective, violence against women is considered a multifactorial problem requiring a multifaceted explanation. During the 1970s and 80s, an "Ecological Conceptual Model" was applied for the understanding of child abuse (Belsky, 1980; Garbarino & Crouter, 1978). In the late 1990s, this model was used also to enhance the understanding of the multidimensional nature of intimate partner violence (Heise, 1998).

The model describes the interaction of factors at four different levels of societal organization influencing individual behaviour eventually leading to violence. These levels are presented as concentric circles, from inside to outside: the individual, the family, the community and societal level, as presented in Figure 2. The individual level includes biological or personal aspects that could influence the behaviour of individuals, increasing the possibility of committing aggressive acts towards others. The family level refers to explanatory factors within the proximal social relationships of the women such as the school, workplace or neighborhood. At the community level women's isolation and lack of social support, together with male peer groups that condone and legitimize men's violence, predict higher rates of violence and finally the societal level refers to causal factors related to the social structure, laws, policies, cultural norms and attitudes that reinforce violence against women in society. One most important factor at this level is gender relations and how these shape men's and women's life circumstances. The gender relations embraced by individual societies and cultures differ and also change over time.

The ecological model integrates many of the previous explanations of violence given by different theoretical disciplines, though within a frame of a multidimensional explanation of the problem. Each level in the model can be a platform for the development of intervention strategies for prevention and treatment. A wide range of studies support this model in that factors at each of these levels have been found to contribute to the likelihood that a man will abuse his partner (Heise, 1998).

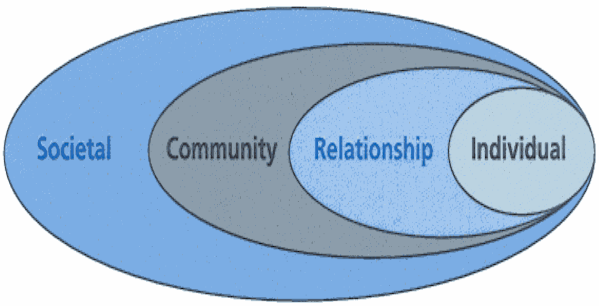

Figure 2. Ecological model of factors associated with partner abuse.

Understanding these situations and the manifold of causes creates opportunities to intervene before violent acts occur and provide policy-makers with concrete options to prevent violence (Heise, 1998; Yllo, 2005).

IMPACT OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN

The consequences of partner abuse are devastating, impacting all the spheres of women's lives: their self-esteem, productivity, autonomy, capacity to care for themselves and their children, their health and wellbeing, ability to participate socially, i.e. their overall quality of life (Garcia-Moreno, 1999). One of the most tragic consequences of intimate partner violence is that it perpetuates the violence within the family as well as in society in that children who have witnessed violence perpetration between their parents will also be more at risk of using violence themselves later in life (Bensley et al., 2003; Valladares, 2005).

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Partner violence increases women's risk of a wide range of negative health outcomes and even death. It has been linked to short and long-term health problems and the impact appears to be cumulative (Felitti et al., 1998; Koss et al., 1991). Four types of health conditions are generally acknowledged as effects of partner violence: physical trauma, sexual/reproductive problems, psychological-behavioral problems, and fatal health consequences.

Partner violence can lead to direct consequences of the violent act, such as trauma, or indirect consequences, such as increased risk of negative behaviour, including alcohol or drug abuse, eating and sleeping disorders. Examples of direct consequences are physical trauma such as abrasions, bruises, welts, fractures and abdominal thoracic injuries, but also sexual and reproductive problems such as STDs including HIV/AIDS, abortions, miscarriages and sexual dysfunction (Krug et al., 2000). Common mental health problems are anxiety, depression, and sleeping problems but also humiliation, feelings of inferiority and subordination, and blocked escape or entrapment. Among fatal consequences of violence are suicides, homicides, maternal mortality and AIDS-related death (Krug et al., 2000).

THEORETICAL FRAMEWORK

This project is founded in public health and includes epidemiological principles, qualitative methodology and gender aspects. Public health is to be understood as the science and art of promoting health, preventing disease and prolonging life through the organized efforts of society (Winslow, 1926). Applied to violence in intimate relationships it translates into estimating the magnitude of the problem in a population, identifying its socio-demographic and psychosocial risk factors and health consequences and suggesting interventions and preventive measures. By integrating a gender perspective into public health, the differing life circumstances that men and women face, including the power differential, i.e. women's subordinate status in society is acknowledged.

To illustrate how this thesis and its studies are planned, Heise's ecological model (1998) was used and adapted into a public health framework, see Figure 3 below. The different levels of societal organization carry different risk factors, of which examples are given below. Some of these risk factors were investigated in this thesis, leading to violence experience and further to its health effects.

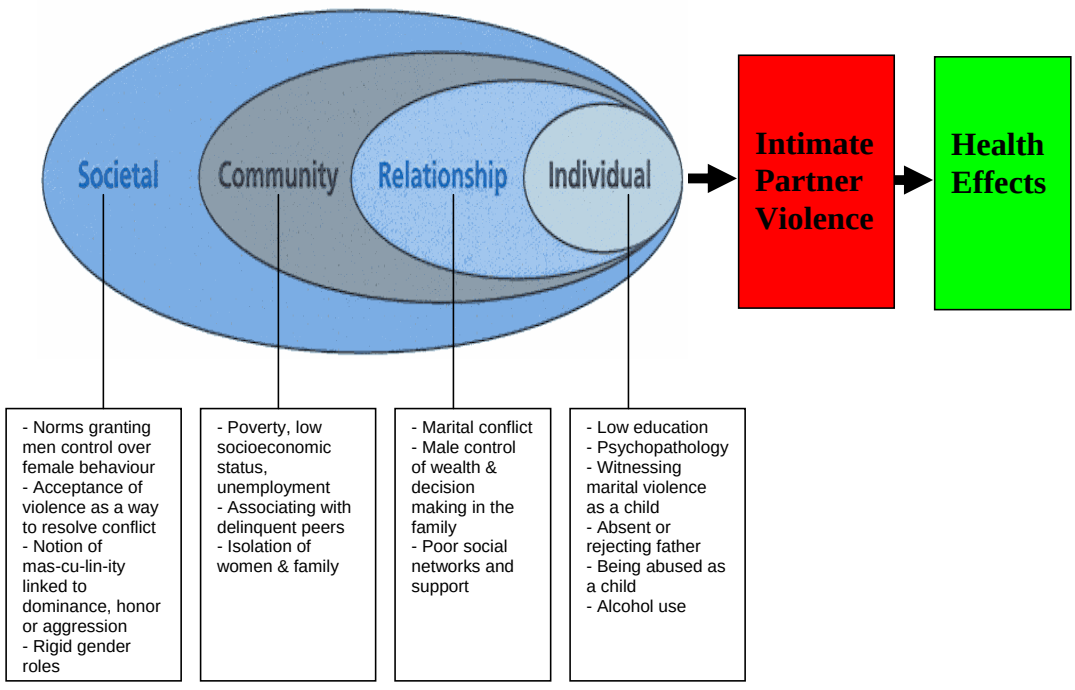

Figure 3. Theoretical framework of the study with examples of risk factors at the different levels of societal organization.

Before going further into the studies and its findings, a short description of Vietnam will follow, concentrated on geography, demography and economics, culture and religion and also gender relations and intimate partner violence.

VIETNAM

Geography, demography and economy

Vietnam borders China in the north, Laos in the northwest and centre, and Cambodia in the southwest. Its 3,444 kilometers of coastline run from its border with Cambodia on the Gulf of Thailand along the South China Sea to its border with China. Vietnam contains a variety of agro-economic zones. The river deltas of Vietnam's two great rivers, the Red River in the north and the Mekong in the south, dominate those two regions. The country is largely lush and tropical, though the temperature in the northern mountains can become near freezing in the winter and the central regions often experience droughts.

According to the Vietnamese Ministry of Health (MoH), the current population is approximately 83 million with almost exclusively indigenous peoples. The largest group is the ethnic Vietnamese (Kinh), who comprise over 85 % of the population. Other significant ethnic groups include the Hmong, Thai, Muong, Khmer, Cham, and Chinese, though none of these has a population over one million. The country's two largest population centres are Hanoi and Ho Chi Minh City, but 75% of the population lives in rural areas. The country's birth rate, estimated to increase with 1.32% per year, has led to rapid population growth since the 1980s with approximately 34% of the population under 14 years of age. In order to limit population growth, a stringent population policy was introduced in the 1980s, advocating a limit on family size to one or two children. A rapid fertility decline has taken place in recent decades, from a total fertility rate of six children per woman to an average of 2.11 in 2005 (GSO, 2005).

When the war against America ended in 1975, the North and the South of Vietnam were reunited under a socialist government. In 1986 a new economic policy was introduced—"*Doi moi"* (renovation)—changing from the 'subsidized' socialist economy to a market-oriented economy. Since the initiation of "*Doi moi"*, Vietnam has made substantial progress in improving economic conditions. For example the number of poor households (defined as income insufficient to provide meals of 2,100 calories/person/day) fell from 58% to 29% between 1993 and 2000 and Gross Domestic Product (GDP) growth rate increased 7.5% annually (Huong, 2006; Huy, 2007; Khe, 2004). However, Vietnam is still considered a low-income country (Bondurant et al., 2003). Some basic data and health indicators are presented in Table 1.

Table 1. Vietnam: Demographic profile

Indicators	Value
Area (km^2)	329,314
Population (million)	84,155
Female (million)	42,801
Population density (person/km^2)	254
Life expectancy (year)	72.0
Infant mortality rate	16/1,000 live births
Under 5 mortality ratio	26/1,000 live births
Maternal mortality rate	75.1/100,000 live births
Low birth weight (< 2500 g, %)	5.3
Under 5 malnutrition rate (%)	23.4
GDP per capita (USD)	718.7

Source: MoH, Vietnam, 2006

Culture and religions

In Vietnam, Confucianism, Buddhism and Taoism have coexisted for many centuries (Anh, 1998). They are known as "triple religion" *(tam giao)* and have pervaded all aspects of Vietnamese life. In a poetic metaphor, this blend of elements in East Asian cultures has been likened to a 'grand tapestry' with Confucianism as the 'warp', providing morality, and practical norms for human relation, Taoism as the 'woof' that defines human relations with the universe and the cyclical changes of nature, while Buddhism, with its notions of compassion and the afterlife, is the 'golden thread' in the tapestry (Johansson, 1998; Saso, 1990). Other religions, including Christianity (Catholicism and Protestantism), Islam, Cao Dai and Hoa Hao also coexist.

Within the diversity of cultural influences in Vietnam, the concept of family is deeply influenced by traditional Confucian doctrine. In the family, men are assumed to have hot characters (temperamental), to be the heads and to have the last word in making decisions on production, business and investment of household resources (Drummond & Rydström, 2004; Que et al., 1999; Rydström, 2003). Traditionally, a Vietnamese woman should follow 'the three obediences' *(tam tong)*, i.e. obey her father as daughter, her husband as wife and her eldest son if the husband has died (Bich, 1999; Tuyet & Thu, 1978). The power sphere of women in rural areas is mainly within the household with chores such as child rearing, responsibility for household work and expenses while they have little influence in other important issues (Anh, 1991; Liljestrom, 1991; Long, 2000).

Over the years however, there have been important changes in Vietnamese society with improvements in women's status and education. The reduction in fertility has led to a decrease in household size and increased numbers of women in salaried employment. Despite this, the traditional Vietnamese family seems fundamentally unchanged, especially in rural areas, and son preference is still strong, as exemplified by the Vietnamese proverb, "*having ten daughters but no son is the same as having no children"* (Bélanger et al., 2002; Dong, 1991; Rydström, 1998). The deep cultural value of sons in combination with the strong Government policies advocating a small family has created conflicts and dilemmas for Vietnamese families if no son is born, especially for the women (Johansson, 1998). An expression of this is the recent indication that sex ratios may be rising in some provinces of Vietnam with unexpectedly more boys being born than girls (Bélanger et al., 2002b).

The renovation policy ("Doi Moi") in the late 20th century and globalization opened Vietnam to new influences and linked it into the international order of human rights and the free market. Even so, the Vietnamese society and its social structure carry a strong imprint of Confucian thought, which together with Buddhism is again regaining influence, as the influence of communism in daily life is fading (Rubensson, 2005).

GENDER ISSUES AND INTIMATE PARTNER VIOLENCE IN VIETNAM

Gender equality

The Vietnamese people's health has been significantly improved in the past decades since "Doi moi" (Renovation) in 1986. After Doi moi, Vietnam has gained significant socio-economic achievement (MoH, 2002). Changes in the economy will inevitably have repercussions on society and everyday social relations. However, some aspects of social relations are more resilient than others. Gender appears to be one of them. Gender relations in Vietnam are at the present a compound of norms, values and practices inherited from a distant Confucian past as well as a more recent socialist one, together with changes associated with the current period of transition to the market and integration into global economy (Werner & Belanger, 2002). Strong cultural traditions, often centered on patriarchal norms about family and gender role, continue to prevail despite being increasingly against the economic reality of the lives of women and men. Gender relations are, in other words, in a state of change with attempts to maintain older patriarchal norms concerning gender roles by referring to "tradition" and "customs" coexisting with increased opportunities for women to participate alongside men in the economy and in society at large (Kabeer et al., 2005).

In international terms, Vietnam performs well in terms of its GDI (gender development index) ranking relative to its per capita GNP. It was ranked 89 out of 146 countries in 2002, scoring well above many other countries at a similar level of economic development.

At the same time, men continue to be seen as the primary breadwinners. Women have primary responsibility for housework and childcare and are expected to maintain family harmony and happiness (Long et al., 2000). However, they are also expected to contribute to household livelihoods. Due to heavy and double work burdens, women have limited time and energy to participate in social activities, additional learning and local democracy (Kabeer et al., 2005).

Women have however historically played an important role in Vietnamese society and it is believed that women in Vietnam traditionally held "a special position and prestige in family and society" in comparison with women in other countries in the region (OMCT, 2001; WU, 1989). The arrival of Confucianism in Vietnam during the Chinese occupation of the northern half of the country more than 1000 years ago substantially weakened this traditional gender equity and some authors have argued that it was at this point that patriarchy became entrenched as the dominant form of gender relation (Quy, 2000). With the advent of the Socialist government, formal equality was established in the Constitution and in many government policies and grassroots women's organizations were established. Nevertheless, discrimination against women continues to exist in Vietnam and women encounter substantial legal and social obstacles when attempting to enforce their rights (OMCT, 2001).

Present-day Vietnamese society has been described as a combination of old patriarchal traditions, emphasizing the subordinate role of women, and modern Communist party ideology advocating equality by law (Johansson, 1998; Thinh, 2001). This has also been expressed as "Vietnamese women today live in two worlds. They do the work of modern women, while they are still expected to behave like their grandmothers".

Even though Confucian influence has left strong imprints on family ideology and norms for social relations (Johansson, 2000), a number of changes have taken place during the 1990s. Relations between generations have changed, fertility rate has been reduced, number of women working outside the home has increased and women's education has improved. Despite this, men are the main decision-makers concerning production and allocation of resources, while the power sphere of women in many cases is restricted to the household. Women participate in community activities but the number of women in decision-making positions is still low (Franklin, 2000; Johansson, 2000).

Polygamy is still practiced in rural areas although it became illegal in 1960. It has been justified on the grounds that the family in Vietnam's traditional patriarchal society formed the main economic unit, where women performed the main bulk of work but under male supervision. Consequently, the more wives, daughters and female servants a male had, the more work could be performed and the more the family could produce (Bunck, 1997). Official documents (Gender equity and the marriage and family law) state that polygamy is today virtually non-existent apart from in some rural areas where the law is difficult to apply. The actual number of polygamous relationships is not officially known.

Intimate partner violence in Vietnam

The women's liberation movement in Vietnam has reached important achievements, especially in the legal field. According to statistics of the National Committee for Vietnam Women's Advancement in 2000, Vietnamese women's rights have been covered in 20 legal contexts, including constitutions of codes, rules and regulations. However domestic violence, especially intimate partner violence against women, is a common and serious problem in society and it is still not well documented: "now there is still not any official data and concrete figures on prevalence of the violence against women nationwide. Even though we could see the violence appears everywhere, every time and at all social classes of Vietnam's society"(Thu, 2001) .

The term 'marital rape' appears to be unrecognized in the Vietnamese society. However, there is evidence that 'forced sex' in the context of marriage does occur (OMCT, 2001) but no cases of marital rape have so far been brought before the Vietnamese court. This is largely due to the perception of conjugal affairs as being private and to the patriarchal norm that wives should obey their husbands and cannot refuse their demands for sex (ADB, 2005).

Due to the influence of Oriental culture violence against women in Vietnam, as in other Asian countries, is considered as a private problem and not discussed in public. The ideas of "Xau chang ho ai" (husband make something wrong, the wife feels ashamed) and "Dong cua bao nhau" (when there is conflict in the family, spouses

should have a talk within closed doors to ease the conflict) lead to silence and acceptance and tolerance of violence against women, and when "Dong cua bao nhau" is performed, this is also a form of violence.

Most women tolerate some abuse and do not often inform outsiders. Women seek help mainly from neighbors, friends and relatives, but seem to hesitate to seek care at local health facilities. There are formal networks at community level to solve conflicts between husband and wife, such as local authorities, residents' units, reconciliation groups and Women's unions (Krantz et al., 2005; Loi et al., 2000).

Violence against women is however not accepted as part of normal behaviour in Vietnam (Duc, 2004). Women's organizations are increasingly putting this issue forward and encourage women to report to the police and to take legal action against violence inflicted upon them. There are at present no shelters for abused women (Duc, 2004), but there are a number of small, independent research centers investigating this problem.

Until recently, domestic violence and intimate partner violence were considered a sensitive and private issue in Vietnam (Romedenne & Loi, 2006). However, in the Comprehensive Poverty Reduction and Growth Strategy of Vietnam (CPRGS, 2002) gender inequality and domestic violence are viewed as obstacles to development. Vietnam's Development Targets within the Millennium Declaration address the need to reduce women's exposure to domestic violence. The Population Ordinance (2003) condemns the use of force to prevent or to force someone to use family planning methods. The Ordinance also prohibits sex-selective abortions. In July 2004, The Prime Minister signed the Decision number 130/2004/QD-TTg, which approved Vietnam's National Plan of Action for 2004–2010 against trafficking of women and children. In May 2005, the Prime Minister signed the Decision number 106/2005/QD-TTg ratifying Vietnam's Strategy on the Family, which sets forth targets to strongly reduce domestic violence, especially intimate partner violence against women. In November 2007, the National Assembly of Vietnam approved the law on prevention and control of domestic violence. These most recent developments indicate the determination of the Government to prevent domestic violence.

Small-scale studies of IPV in Vietnam reveal that it occurs in urban and rural settings and in all social strata (Loi et al., 2000). District and commune level officials estimated that verbal violence occurred in 20–50% of families and physical violence in 5–20%. They further found that all forms of violence occurred less frequently in households where the husband and wife were equal income earners and that verbal abuse was highest in households where the woman was the main income earner (Loi et al., 2000).

RATIONALE OF THE STUDY

There are few studies on intimate partner violence in Vietnam and most of the studies performed to date used qualitative methods. A few quantitative studies are at hand where sample sizes are rather small and data on prevalence, risk factors and health effects are scarce.

This study contributes to the general knowledge by presenting representative figures on the prevalence and characteristics of violence and abuse towards married women from their partner in rural parts of Vietnam. A qualitative approach was also used in an attempt to improve the understanding of how rural women perceive this kind of violence with their suggestions for interventions.

3. AIMS

OVERALL AIM

The overall aim of this study was to improve knowledge on intimate partner violence in a Vietnamese context by use of qualitative and quantitative methods to be able to suggest appropriate interventions and prevention measures of this serious public health issue. Focus is on understanding how professionals and lay people perceive intimate partner violence and to present data on prevalence, risk factors and health effects.

Two study populations were engaged, one comprising professionals and lay people, men and women, and the other comprised women aged 17–60, both from a rural district in Northern Vietnam.

SPECIFIC AIMS

- To explore professionals' and trusted community inhabitants' explanations of the violence between intimate partners and their suggestions for preventive activities (paper I).

- To determine different forms, magnitude and risk factors of men's violence against women in intimate relationships and whether a difference in risk factors were at hand for the different forms of violence (paper II).

- To explore the role of witnessing inter-parental violence as a girl and its association with her own experience of intimate partner violence later in life. A more tolerant attitude to violence is tested as one explanatory factor (paper III).

- To investigate health effects and need of health care among women exposed to violence from their husbands/partners (paper IV).

4. SUBJECTS AND METHODS

STUDY SETTING

All studies included in the thesis were conducted in the Ba Vi District in the Ha Tay Province of northern Vietnam where a demographic surveillance system, referred to as a field laboratory and named FilaBavi, was established in 1999 (Chuc & Diwan, 2003). FilaBavi was developed within the Health Systems Research Project supported by Sida/SAREC, Sweden, with the overall aim to implement a longitudinal epidemiological surveillance system in the Ba Vi District that could generate basic health and health care data, supply information for health planning and policy making, serve as a background and sampling frame for specific studies, and constitute a setting for epidemiological and public health training of master and doctoral students.

Ba Vi is a district in the Ha Tay Province in the Red River Delta Region in northern Vietnam. The district is 60 km west of Hanoi and covers an area of 410 km^2, with lowland, highland, and mountainous areas, and ranges in altitude from 20 to 1297 meters above sea level. The District contains approximately 240,000 people, belonging to the Kinh ethnic group (91%), with Muong (8%) and minorities of Dao, Tay, Hoa, and Khme. Children under one year of age comprise 1.5% of the total population; children under 5 years of age constitute 7.9%. Women aged 15 to 49 years form 27.1% of the total population.

The district consists of 32 communes, each with 6,000 to 10,000 inhabitants. Each commune is divided into a number of hamlets. Most people in Ba Vi are farmers (81%) with agricultural production and livestock breeding as the main economic activities. The average income per capita in the district is approximately 300 USD (FilaBavi annual report 2005).

Sixty-nine clusters in the district were selected randomly to constitute the sample for FilaBavi. These had 11,089 households with 51,024 inhabitants, of which approximately 16,100 are women aged 15–49. A cluster was defined as an administrative unit, usually a village, although if the village was too large it could be divided into two clusters. On average, there are about 600–700 inhabitants in each cluster.

To obtain the regularly sampled data, 39 female field surveyors were employed, divided into six groups, each led by a field supervisor. The criteria for selection of surveyors were that they should be living in the district and have completed high school education. All surveyors were trained before starting their fieldwork and frequently updated in order to ensure the quality of data collection. Field supervisors were persons with a medical background, such as assistant doctors or nurses. Each supervisor was in charge of a group of 6–8 surveyors. The main task of a field supervisor was to check manually all survey forms filled by the surveyors in the group. She or he was also responsible for conducting re-interviews on approximately five percent of the home visits in the quarterly follow-up surveys. Feedback was given to the surveyors in weekly meetings.

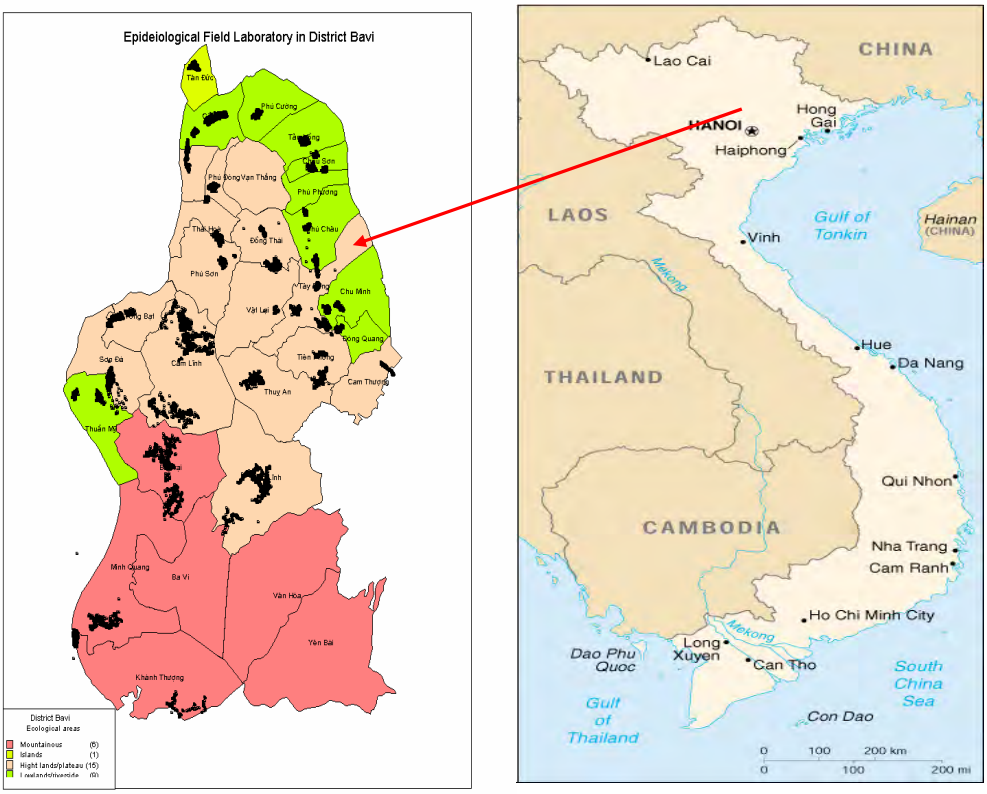

Figure 4. Location and structure of the study setting (FilaBavi).

The lightly shaded areas in the north and north-east are the riverside areas. The darker areas in the south are mountainous areas. The black spots show the sampled clusters.

An initial baseline survey was carried out in early 1999. Since then household follow-up surveys have been conducted quarterly. A re-census with basically the same scope as the baseline survey has been conducted every second year, i.e. in 2001, 2003, 2005, and 2007. At baseline and re-census, socio-economic information at household level and characteristics of household members have been collected.

At follow-up surveys, performed every third month, demographic and household information has been updated. Particularly vital events, births, deaths and migration are recorded. Up to August 2008, 36 follow-up surveys had been conducted.

STUDY DESIGN AND DATA COLLECTION

Both qualitative and quantitative approaches were applied in the studies presented in this thesis. The study design and study populations and data collection techniques used in the studies are summarized in Table 2.

Table 2. Summary of study design, population and data collection methods

STUDY AND STUDY TYPE	SOURCE OF INFORMATION	METHOD AND COLLECTED DATA
Study 1 (paper I) Title: Violence against women in intimate relationships: Explanations and suggestions for interventions as perceived by healthcare workers, local leaders, and trusted community members in a northern district of Vietnam Performed in May–June 2002 Qualitative study	Focus group discussions (FGDs) with commune health workers, district health workers, district officers, community level (men), community level (women) Moderator Notes taker Tape transcripts	Five FGDs were analyzed using a phenomenographical approach.
Study 2 (paper II) Title: Intimate partner violence against women in rural Vietnam—different socio-demographic factors are associated with different forms of violence: Need for new intervention guidelines? Data collected in July–September 2002 Quantitative study	– 883 married/partnered women aged 17–60 – FilaBavi field supervisors and surveyors [6 supervisors (4 women, two men); 33 surveyors (all women)]	Face-to-face interviews Structured questionnaires developed by WHO for use in violence research
Study 3 (paper III) Title: Is a history of witnessing interparental violence associated with women's risk of intimate partner violence? A population-based study from rural Vietnam. Data collected in July–September 2002 Quantitative study	– 730 married/partnered women aged 17–60 – FilaBavi field supervisors and surveyors [6 supervisors (4 women, two men); 33 surveyors (all women)]	Face-to-face interviews Structured questionnaires developed by WHO for use in violence research
Study 4 (paper IV) Title: The contribution of intimate partner violence to common illnesses and suicidal thoughts. Data collected in July–September 2002 Quantitative study	– 883 married/partnered women aged 17–60 – FilaBavi field supervisors and surveyors [6 supervisors (4 women, two men); 33 surveyors (all women)]	Face-to-face interviews Structured questionnaires developed by WHO for use in violence research

Qualitative approach

Focus group discussion (paper I)

The informants were strategically selected from groups of people who encounter IPV either as professionals or as volunteers. These were healthcare workers, persons holding positions at district or local community level and farmers, representing of local reconciliation groups, or being heads of local unions. The informants were also strategically selected with regard to sex and for their ability to express their views on

different subjects. The selection was made with the support of the deputy director of the district health centre, as he was well acquainted with local conditions. In all, 40 persons, 20 men and 20 women, were selected. Data were collected in five focus-group discussions (FGD) (Barbour & Kitzinger, 2000) conducted in May and June 2002.

The focus group discussions were semi-structured, informal in style, and lasted for approximately one and a half hours. Two main themes were explored: the informants' perceptions of explanations of IPV in the district and their suggestions for preventive activities. The guiding questions were of a comprehensive character, such as: In your opinion, what are the possible explanations for violence between husband and wife? What kind of situation leads to violence? As you see it, how do husband and wife settle their problems? What do you think could be done to reduce this violence? Please give examples.

Table 3. Characteristics of the focus-group participants, position and gender and venue for the focus-group discussions.

Position	Male/female	Venue
G1: Commune health workers: Assistant physicians (6), village health workers (2)	3/5	CHS
G2: District health professionals: Physicians (5), assistant physicians (2), nurse (1)	4/4	DHC
G3: District officers: Representatives from: farmers' association (1), women's union (1), youth union (1), inspection office (1), court institution (1), propaganda unit (1), health office (1)	4/3	DHC
G4: Men at community level: Farmers (5), representatives from: farmers' association (1), youth union (1), Commune People's Committee (2)	9/0	CHS
G5: Women at community level: Farmers (5), representatives from: Commune People's Committee (1), women's union (1), youth union (1)	0/8	CHS

G: Focus group; CHS: Commune Health Station; DHC: District Health Centre

Quantitative studies (papers II–IV)

The quantitative data were obtained from a specific study on intimate partner violence against women performed in the context of the FilaBavi surveillance site.

A random selection of study participants was made from the FilaBavi cohort such that a number of households were selected from each cluster, proportional to the total number of households in each cluster. One woman in each selected household, aged 17–60, was asked to participate. Exclusion criteria: women with mental ill-health or hearing loss.

Face-to-face interviewing was used for data collection. The 39 female interviewers and six field supervisors engaged in the regular FilaBavi data collections were trained by the principal investigator in how to manage the specific challenges and difficulties encountered in studies on violence. As IPV might generate feelings of insecurity and frustration also among the interviewers, a pilot study was performed and the interviewers were encouraged to renounce participation if not feeling comfortable, but no one did.

Power calculations showed that in order to detect a twofold increase in risk with 80% probability, with a hypothesized prevalence of the exposure of 20% in the study sample, a sample size of 850 individuals was needed. In all, 884 households containing a married or partnered woman aged 17–60 years were invited to take part in the study. Of these women, 867 were currently married and 16 were in a stable sexual relationship with a man (henceforth referred to as married women). Only one woman declined to participate due to psychiatric illness.
Only married/partnered women were included due to difficulties in asking sensitive questions to unmarried young women such as whether they were having sexual relationships before marriage.

Data collection instrument

The data collection instrument used was the Multi-country Study on Women's Health and Life Experiences Questionnaire developed by the World Health Organization (WHO) for studies within public health with focus on interpersonal violence (WHO, 2000). The questionnaire was developed for use in different cultures and is considered to be cross-culturally appropriate. The abuse questions were developed on the basis of a variety of other abuse assessment scales (Index of Spouse Abuse and the Conflict Tactics Scales) with established high reliability and construct validity (Hudson & McIntosh, 1981) (Straus et al., 1996). This instrument was revised and translated into Vietnamese.

The revisions made consisted of selected sections and items being removed as this data was either obtained from the FilaBavi database (socio-demographic data) or considered inappropriate in the Vietnamese context (dowry related items). In a one-day seminar and in a pilot interview, the questionnaire was further validated through a review panel process where each item was considered for appropriateness.

Only women took direct part in this study and data related to husbands/partners were obtained from the participating women.

Variables

Violence variables

Violence occurrence was assessed by types (physical, psychological and sexual abuse), timing (life-time and past year exposure) and frequency (how often it occurred). Physical abuse was assessed by 11 items: slapping, throwing things, pushing or shoving which were classified as moderate physical abuse behaviours. Further hitting, kicking, dragging, beating, choking, burning and threatening with or

using a weapon (knife, scissors or object) were classified as severe physical violence (Hudson & McIntosh, 1981). Sexual abuse was assessed by three items: having sexual intercourse against the respondent's will, using physical force for sexual intercourse, and forcing the respondent to sexually degrading acts. Psychological abuse was assessed by four items: insults or degrading activities, belittlement or humiliation, scaring the respondent on purpose and threats to hurt the respondent or someone she cares about.

In paper II, two dependent variables were created, physical and sexual violence combined and pure psychological abuse. Physical and sexual violence was defined as the respondent being subjected to any act of physical or sexual violence or both (henceforth referred to as physical/sexual violence); psychological abuse alone was defined as being subjected to any item of psychological abuse without overlap of any other kind of violence (referred to as psychological abuse alone) (Saltzman et al., 1999).

Time wise two different measurements were used. These were *lifetime occurrence* of any kind of violence, which was defined as experience of any act of violence to date of the interview from a current or former husband/partner and *abuse taking place within the past year,* defined as any act of violence taking place within the past 12 months. For bi- and multivariate analyses the dependent variables were dichotomized into experience of violence as opposed to no experience of violence. For these analyses, those with only one single experience of violence over the lifetime were considered as non-exposed, to strengthen the criterion for violence exposure.

Socio-demographic and psychosocial variables (paper II)

Socio-demographic and psychosocial variables were tried as independent risk factors. Age was divided into three groups: 17–29; 30–45 and 46–60. Educational attainment was grouped into primary (5 years) and secondary schooling (9 years) and higher education (> 9 years) respectively, and dichotomized with higher education as the reference category. Annual household income was divided into quintiles and later into three groups (lowest income group, < 288 USD, low and middle income groups, 288–570 USD and high and highest income groups, > 570 USD) and further dichotomized for the multivariate analyses whereby a household income in the lowest and in the low income groups, < 425 USD, was treated as the exposure category. The husband's working specifics were also grouped into three categories and dichotomized into professionals as the reference and semi-skilled and unskilled combined as the exposure group.

Witnessing interparental violence (**paper III**)

Witnessing interparental violence is an independent variable: The items relating to childhood experience of witnessing interparental violence were phrased as: "When you were a child, was your mother hit by your father (or her husband or boyfriend)?'' The next question was: "As a child, did you see or hear this violence?" The witnessing interparental violence variable was dichotomized into 'witnessing', if the answer was "yes", and 'not witnessing', if the answer was "no" to both questions. Only the father's use of violence towards the mother was analyzed and this will subsequently be referred to as witnessing interparental violence. Of the 883 who were interviewed, 730 women gave a clear response to whether or not they had witnessed

violence by their father towards their mother and only these were included in this study.

Attitudes to violence (paper III)

Six different situations were inquired about, reflecting opinions on the use of violence within an intimate relationship. These were: "In your opinion, does a man have a good reason to hit his wife if: (a) She does not complete her housework to his satisfaction (yes/no), (b) She disobeys him (yes/no), (c) She refuses to have sexual relations with him (yes/no), (d) She asks him whether he has other girlfriends (yes/no), (e) He suspects that she is unfaithful (yes/no) and (f) He finds out that she has been unfaithful (yes/no)?" In the interpretation, the answer "yes" is considered to be in line with a tolerant attitude towards violence and the answer "no" is considered to be equivalent to not accepting violence.

Health conditions (paper IV)

The women were asked about their *general health* using a five-point scale (excellent, good, fair, poor, or very poor). Women were considered to be in poor health if they reported one of the two lowest categories. All the women were also asked about *six physical and mental symptoms* during the past twelve months; these were difficulty walking, difficulty performing daily activities, pain or discomfort, memory or concentration problems (five-point scale ranging from no problems to extreme memory problems), sadness or depression and suicidal thoughts (yes or no). For the analysis of the symptoms measured with the five-point scale, women were rated as in 'poor health' if they had responded with one of the three lowest categories. For sadness or depression and suicidal thoughts, those who responded with a 'yes' were regarded as exposed. Injuries as a result of the violence inflicted were reported in terms of the type of trauma and whether there was a need for hospital care.

DATA ANALYSIS

Qualitative data analysis (paper I)

A qualitative research approach was applied, and phenomenography was used for analysis. Phenomenography aims to capture people's perceptions of different aspects of a problem (Lepp & Ringsberg, 2002). The discussions were tape-recorded and transcribed verbatim in Vietnamese and thereafter translated into English. Two of the authors, independent of each other, identified codes related to the areas under study. The findings were then agreed on and brought together into categories and themes. The results that evolved were discussed continuously between all the authors. A co-examiner was assigned to test the inter-subjective agreement of the findings in the following way: the themes and the selected quotations were presented separately to the co-examiner, who matched quotations with themes (Lepp & Ringsberg, 2002; Sjöström & Dahlgren, 2002). There was almost a full level of agreement between the researchers and the co-examiner. To secure the validity of the translation, an independent Vietnamese person, proficient in English, read all the selected quotations from the Vietnamese original transcript and re-translated them into English. Quotations are given to facilitate the reader's evaluation of the credibility of the results. The findings were reported back to the informants one year later in a formal meeting in Ba Vi; 28/40 informants were present and they affirmed the findings.

Quantitative data analysis (paper II-IV)

Data were double entered into the Statistical Package for the Social Sciences (SPSS) version 10.0 which was used for all statistical purposes (Kinnear & Gray, 2001). Risk ratios were estimated by odds ratios (OR). Statistical significance was determined at the 95 % confidence interval level.

For the papers I–IV, bi- and multivariate analyses were adjusted for age apart from when age differences were investigated. For the multivariate analyses, variables of theoretical and empirical (statistically significant in the bivariate analyses) interest were entered one by one in a stepwise fashion. To avoid a correlation effect, the multiple logistic regression models included only items with correlation coefficients below 0.4.

In paper IV, the attributable fraction (*AF*) and the population attributable fraction (*PAF*) were calculated for each of the health conditions. *AF* is the proportion of the disease among those exposed to physical/sexual violence that would be eliminated in the absence of physical/sexual violence. It is calculated as $RR - 1/RR$, where *RR* is the risk ratio and could be substituted with OR. *PAF* is the proportion of disease in the total study population, which is attributable to physical/sexual violence**.** It is calculated by multiplying the *AF* with the proportion of exposed cases out of the total number of cases (Beaglehole et al., 1993).

$$PAF = AF \times \frac{Exposed\ cases}{Total\ number\ of\ cases}$$

ETHICAL CONSIDERATIONS

This study was part of a bigger project, a bilateral collaborative programme between Vietnamese and Swedish researchers. When there is a collaborative programme between different countries it is of great importance that before starting the study, ethical committees in both the countries concerned give approval of the study. This study was approved by the institutional review board of the University of Gothenburg, Sweden; Hanoi Medical University and Ministry of Health, Hanoi and Ba Vi district People's Committee and Ba Vi District Health Center, Ha Tay province, Vietnam.

The Guideline on Ethics and Safety for Violence Research, issued by the WHO (1999) was followed, as well as the principles of the Helsinki Declaration (WMA, 1964).

The fundamental document regarding ethical guidelines for human research is the Declaration of Helsinki, originally adopted by the World Medical Assembly in 1964, with later revisions at regular intervals. The Declaration of Helsinki includes several important principles. Human research ethics assume some consensus on four basic principles for conduct: The *Principle of Autonomy* implies that all persons have a right to decide about their actions and resources and that society has a moral duty to respect this right. The *Principle of Nonmaleficence* is referred to as the principle to do

no harm. The *Principle of beneficence* refers to a moral obligation to do as much good as possible and is not limited to mercy, kindness, or charity. The *Principle of Justice* requires that human beings be treated equally unless there is a strong ethical justification for treating them differently. These principles comprise the foundation of all regulations or guidelines governing human research ethics and transcend all geographic, cultural, economic, legal, and political boundaries and are extensively discussed by Beauchamp and Childress (1989). These principles were taken into consideration when performing this study.

The World Health Organization has issued guidelines for violence research (WHO, 2001) and these were strictly followed. Interviews were held in strict privacy, mainly in the respondents' homes, with no one able to overhear the conversation. In a few cases when privacy was not possible to establish, the interview was performed at a nearby commune health centre. The participants were informed about their possibility to withdraw at any point during the research phase and gave written informed consent to participate.

Dahlgren et al (2004) discuss ethical considerations in relation to the use of qualitative methodology in public health research. Qualitative methodology is often regarded as less threatening on an individual level, because of the implied interaction between informants and researchers and the interest in viewing or understanding the 'real world' of the informants. On a societal level it is also often argued that qualitative methodology empowers people through their active participation in the research process. However, even if this is true, there are ethical considerations to be taken in all research, some from a more political and ethical angle and some from a more individual point of view (Dahlgen et al., 2004).

In contrast to the idea that qualitative methodology can be seen as less threatening to the individual, the qualitative approach may be more threatening to the individual than, for example, when one gives the answers in a questionnaire. It is of great importance to ensure confidentiality of the participants of a focus group discussion and that the information, view points and ideas presented within the group during the discussion must not be taken outside of the group. From an ethical point of view it is also important to ensure the participants that the results will be presented in such a way that no individual will be recognized.

The topic of this study was of a sensitive kind and there was a possibility that someone among the participants in the focus group discussions had experienced IPV herself and thus having emotional reactions. In order to be prepared for such an event, that issue had been discussed within the research group before starting the qualitative study. In addition, professional counselors had been contacted in advance to be prepared to take care of any participant that would need such help in connection with the study.
The interviewers employed for the quantitative part of this study were informed that they could renounce participation if they felt this was a difficult subject but no one did.

5. MAIN FINDINGS

The main findings from the four papers (I–IV) and additional analysis of our data are presented below. The focus is on knowledge/perception and risk factors of intimate partner violence as well as health effects of IPV on women's health.

SOCIODEMOGRAPHIC CHARACTERISTICS OF THE SUBJECTS IN THE QUANTITATIVE STUDIES (Papers II–IV)

Of the participating women, the majority (77.4%) were 30 to 60 years of age (Table 4). More women than men had completed secondary school, 63.4% and 58.6%, respectively, although more husbands had attained a higher level of education. Nearly 90% of the respondents were farmers. The majority of the husbands were unskilled workers (73.5%) and 15.5% (n = 130) of the men had more than one wife/partner. Twenty % of the study population was extremely poor, and had a household income below the official poverty line. More than half of the respondents answered to the norm of the two-child policy, i.e. a woman should not give birth to more than two children (55.3%) (Table 4).

Table 4. Socio-demographic and psychosocial factors of respondents and their husbands. *N* = 883

Variables	n	%
Respondents		
1. Age groups		
17–29	200	22.6
30–45	406	46.0
46–60	277	31.4
2. Education		
High school or higher education (≥ 10 years)	134	15.2
Secondary school (6–9 years)	560	63.4
Primary school (< 6 years)	189	21.4
3. Occupation		
Agricultural labor	761	86.2
Other (hired labor, breeding farmer, tailor, construction assistant, etc…)	122	13.8
Husbands/Partners		
4. Age groups		
20–29	108	12.5
30–45	442	51.0
46–77	316	36.5
5. Education		
High school or higher education (≥ 10 years)	180	22.0
Secondary school (6–9 years)	481	58.6
Primary school (< 6 years)	159	19.4
6. Work specifics		
Professional	171	22.0
Semi-skilled	35	4.5
Unskilled	573	73.5
7. Husband having more than one wife/partner		
No	710	84.5
Yes	130	15.5
Households		
8. HH income per year		
< 288 USD	176	20.0
288–570 USD	353	40.1
> 570 USD	351	39.9
9. Number of children		
No children	16	1.8
1–2 children	466	53.5
3 children or more	389	44.7

PREVALENCES AND OVERLAPS OF IPV (Paper II)

Of the 883 women, 30.9% (n = 273) had been subject to some form of physical violence in their lifetime, and 8.5% in the preceding year. For the combined exposure to physical and sexual violence, the corresponding figures were 32.7% and 9.2%. The most commonly occurring form was psychological abuse (lifetime 55.4%, n = 489; past year 33.7%, n = 298). For physical violence reported for one's lifetime, 47% was classified as being severe and for the past year it was 53%. In the majority of cases, the violence was exerted as repeated acts. Lifetime experience of sexual violence was reported by 6.6% of the women, and by 2.2% for previous year exposure (Table 5).

The different forms of violence and their overlap are displayed in detail in the Venn diagrams in Figure 5. These illustrate that the most commonly occurring form of violence was psychological abuse alone (lifetime 27.9%, n = 246; past year 25.4%, n = 224) followed by physical and psychological abuse combined (lifetime 21.2%, n = 187; past year 6.5%, n = 57). Just one woman reported sexual violence as a single exposure (0.1%).

Table 5. Lifetime and past year prevalence of different forms of violence among married women. $N = 883$

Forms of Violence	Lifetime prevalence				Past year prevalence			
	Violence exp. % (*n*)	Number of events			Violence exp. % (*n*)	Number of events		
		Once	2–5 times	> 5 times		Once	2–5 times	> 5 times
Physical Violence §		% (*n*)	% (*n*)	% (*n*)		% (*n*)	% (*n*)	% (*n*)
Moderate physical violence:	16.3 (144)	5.9 (52)	8.2 (72)	2.3 (20)	3.9 (34)	2.6 (23)	1.0 (9)	0.2 (2)
- Slapped/threw something	27.0 (238)	6.7 (59)	12.1 (107)	8.1 (72)	7.1 (63)	3.3 (29)	3.1 (27)	0.8 (7)
- Pushed/shoved	5.8 (51)	0.8 (7)	1.9 (17)	3.1 (27)	2.6 (23)	0.7 (6)	1.4 (12)	0.6 (5)
Severe physical violence:	14.6 (129)	2.9 (26)	6.1 (54)	5.5 (49)	4.4 (39)	0.8 (7)	2.8 (25)	0.8 (7)
- Hit that could hurt	11.6 (102)	2.6 (23)	3.7 (33)	5.2 (46)	3.4 (30)	1.1 (10)	1.6 (14)	0.7 (6)
- Kicked/dragged or beat	8.6 (76)	1.9 (17)	3.1 (27)	3.6 (32)	3.1 (27)	1.2 (11)	1.2 (11)	0.6 (5)
- Choked or burned	1.7 (15)	0.6 (5)	0.6 (5)	0.6 (5)	0.3 (3)	0.0 (0)	0.2 (2)	0.1 (1)
- Threatened to use or used a weapon	1.8 (16)	0.8 (7)	0.5 (4)	0.6 (5)	0.5 (4)	0.1 (1)	0.2 (2)	0.1 (1)
Summary measure of Physical Violence	30.9 (273)	8.5 (75)	22.4 (198)		8.3 (73)	3.6 (32)	4.6 (41)	
Sexual Violence §								
- Physically forced to have sexual intercourse	2.7 (24)	0.2 (2)	1.1 (10)	1.4 (12)	0.5 (4)	0.0 (0)	0.2 (2)	0.2 (2)
- Did not want to have sexual intercourse	4.9 (43)	0.7 (6)	2.4 (21)	1.8 (16)	1.8 (16)	0.9 (8)	0.7 (6)	0.2 (2)
- Forced to do something sexual that felt degrading	1.0 (9)	0.0 (0)	0.6 (5)	0.5 (4)	0.5 (4)	0.0 (0)	0.2 (2)	0.2 (2)
Summary measure of Sexual Violence	6.6 (58)	0.7 (6)	5.9 (52)		2.2 (19)	0.9 (8)	1.3 (11)	
Physical and sexual violence	32.7 (289)	10.0 (88)	22.8 (201)		9.2 (81)	4.1 (36)	5.1 (45)	
Psychological abuse §								
- Insulted or made her feel bad about herself	20.0 (177)	0.9 (8)	6.1 (54)	12.6 (111)	9.4 (83)	1.4 (12)	5.2 (46)	2.8 (25)
- Belittled or humiliated her	10.6 (94)	0.2 (2)	3.5 (31)	6.7 (59)	5.7 (50)	1.2 (11)	3.3 (29)	1.1 (10)
- Did things to scare or intimidate her on purpose	49.2 (434)	1.9 (17)	13.0 (115)	32.5 (287)	30.4 (268)	5.9 (52)	18.7 (165)	5.8 (51)
- Threatened to hurt her or someone she cared about	12.9 (114)	1.0 (9)	5.3 (47)	6.3 (56)	5.9 (52)	1.2 (11)	3.2 (28)	1.5 (13)
Summary measures of Psychological abuse	55.4 (489)	2.2 (19)	53.2 (470)		33.7 (298)	5.3 (47)	28.4 (251)	
Psychological abuse alone	27.9 (246)	1.8 (16)	26.0 (230)		25.4 (224)	4.3 (38)	22.4 (186)	
Summary measures all forms of violence	60.6 (535)	10.0 (88)	50.6 (447)		34.5 (305)	5.4 (48)	29.8 (263)	

§ Respondents can report more than one alternative.

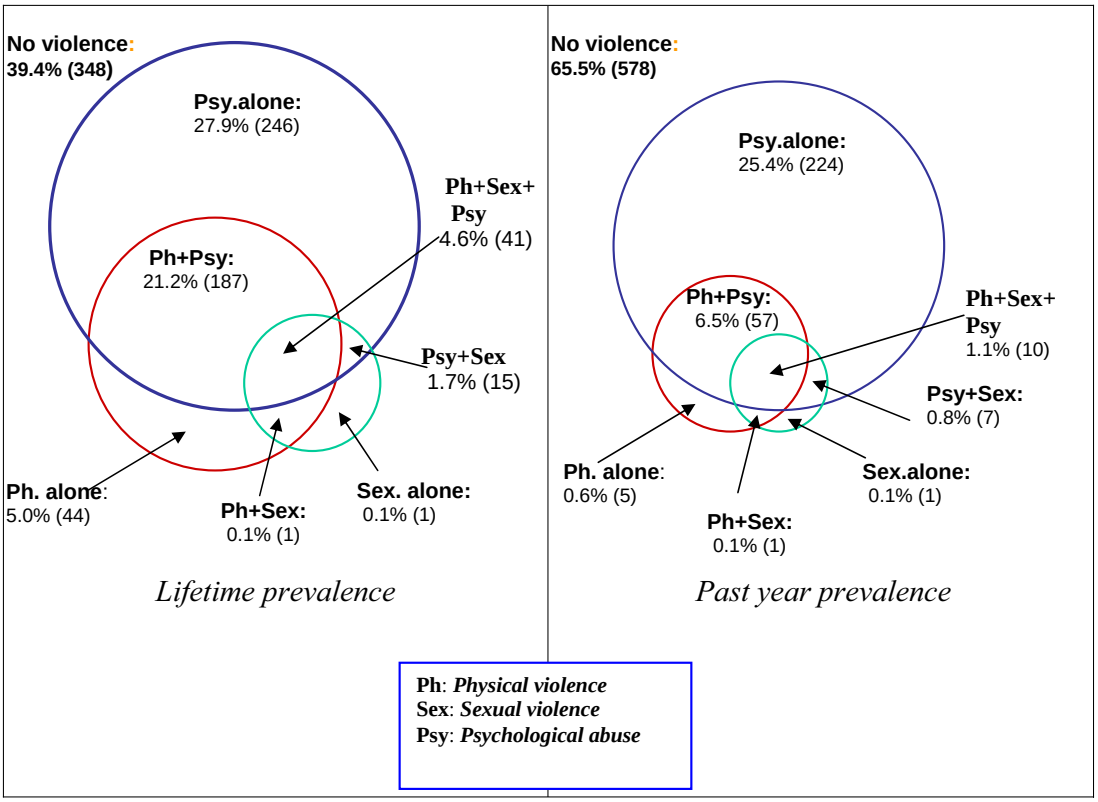

Figure 5. Overlaps between different types of Intimate Partner Violence.

RISK FACTORS

How people explain violence occurrence (paper I)

Explanations for why IPV occurs

The qualitative study collected its data through five focus group discussions. It was revealed that the informants defined the explanations for IPV as a complex interplay between many different factors. The main factors (sub-categories) discussed in the FGDs were educational attainment, life-style related behaviour, unequal workloads, challenging gender norms, the extended family, resource-poor society, patriarchal norms and boy preference. During the analysis phase it became obvious that these factors were related to different levels in society and these became the main categories: the individual level, partner and family level, local community level, and a societal level, i.e. socio-cultural norms and practices. The findings hereby fitted well into Heise's ecological model.

Individual factors

Education
The informants stated that IPV exists among both well- and less well-educated couples,
but that it occurs more frequently in less educated couples. Some informants stressed that less well educated men mainly use physical violence, while the more educated men exercise psychological violence, also referred to as maltreatment by the informants.

Lifestyle-related behaviour
The role of certain types of lifestyle-related behaviour, also referred to as social evils (i.e., alcohol addiction, gambling, drug addiction, etc…) was the topic of lively discussion in all groups. Most of the informants said that this behaviour was linked to the husband's use of violence towards his wife/partner.

Factors related to partner and family

Unequal workloads
The informants referred to rural women's heavy and tiring workload, being responsible for both farming and taking care of the household, including the children, as a reason for violence occurrence.

Women perform work in the rice field, at home, take care of the children and have to care for the husband. If she is not doing well, such as not completing the household work satisfactorily, she might be at risk of violence as the husband is considered the head of the household and he must be served in a good way. The informants stated that due to women's heavy and tiring workload they would not always be able to have food ready on time when the husband comes back from work. This was mentioned as a common reason for violence occurrence, as was the wife's denial of sex due to tiredness.

Challenging gender norms
Both women and men discussed the norms in Vietnamese culture, which prescribe that women should have a submissive attitude and behave accordingly. If a woman challenges this norm, it may end in violence. Some of the informants in the exclusively female group explained why women themselves could be blamed for the violence to which they were subjected.

> *"The main reason for the maltreatment of women comes mostly from the women themselves. If a woman is faithful and takes good care of her husband, parents-in-law and children and is a little more modest in her behaviour, there is less violence."*
> *(Female nurse)*

No male informant in any of the groups expressed anything similar. A male informant stressed that when the woman is the main income earner in the family, she also challenges current gender norms. This could eventually give rise to the husband feeling inferior and increase the risk of violence.

The extended family
The extended family system, with three generations together, was regarded as a potential threat to the woman. The daughter-in-law holds the lowest position in the household and, if she does not serve the other members of the family satisfactorily, they could use violence towards her.

Local community factors

Resource-poor society
It was pointed out that the local communities in Vietnam are fairly resource-poor and that people in general are poorly educated, and as a result have difficulties in finding a job outside the family farm. The informants stressed that poverty and anxiety about the family's well-being often lead to rows ending in violence.

Socio-cultural norms and practices

PATRIARCHAL NORMS
''Feudal ideologies'' were referred to frequently by the informants, especially by the representatives of district and community organizations. Feudal ideologies prescribe patriarchal norms and women's subordinate status in society at large and how they exert influence on men's and women's behavior.
One informant expressed feudal ideology as:

> *"... the perspective of the three subjections of women: 'The daughter is subject to her father, when she leaves home, she is subject to her husband and, when her husband dies, she is subject to her son.' In this way, girls must serve their husband, their family and their husband's family, that is too much of a burden".*
> *(Male deputy-director of district health centre)*

BOY PREFERENCE
The strong Vietnamese notion that in each family there should be at least one male child was also discussed. Most of the informants said that there is great pressure on a woman to give birth to a son. Women who do not give birth to at least one son risk being ridiculed and abused. One female informant said:

> *"... husbands and wives often have rows because the wife has not given birth to a son. This might end up in divorce".*
> *(Female member of Women's Union)*

Summarizing the findings, the informants perceived violence as an interplay between individual and family-related factors and socio-cultural norms and practices where Confucian ideology exerted a strong influence. Furthermore, it was pointed out that violence against women was not discussed openly in the community and women subjected to violence kept silent and avoided seeking help in order not to reveal what was happening in the family.

Risk factors found in the epidemiological studies (papers II, III)

The focus group discussions served the purpose of informing the research group on what perceptions professionals and activists had on why violence occurs in society. Some of these findings were further tested in the epidemiological studies.

Below follows a detailed description of the risk factors found and evidence was sought for the notion that well-educated men use mainly psychological violence while less educated men mainly exercise physical violence.

Associations with socio-demographic and psychosocial factors (paper II)

The youngest age group was the most exposed to physical/sexual and also psychological abuse alone in the past year, with a slight decrease over the age groups. The number of children in the family did not influence violence occurrence, irrespective of type of violence or time span (Tables 6a and 6b).

Respondents' as well as partners' low educational attainment were statistically significant risk factors for lifetime physical/sexual violence as was low household income and polygamy (Table 6a). If the husband had passed primary school only, the risk of physical/sexual violence was more than twice as high as if the husband was highly educated (OR 2.33 with 95% confidence intervals, CI, of 1.35–4.02). For women married to a husband with multiple wives there was a more than two-fold risk increase of lifetime physical/sexual violence (OR 2.44; 1.60–3.72).

For past year physical/sexual violence, only husband's low educational attainment and the family being extremely poor came out as statistically significant risk factors (OR 2.77, 1.34–5.73 and OR 2.10, 1.12–3.94, respectively). Living with a husband with multiple wives failed to reach statistical significance as a risk factor (OR 2.03; 0.87–4.74), probably due to small sample size.

For psychological abuse alone a difference in risk factors appeared. Women with secondary schooling were at twice as high a risk of having experienced violence in her lifetime than those with higher education (OR 2.00; 1.23–3.25) while primary schooling did not show statistical significance as a risk factor (Table 6b). Also, for a woman married to an unskilled/semiskilled worker the risk of psychological abuse was high (OR 2.68; 1.68–4.28), while husbands' educational level was of no statistical significance. The same pattern was found for past year psychological abuse alone.

Interestingly, women married to men with more than one wife were at risk of physical/sexual violence but not of psychological abuse alone. Separate analyses of the 130 polygamous households revealed that they belonged to the poorest strata, that the husbands were likely to be of older age (72% were 40 years of age or older), low-educated and with son-preference attitudes.

Table 6a. Associations between socio-demographic and psychosocial variables and lifetime and past year physical/sexual violence, age adjusted. N = 883

Variables	Lifetime prevalence of physical and sexual violence (*n* = 201)		Past year prevalence of physical and sexual violence (*n* = 81)	
	% (*n*) with violence exp.	OR (95% CI)	% (*n*) with violence exp.	OR (95% CI)
1. Respondent's age				
46–60	23.1 (64)	1	5.1 (14)	1
30–45	23.9 (97)	0.97 (0.49–1.91)	9.6 (39)	1.21 (0.41–3.58)
17–29	20.0 (40)	0.73 (0.24–2.24)	14.0 (28)	1.26 (0.23–6.86)
2. Respondent's education				
High school or Higher education	12.7 (17)	1	6.7 (9)	1
Secondary school	24.6 (138)	2.25 (1.30–3.87)	10.2 (57)	1.67 (0.80–3.49)
Primary school	24.3 (46)	2.18 (1.16–4.10)	7.9 (15)	1.89 (0.77–4.63)
3. Husband's education				
High school or Higher education	14.4 (26)	1	7.2 (13)	1
Secondary school	24.5 (118)	1.93 (1.21–3.06)	8.7 (42)	1.28 (0.67–2.47)
Primary school	28.3 (45)	2.33 (1.35–4.02)	15.1 (24)	2.77 (1.34–5.73)
4. Annual household income				
> 570 USD	16.2 (57)	1	6.0 (21)	1
288–570 USD	26.6 (94)	1.91 (1.32–2.77)	10.2 (36)	1.61 (0.91–2.84)
< 288 USD	27.3 (48)	1.98 (1.28–3.07)	13.1 (23)	2.10 (1.12–3.94)
5. Number of children				
1–2 children	23.4 (109)	1	10.7 (50)	1
> 2 children	23.1 (90)	0.96 (0.66–1.40)	7.7 (30)	1.30 (0.72–2.36)
6. Husband's working specifics				
Professional	18.7 (32)	1	7.0 (12)	1
Unskilled or semi-skilled	24.4 (140)	1.43 (0.93–2.21)	10.5 (60)	1.47 (0.77–2.80)
7. Husband having more than one wife/partner				
No	20.0 (142)	1	9.0 (64)	1
Yes	36.9 (48)	2.44 (1.60–3.72)	8.5 (11)	1.30 (0.64–2.63)

OR: Odds ratios; CI: confidence interval.

Table 6b. Associations between socio-demographic and psychosocial variables and lifetime and past year psychological abuse alone, age adjusted. *N* = 883

Variables	Lifetime prevalence of psychological abuse alone (*n* = 230)		Past year prevalence of psychological abuse alone (*n* = 224)	
	% (*n*) with Violence	OR (95% CI)	% (*n*) with Violence	OR (95% CI)
1. Respondent's age*				
46–60	26.4 (73)	1	20.6 (57)	1
30–45	25.1 (103)	1.32 (0.68–2.53)	26.4 (107)	1.43 (0.73–2.80)
17–29	27.5 (55)	1.96 (0.66–5.78)	30.0 (60)	1.76 (0.59–5.27)
2. Respondent's education				
High school or higher education	17.2 (23)	1	18.7 (25)	1
Secondary school	29.5 (165)	2.00 (1.23–3.25)	29.3 (164)	1.83 (1.14–2.94)
Primary school	22.2 (42)	1.29 (0.72–2.33)	18.5 (35)	1.19 (0.63–2.25)
3. Husband's education				
High school or higher education	25.6 (46)	1	22.8 (41)	1
Secondary school	28.3 (136)	1.14 (0.77–1.69)	28.1 (135)	1.34 (0.89–2.00)
Primary school	25.2 (40)	0.95 (0.58–1.55)	25.8 (41)	1.24 (0.75–2.04)
4. Annual household income				
> 570 USD288–	27.4 (96)	1	23.9 (84)	1
570 USD	26.3 (93)	1.27 (0.83–1.95)	28.0 (99)	1.19 (0.85–1.68)
< 288 USD	22.7 (40)	1.22 (0.80–1.86)	22.2 (39)	0.86 (0.56–1.33)
5. Number of children				
1–2 children	25.1 (117)	1	26.2 (122)	1
> 2 children	28.0 (109)	1.20 (0.84–1.73)	24.4 (95)	0.91 (0.67–1.24)
6. Husband's work specifics				
Professional	14.0 (24)	1	17.0 (29)	1
Unskilled or semi-skilled	30.2 (173)	2.68 (1.68–4.28)	31.2 (179)	2.23 (1.44–3.44)
7. Husband having more than one wife/partner				
No	27.6 (196)	1	26.9 (191)	1
Yes	21.5 (28)	0.69 (0.44–1.10)	20.0 (26)	0.68 (0.43–1.08)

OR: Odds ratios; CI: confidence interval.

Multiple logistic regression analyses were performed in four separate models with dichotomized independent variables to further investigate chains of associations and to control for possible confounding factors, displayed in Table 7. This procedure did not change the risk factor pattern for either lifetime physical/sexual violence or psychological abuse, whether lifetime or past year exposure. For past year occurrence of physical/sexual violence, only low household income remained as a statistically significant factor all through the analysis (Table 7).

Table 7. Associations between socio-demographic and psychosocial variables and physical/sexual and psychological abuse alone, final models, age adjusted. *N* = 883.

Variables	Physical/sexual violence over the lifetime OR (95% CI)	Physical/sexual violence, past year OR (95% CI)	Psychological abuse alone, lifetime OR (95% CI)	Psychological abuse alone, past year OR (95% CI)
Respondent's education				
Secondary school	1.90 (1.04–3.48)	1.46 (0.65–3.28)	1.86 (1.07–3.23)	1.67 (0.99–2.83)
Primary school	1.69 (0.82–3.47)	1.72 (0.64–4.64)	1.18 (0.59–2.36)	1.17 (0.60–2.28)
Husband's low education	1.77 (1.08–2.92)	1.24 (0.63–2.46)	2.73 (1.66–4.49)	2.41 (1.50–3.87)
Low household income	1.74 (1.22–2.49)	1.88 (1.13–3.13)	0.80 (0.56–1.16)	0.89 (0.63–1.28)
Husband with more than one wife/partner	2.48 (1.55–3.98)	1.34 (0.64–2.81)	1.02 (0.60–1.73)	0.93 (0.55–1.59)

OR: Odds ratios; CI: confidence interval.

Effect modification of husband's and respondent's educational level combined and lifetime and past year risk of physical/sexual violence (not in the papers)

Educational attainment appeared a most important factor for any form of violence occurrence. To further investigate this, interaction analyses were performed with a combined variable for the respondents' and her husbands' educational achievements, as shown in Table 8. This data has not been presented in any paper but was performed due to interest.

For lifetime physical/sexual violence, the two combinations indicating status inconsistency were highly significant as risk factors. However, the highest risk was displayed when both partners were low-educated, giving an almost five-fold risk increase (OR 4.75; 1.88–12.03).

Regarding psychological violence alone, there was a somewhat different pattern. Here, any combinations apart from both being highly educated came out as statistically significant risk factors for psychological violence alone, with the respondent being low-educated and the husband high-educated displaying the highest risk (OR 4.84; 2.02–11.57) (Table 8).

Taking together the findings on the husbands' educational level and its association with violence perpetration, there is some support for the view put forward by the informants in the focus group discussions that more educated men use psychological violence to a higher extent than low-educated men who exercise mainly physical violence. However, the findings are not totally conclusive and more research is needed to disentangle these associations in detail.

Table 8. Effect modification of husband's and respondent's educational levels combined and lifetime and past year risk of physical/sexual violence, age-adjusted. *N* = 883

Variables	Lifetime risk of physical/ sexual violence (*n* = 201) OR (95% CI)	Lifetime risk of psychological violence alone (*n* = 230) OR (95% CI)
Respondent high education and husband high education (*N* = 72)	1	1
Respondent low education and husband high education (*N* = 113)	3.07 (1.10–8.55)	4.84 (2.02–11.57)
Respondent high education and husband low education (*N* = 62)	3.22 (1.07–9.72)	3.22 (1.23–8.46)
Respondent low education and husband low education (*N* = 578)	4.75 (1.88–12.03)	3.51 (1.57–7.83)

Association between witnessing interparental violence and IPV in women's later life (paper III)

Women who had witnessed interparental violence as a child were almost three times as likely to have experienced physical/sexual violence within their own relationship than women with no such experience, OR 2.85 and 95% confidence interval of 1.88–4.34 for lifetime exposure and OR 2.33 (1.31–4.15) for past-year exposure. These associations remained the same strength for lifetime and past year physical/sexual violence also when controlling for statistically significant socio-demographic factors, OR 2.84 (1.82–4.41) and OR 2.04 (1.10–3.75), respectively (Table 9).

Table 9. Association between witnessed interparental violence and IPV, final models *N* = 730.

	Lifetime physical/sexual violence OR (95% CI)	Past-year physical/sexual violence OR (95% CI)
Witnessed interparental violence as a child *(yes/no)*	2.84 (1.82–4.41)	2.04 (1.10–3.75)
Husband's education *(primary school/higher education)*	1.07 (0.67–1.71)	1.89 (1.02–3.51)
Annual household income *(< 425 USD/ ≥ 425 USD)*	1.73 (1.18–2.53)	1.77 (1.02–3.05)

Unfortunately our data did not reveal whether the participating women themselves had been abused during childhood.

Childhood history of witnessing parental violence and attitudes to violence (Paper III)

In our study, we wanted to test the hypothesis that women who had witnessed inter-parental violence would be more tolerant to violence and abuse than those who had no such experience. Six items were used to test this hypothesis and these are presented in Table 10 below. A "yes" response to any of the six attitudinal items was considered to reflect a higher level of tolerance towards violence. It was found that women who had witnessed violence to a greater extent gave a "yes" response to all items but one (suspecting unfaithfulness) than those with no such childhood experience. For the items 'not completing housework satisfactorily' and 'being disobedient', there were statistically significant differences in opinion between the groups of women with and without a history of interparental violence (p = 0.011 & p<0.001, respectively).

Table 10. Attitudes to violence among women with and without a history of interparental violence, N = 730.

	Attitudes to violence	Not witnessed interparental violence (n = 611)	Witnessed interparental violence (n = 119)	p
Agreement with the statement: "Does a man have a good reason to hit his wife if:"				
1	She does not complete her housework			
	Disagree	84.2 (513)	74.6 (88)	0.011
	Agree	15.8 (96)	25.4 (30)	
2	She disobeys him			
	Disagree	76.9 (466)	59.3 (70)	< 0.001
	Agree	23.1 (140)	40.7 (48)	
3	She refuses to have sex with him			
	Disagree	87.6 (525)	82.4 (98)	0.120
	Agree	12.4 (74)	17.6 (21)	
4	She asks him whether he has girlfriends			
	Disagree	95.8 (573)	94.9 (111)	0.646
	Agree	4.2 (25)	5.1 (6)	
5	He suspects that she is unfaithful			
	Disagree	88.8 (530)	89.8 (106)	0.739
	Agree	11.2 (67)	10.2 (12)	
6	He finds out that she has been unfaithful			
	Disagree	51.5 (308)	44.1 (52)	0.140
	Agree	48.5 (290)	55.9 (66)	

HEALTH CONDITIONS AND HEALTH CARE SEEKING (Paper IV)

Violence exposure and the respondents' health

Only past-year experience of violence was investigated as the health problems reported reflected the same time period. Statistically significant associations were found between past year experience of physical and sexual violence and memory or concentration problems, pain or discomfort, sadness or depression and suicidal thoughts indicating a more than 3-fold risk increase for all of these health measures (Table 11). These associations remained statistically significant after controlling for variables that showed statistical significance in the bivariate analyses, i.e. age, educational level, annual household income and husband having more than one wife/partner. The odds ratio (OR) for memory or concentration problems was then 3.7 with 95% confidence intervals of 1.8 and 7.5, for pain or discomfort OR was 3.8; 2.3–6.3, further for sadness or depression the OR was 4.5; 2.7–7.5 and for suicidal thoughts the OR was 2.8; 1.04–7.3, which indicates highly elevated risks of several serious health conditions for women exposed to physical and sexual violence (Table 11).

Table 11. Associations between selected health conditions and experience of past year physical/sexual violence. Crude and adjusted odds ratios. *N* = 883.

Health measures	Crude OR	95% CI	Adjusted OR	95% CI
Self-reported general health poor or very poor	0.9	0.5–1.5		
Difficulty walking around in the past year	1.0	0.6–1.7		
Difficulty performing usual activities in the past year	1.1	0.6–1.9		
Problem with memory or concentration in the past year	3.7	2.0–7.1	3.7	1.8–7.5
Pain or discomfort in the past year	3.8	2.2–6.4	3.8	2.3–6.3
Sadness or depression in the past year	3.9	2.4–6.3	4.5	2.7–7.5
Suicidal thoughts in the past year	3.1	1.3–7.4	2.8	1.04–7.3

The contribution of physical and sexual violence to ill health in the population (paper IV)

Attributable fraction (AF) and Population attributable fraction (PAF) were used to calculate the contribution of physical and sexual violence to ill health in the population. If physical and sexual violence could be eliminated among the 81 women exposed, their health would improve substantially as between 64 % and 78 % of all cases of the different conditions investigated could be attributed to physical or sexual violence (Table 12).

PAF indicates substantial reductions in ill health in the total population if physical and sexual violence could be eliminated. For pain or discomfort this reduction would be 16.8% of all cases, for memory and concentration problems the comparable figure would be 18.0%, for sadness or depression a possible 15.7% reduction in cases and for suicidal thoughts the reduction would be 12.4% if violence could be eliminated.

Table 12. Attributable fraction and Population attributable fraction of past year physical/sexual violence to four different health measures. *N* = 883.

Health measures	Attributable fraction	Population attributable fraction
Pain or discomfort	73.7 %	16.8 %
Memory or concentration problems	73.0 %	18.0 %
Sadness or depression	77.8 %	15.7 %
Suicidal thoughts	64.3 %	12.4 %

Of the 81 women exposed to physical/sexual violence in the past year, 40 reported injuries (49.4%). The most commonly reported injuries were bruises, scratches and abrasions, followed by cuts, bites, sprains, dislocations and fractures and also broken ear drums and eye damages. Of the injured women, 23 had to seek health care (57.5%). This indicates that the majority of the injuries were of a severe character.

SUGGESTIONS FOR INTERVENTIONS (Paper I)

Suggestions for preventive action

From the qualitative study several activities were suggested by the informants on how to prevent the violence ongoing between intimate partners. The suggestions for preventive activities were related to the different levels of societal organization, i.e. to the different levels in the ecological model and are presented here.

Further suggestions, as an outcome of the findings from the epidemiological studies, will be presented in the Conclusions section as they were not directly asked about but are conclusions drawn from the results.

Actions suggested at individual, partner and family level

Gender equality

The need for improved knowledge and understanding of gender equality issues among rural people was underlined. The healthcare staff and the farmers stressed the need for more equal life circumstances for husband and wife, where couples help and support each other, as a way to reduce violence.

Building a cultured family

In response to behaviour that has a harmful effect on lifestyle, several informants identified building 'cultured families', as a way to prevent a detrimental life-style. It means the family has to meet several criteria such as their children being good at studying, obedience towards parents, no one in the family is addicted to alcohol or drugs or gambling, there is no quarrel, no fighting or any other kind of violence in their family. Such families can be awarded a certificate by Commune people's Committee and it was seen as a successful way of reducing violence.

Action suggested at local community level

Mediation
Female informants underlined the value of women's unions as a place where women could go for meetings to discuss ways of sharing household responsibilities and other gender-related issues. All the informants, apart from some of the male physicians, regarded local reconciliation groups as effective in intervening in families where violence occurred.

Health care professionals
In the focus group with health professionals, the physicians and assistant physicians expressed hesitation about ways of treating violence against women. They expressed little knowledge of the magnitude of the problem in their own catchment area. The physicians suggested that violence victimization and perpetration should be the responsibility of local authorities other than the healthcare services.

Action suggested at societal level

Educate and inform
The question of how to educate and inform rural people about norms and behaviour in a changing society was discussed extensively. ‘‘Social evils’’, such as gambling, alcohol and drug addiction, have to be fought in order to reduce violence against women. In this context, it was felt that the mass media had a role to play.
Almost all the participants felt it was the party’s and the government’s responsibility to act.

Enforce policy and legislation
Among the district officials, legal action, especially the role of the local courts in relation to divorce, was discussed extensively. A female director claimed that the local courts were able to mediate in about 50% of cases.

6. DISCUSSION

SUMMARY OF MAIN FINDINGS

From the qualitative and quantitative studies we found that men's violence against women in intimate relationships is commonly occurring in rural Vietnam. In most cases the violence was of a severe nature and exercised as repeated acts over time.

From the qualitative study, it was found that violence was perceived as an interplay between individual and family-related factors and socio-cultural norms and practices, where Confucian ideology exerted a strong influence. Violence against women was found not to be discussed openly in the community and women subjected to violence kept silent.

The risk factors for lifetime and past year physical/sexual violence were women's low educational level, husbands' low education, low household income and males having more than one recognized wife. The pattern of factors associated with psychological abuse alone was somewhat different in that husbands' low professional status and women's intermediate level of education appeared as risk factors.

Having witnessed interparental violence during childhood appeared as a strong risk factor. Women with such experience were significantly more likely to report experience of physical and sexual intimate partner violence in their own adult life and they seemed to be holding a more tolerant attitude towards violence.

Health effects were also severe. Physical and sexual violence caused pain, injuries and mental health problems in exposed women. Physical/sexual violence in this way contributed extensively to common illnesses and mental ill health in exposed women. Injuries were commonly inflicted and these were fairly severe.

The findings are summarized in Figure 6 below indicating only those risk factors and health effects found in this study.

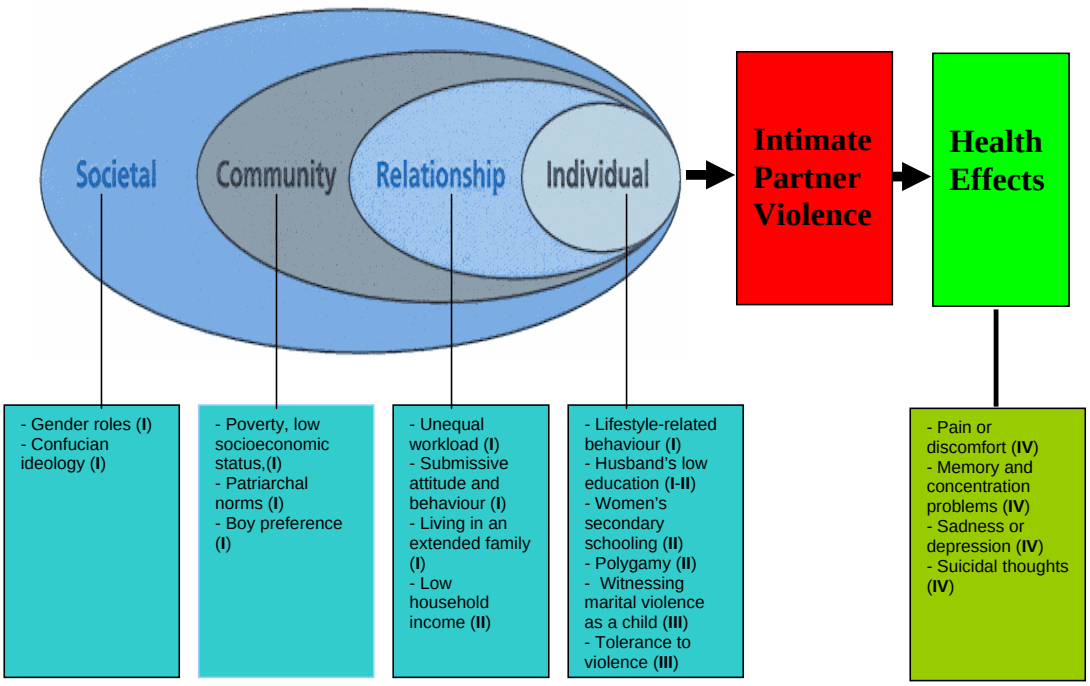

Figure 6. Summary of the findings of risk factors and health effects in this study

METHODOLOGICAL CONSIDERATIONS

Causality direction

This is a cross-sectional study and the direction of the associations for some of the variables is not possible to establish. However, statements about causality can be formulated due to time sequencing when investigating some of the socio-demographic and psychosocial factors. This pertains particularly to childhood experiences and their associations with adult violence victimization while for other factors the direction of the association can only be discussed in terms of plausibility.

Underreporting

When researching such a sensitive matter as violence within the family, underreporting is a universal phenomenon (Hegarty et al., 2000). In this study the data was collected by experienced and trained female field interviewers recognized by the respondents as collectors of general field site data every third month in face-to-face interviews. The field workers were however not living in the same area as the respondents. The fact that the field workers were somewhat known to the respondents could have restrained some women from telling about violence experiences, but we believe that this relative familiarity rather contributed to feelings of trust and

confidence and made disclosure rates higher. The rationale behind this conclusion is that women, and also men for that matter, seemed not to hesitate to talk about such a sensitive matter in the focus groups and some of the female informants also stated that they appreciated being asked about this commonly occurring problem in the community. Hereby it is believed that the women in the individual interviews would to a high extent feel the same.

On the other hand, the results could have been affected also by the fact that all data were based on self reports and hereby inflated. Women suffering from depression for instance might suffer a generally negativistic attitude and hereby rate the violence inflicted upon her as more serious or more often occurring than a woman who is not depressed. In this sense there might be a risk of over-reporting of violence experiences.

It is widely assumed that experience of violence or abuse might be underestimated because of mere underreporting, as a woman's experience of childhood or adult violence is a sensitive piece of information, which she might hesitate to reveal (Krantz & Östergren, 2000). According to the Vietnamese tradition of not telling outsiders about family matters and the fact that any form of violence is a serious event that should be kept within the family, the phenomenon of over-reporting is judged not to be a problem in these studies. Furthermore, the fact that several of the independent variables showed low inter-correlation, and came out as independent of each other in the multivariate analysis, speaks strongly against this.

Recall bias

Past-year prevalence is often thought to be a more reliable assessment of intimate partner violence because of the assumption of less recall bias (Gil-Gonzales et al., 2007). However, recent events of violence might be more difficult to report due to feelings of shame or fear of retaliation when disclosing such family problems, especially sexual violence incidents.

There is an advantage to report both lifetime and past-year prevalence as they indicate different time perspectives. It further might be that recall bias is generally less in studies on such grievous experiences as intimate partner violence than when inquiring about less sensitive matters. There is support for this notion in a study from Tanzania (Moshiro et al., 2005) but as violence is something women in general and also in Vietnam are not immediately willing to disclose, there is always a risk of underreporting. Another important bias regarding the life-time risk is of course differential recall bias, but if at hand, it will lead to an underestimation of the found risks. Therefore our results probably represent rather conservative estimates.

It could be argued that this is a case-control study where the cases produced during a certain time period are collected at the same time as the controls. Ideally, exposure of risk factors should be compared between cases and the complete population in a case-control study, while here exposure is compared between cases and non-cases. This will result in an overestimation of risk ratios, if risk factors are more prevalent in the complete population, compared to the non-cases. This is usually an error within acceptable limits if the risk is less than 20% (Rothman, 2002). Regarding the risk of past-year IPV, only 'psychological abuse alone' exceeded this risk (25.4%).

Health measures chosen

Some of the health measures used were conditions commonly occurring in women, not specifically related to violence experience but occurring for several different reasons, such as chronic pain, sadness and depression and general health. These may also mirror a state of stress, while for instance suicidal thoughts mirror more serious mental ill health. There is reason to believe that women being subjected to violence also suffer constant stress. In support of this, the Attributable Fraction (AF) and Population Attributable Fraction (PAF) indicated to what extent these conditions were associated with being a victim of violence. It was found that IPV made substantial contributions to common illnesses as well as to more serious conditions. This makes us believe the health measures chosen were relevant.

COMPARING RESULTS WITH FINDINGS IN OTHER STUDIES

Prevalence of IPV and overlap between different forms of IPV

From neighboring China, a study from an out-patient gynaecological clinic used the same violence definitions and methodology as in this study but was healthcare-based (Xu et al., 2005). It revealed that 38% of the women seeking care reported physical violence experience over their lifetime while 21% reported past-year exposure and the corresponding figures for physical and sexual violence were 43% and 26%, respectively.

In the WHO-multi country study, presenting data from ten countries on lifetime experience of physical violence, severe and repeated violence was reported as ranging from four percent in urban Japan to 49 % in provincial Peru (Garcia-Moreno et al., 2006), to be compared with 15 % in our study. In a population based survey from Nicaragua, the corresponding figure was much higher (52 %) (Ellsberg et al., 2000).

Disclosing violence experiences is dependent on several factors mentioned earlier, which explains the wide variations found in studies from different countries. Valladares et al, (2005) stress fear of retaliation and whether any support is available as strong reasons for probable under-reporting. Sexual violence was probably underreported in our study as less than three percent of the women reported having been physically forced to sexual intercourse. This conclusion is based on findings from an earlier qualitative study where sexual violence was discussed by mainly health care staff who reported it to be a rather common phenomenon in rural parts (Krantz et al., 2005). Also, rape within marriage in Vietnam is not acknowledged as a crime, which probably contributes to low reporting of sexual violence.

Few studies investigated the overlaps between different forms of violence but in studies reporting from Nicaragua and South Africa, physical and psychological abuse combined was the most commonly occurring form closely followed by psychological abuse as a single form of violence (Dunkle et al., 2004; Ellsberg et al., 2000). This is opposite from what was found in our study. It might be explained by differences between countries in what acts that are considered as violence; especially acts of psychological oppression might be interpreted differently in different cultural contexts.

Risk factors

In the qualitative study, perceptions and experiences of IPV were discussed. In doing the analysis, the informants' explanations of why IPV occurs appeared as an interplay between individual, family-related factors and socio-cultural norms relating to gender roles and practices in line with Heise's ecological model (1998) for ways of understanding risk factors for IPV.

As the informants in this study were either professionals or lay people involved in IPV at the local level, the explanations reflected their involvement in this issue and desire to understand why violence happens. Individual male factors considered to cause violence were low educational attainment, detrimental lifestyle behaviours (''social evils''), and notions about women's inferior status. If a woman challenged existing gender norms by earning a higher salary than her husband or was in a higher position, this was perceived as contributing to IPV. There is support for these findings in other studies where women's higher status in the family has been found to be a greater risk factor for violence than absolute income (Jewkes, 2002).

Following upon this qualitative study was the prevalence study where poor socio-economic conditions also appeared as a statistically significant risk factor, which is much in support of the findings from the qualitative study.

This is also a general finding in many studies, i.e. that poor socio-economic conditions contribute to violence in the family (Koenig et al., 2003; Malcoe et al., 2004; Swahnberg et al., 2004; Valladares et al., 2005). However, findings like these mainly refer to physical violence while the issue of psychological abuse as a single entity is not much researched. Study II indicated a clear association between low SES and physical violence, in that regardless of how SES was measured (educational level or income), low SES in the husband was associated with a higher risk of physical violence. However, regarding the association between the husband's SES and psychological abuse, the pattern was less clear. Low professional status of the husband was associated with a high risk of this type of violence while the associations with the husband's education and household income were weak. The reason for this pattern might be complex and involving factors like education as both a source of information and a change agent for social norms, which could interact with factors like concordance in spouses' levels of education.

Staying with a co-wife was the strongest single risk factor for lifetime physical/sexual violence. Similar findings have been reported in studies from China (Xu et al., 2005) and Uganda (Kaye et al., 2002). But interestingly enough, in our study this factor was not associated with psychological abuse.

The suggested difference in socio-demographic risk factors as pertains to physical/sexual and psychological abuse as a single entity was an interesting finding. A common violence escalation pattern has been described that starts with milder forms of psychological abuse that over time steps up to include controlling behaviours and later into serious forms of physical violence (Piquero et al., 2006). However, we found that a considerable proportion of the participating women had never been physically victimized but psychologically abused and possibly over a longer period of time as the majority (175 women, 20%) were 30 years of age or above. This gives support to our hypothesis that the two forms of violence,

physical/sexual on the one hand and psychological abuse alone on the other hand, might occur as separate entities where the perpetrators might differ in several aspects.

The qualitative findings were supported by the quantitative results in that violence against women in intimate relationships is a common phenomenon in Vietnam; it is often exercised as repeated acts and low-educated men seemed to use physical/sexual violence more often, while high-educated men seemed to use psychological violence more often.

Association between witnessing parental violence as a child and lifetime & past year physical/sexual violence and women's tolerance with violence

In a next step the association between having witnessed interparental violence as a girl child and the risk of later becoming a victim of violence was investigated and specifically the hypothesis that such early life experience could give rise to a more tolerant attitude to violence.

Studies report diverging results when it comes to an association between a history of witnessing interparental violence as a girl and subsequent exposure to intimate partner violence. In general, there is more consistent support for offender characteristics, rather than victim characteristics, being related to the occurrence of wife assault (Hotalling & Sugarman, 1990). However, in a population-based telephone survey in Washington state, USA, Bensley et al (2003) found that among women who had witnessed interparental violence there was an almost four-fold increase in the risk of physical IPV. Another well-controlled study that included 1443 women seeking medical care reported a similar result (Coker et al., 2000) whereas Hotaling and Sugarman (1990) compared four review studies and found support for this association in only two of them.

Attitudes towards violence

It has been suggested that women who have witnessed violence between parents may perceive such violence as a normal part of family life, resulting in a higher tolerance towards such violence and aggression (Henning et al., 1996). It has further been found that women who experienced intimate partner violence express views consistent with more traditional values (Xu et al., 2005).

As a clear association was found between witnessing violence between parents and own exposure to intimate partner violence in later life, the aim was to try the hypothesis that this was linked to a more tolerant attitude towards violence among those women who carried experience of violence between parents since they were young.

In our study, it was also found that women who had witnessed interparental violence tolerated their husband's use of violence to a higher degree. This conclusion rests on the finding that more women in the "witnessing group" agreed with the six attitudinal statements following on from "Does a man have a good reason to hit his wife if…" than among those who had not witnessed any interparental violence. For the two items describing events occurring fairly frequently (not completed housework satisfactorily and disobeying the husband), a statistically significant difference

between the groups was found. Our interpretation is that in relation to such commonplace life events where one would not expect any woman to tolerate violent behaviour, it seems the women with a history of interparental violence did so anyway.

However, when it came to more sensitive relationship matters (refusing to have sex, infidelity matters), the women with childhood experience of interparental violence were ready to accept violence to a certain degree, but so were also the women with no experience of interparental violence during childhood. This latter phenomenon may mirror cultural thinking being embraced by all women, reflecting men's preferential right of interpretation in such matters (Kabeer et al., 2005), rather than an acquired tolerance based on one's own life experiences. This higher level of tolerance among women with childhood experiences of interparental violence is an important finding not actually investigated in many studies but mentioned as a plausible explanation (Bensley et al., 2003; Carlson, 1984; Columbus et al., 1988; Forsstrom-Cohen & Rosenbaum, 1985; Haj-Yahia, 2001; Jaffe et al., 1990; McDonald & Jouriles, 1991; Straus, 1992; Straus et al., 1980; Wolak & Finkelhor, 1998).

Drawing on the findings by Haj-Yahia (2001), who observed that a history of interparental violence had a stronger impact on females than on males with respect to feelings of hopelessness, it could be argued that hopelessness contributes also to a 'giving-up' attitude resulting in a higher tolerance towards violence victimization. However, it is important to point out that the higher tolerance noted here also could be due to other life circumstances facing women.

Association between intimate partner violence and health effects, population attributable risk

The recent study by Ellsberg and colleagues (2008) from the WHO multi-country study found statistically significant associations between lifetime experiences of partner violence and self-reported poor health, as well as with health problems experienced in the previous four weeks such as difficulty walking, difficulty with daily activities, pain, memory loss, dizziness and suicidal thoughts. Comparisons between this study and our findings are highly relevant to make as we used the same questionnaire and the health measures are the same. Their results are also in support of our findings, but the rather unspecific health measures general health, inability to walk or to perform daily activities did not come out as statistically significant factors in our study. However, the WHO study used pooled data from many countries and lifetime experience of violence, which probably contributed to a higher level of statistical power.

The relationship between intimate partner violence and suicidal tendency among women is a pressing public health problem. Our findings are similar to the findings from USA and Spain in that women who experienced IPV were more likely to attempt suicide than those with no history of IPV (Bonomi et al., 2007; Pico-Alfonso et al., 2006; Reviere et al., 2007).

As some of the health conditions used in these studies are commonly appearing health problems in women (difficulties to walk, self-rated health, chronic pain, sadness or depression) (Krantz & Östergren, 1999) appearing for a number of different reasons, it was decided to calculate the extent to which physical and sexual violence

contributed to these conditions. This was done by calculating the attributable fraction (AF) and the population attributable fraction (PAF) (Beaglehole et al., 1993).

Substantial contributions of physical and sexual violence to women's common illnesses were found. The conclusion to be drawn from this is that if violence in intimate relationships could be stopped, women's health would improve substantially. However, it also draws attention to the fact that when women seek health care for common symptoms and illnesses, health care staff needs to be aware that serious life circumstances, such as being subjected to repeated violence and abuse, also contribute to this kind of illnesses.

However, our interpretation of the estimated AF and PAF should be understood on the basis that these measures indicate only the comparative importance of exposures in question. As clarified by for instance Beaglehole et al (1993), the percentage sum contributed by causal factors in these types of estimates is not limited to 100%.

VALIDITY AND RELIABILITY

Validity and reliability issues have been discussed in the methodological considerations section above as concerns the data sampling procedure etc. However, it seems important to also relate some of the experiences encountered during this research, such as how validity and reliability can be ensured in a study of this kind, investigating a sensitive topic which people have been taught not to talk about? What about willingness to discuss knowledge and perceptions on violence in focus group discussions when some of the participants might have been or still are exposed to this same kind of violence that is being discussed? Were the interviewers reliable, i.e., could they be expected to pose extremely sensitive questions relating to family matters to women? What about their personal exposure to violence? Why were the non-responders so few?

The research team, comprising Swedish and Vietnamese researchers in collaboration, started this project by performing the focus group discussions. A fear was that the males and females asked to participate in the FGDs would disclose own violence experiences. It was underlined that personal experiences were not to be discussed in the FGDs but solely their knowledge and perceptions as professionals. This worked out well.

During the FGDs, the discussions were lively and the participants several times pointed out the importance of being asked about this serious health problem which they often encountered in their roles as professionals. The female participants, in a very polite way but quite often, pointed at divergent opinions on certain matters expressed by male participants. It became obvious that the female participants felt they were more knowledgeable on this topic than the male participants.

For the epidemiological field study, the interviewers employed at the FilaBavi demographic surveillance site were engaged and given special training on violence issues and the questionnaire was thoroughly tested in the group. During this procedure it occurred to the research team that these women might themselves be victims of violence. The way to handle this was to give the interviewers the possibility to

withdraw from the study without stating why. No one took this step and the interviewers were never directly asked about their own experiences of violence.

A problem was however encountered later. It was discovered that the interviewers had not asked unmarried women any questions related to violence victimization. In this way they did not follow the protocol. When asked about this, it became evident that the interviewers regarded unmarried women as out of reach of violence incidents. Also, the interviewers held the strong view that unmarried women could not be asked these kinds of questions (violence items) due to the sensitivity of the topic. This had to be accepted and only married/partnered women were included in this study. Therefore, we have no idea whether or to what extent younger unmarried women also are exposed to violence from, for instance, boyfriends.

GENERALISING THE RESULTS TO THE WHOLE OF VIETNAM

The findings presented in this thesis on violence in intimate relationships can possibly be generalized to rural populations in all of Vietnam, taking cultural factors and educational attainment into consideration.

Our study population consisted to more than 90% of the ethnic majority group Kinh. As Kinh people also form the majority of the total Vietnamese population, there is no reason to believe that any possible cultural influence on violence perpetration would bias the results obtained in this study. Rather these findings could be seen as a proxy for the whole of rural Vietnam. Unfortunately it was not possible to investigate whether patterns of violence or risk factors were different among minority groups as they were poorly represented in our data. The minority groups in Vietnam often live in the poorest areas of the country with the least access to higher education and a common notion is that they are therefore more gender traditional, i.e. patriarchal thinking is more commonly applied to women's and men's expected behavior. As an effect, it could be that minority women are more exposed to violence than the majority people, Kinh.

Urban populations may be different in terms of violence perpetration as educational levels generally are higher, which might lead to less of intimate partner violence. Women are also more often in paid employment, which contributes to their independence and possibly this will reduce their tolerance towards violence. This is however mainly a speculation and we have no data so support this notion.

Studies are needed on violence perpetration among urban, rural and ethnic minority populations in different parts of Vietnam in order to get a comprehensive picture of intimate partner violence against women in the whole of Vietnam.

7. CONCLUSIONS

The findings of this thesis highlight important aspects of a hidden public health problem in a rural district of Vietnam.

i. Men's violence against women in intimate relationships is commonly occurring in rural Vietnam. In most cases the violence is of a severe nature and exercised as repeated acts over time.

ii. Violence perpetration is a serious violation of women's human rights that causes not only long-term suffering in exposed women, it also impairs their productive life and affects negatively the strive towards gender equality and in this sense is an obstacle towards development.

iii. The responsibility of communities, social support groups, authorities, and mass organizations is very important. If they do not intervene to prevent and control IPV comprehensively and effectively, IPV will continue to hamper development towards gender equality.

iv. It is necessary to improve the role of the social support network, and to improve the awareness of the issue among husbands and wives, to ensure gender equality and the legal rights of women.

v. If violence within the family sphere is not combated, it will continue to influence not only women's health but also children's health, causing psychological disorders from which follows both the risk of children growing up to maltreat their future wives and learning to tolerate violence like their mothers did. This is the IPV dilemma cycle.

vi. Women must be better informed about not having to accept violence from their husbands/partners. Women should be encouraged to disclose IPV and seek health care when subjected to any kind of violence with and without physical injuries and not to keep silent or resign to self-treatment.

vii. Collaboration between different sectors at all levels from central to local level, between the health sector and other bodies, and with community leaders and women's union representatives as spokesmen would help to improve openness and reduce society's tolerance of violence against women. Mass media and community officials play an important role in reducing intimate partner violence against women.

IMPLICATIONS FOR ACTION AND RESEARCH

(i) The Ministry of Health in collaboration with the Central Women's Union, the Ministry of Information & Communication (Media), the Ministry of Education and Training, the Ministry of Police, and related sectors are to establish a national programme on prevention and elimination of domestic violence in Vietnam recognized by all bodies. A steering committee from central level to provincial, district and commune levels should be established.

(ii) The Ministry of Health in collaboration with the Ministry of Education and Training and authorities at all levels (central to local) need to launch the programme to decrease/eliminate IPV.

(iii) These sectors will make a plan and disseminate it through the media. Education/training courses, daily working routines and feasible job descriptions for each member of the steering committee in the system will secure a wider spread. Collaboration is needed between health workers, police, media, women's unions, the educational system and authorities at the community level. Curricula, materials on IPV and gender equality education for couples before and after wedding/marriage and even for pupils and students at schools and colleges should be developed.

(iv) A strong legislative framework for disclosing and criminalizing IPV in Vietnam is essential in generating exact information and proper sentences. However, in the present context it must be implemented in parallel with appropriate awareness and more active participation of province, district and commune officials in notification of IPV.

(v) The public awareness of the seriousness of IPV and its consequences needs to be raised. IPV should be discussed through information, education and communication (IEC) programmes to make people understand their legal obligation to report IPV.

(vi) Health care facilities through their health workers should pay adequate attention to IPV victims and provide adequate services, information, consultations, and support (shelters) to them.

(vii) Women's Unions in collaboration with the health sector should organize training courses, meetings and seminars in order to educate people to understand the law on prevention and control of intimate partner violence, to become better informed about IPV, its risk factors and consequences and suitable intervention measures.

(viii) At the commune and village level, women's unions, reconciliation groups and heads of villages need to recognize IPV, implement reconciliation activities and contribute in educating people to understand and prevent IPV against women.

(ix) Emphasis needs to be put on gender equality issues and to improve the role of women in the family and in society at large, including to improve women's autonomy in economic matters and to raise women's awareness of IPV to make women more independent of husbands and family-in-law.

(x) More studies are needed on the role of alcohol, of husbands' controlling behaviours towards their wives and on violence during pregnancy and its consequences to women's and children's health.

(xi) Intervention projects/programmes should focus on risk factors and on the health effects presented in this thesis. Furthermore, studies are needed to follow the improvement of women's status in society, gender roles and on women's economic autonomy, especially in rural parts where the educational levels are low. Assessment of the effectiveness of different intervention measures to reduce IPV in Vietnam is of high importance.

8. ACKNOWLEDGEMENTS

Many people have played a crucial role in the work behind this thesis. My sincere thanks go to all women in the Ba Vi district, FilaBavi surveyors and field supervisors, and especially to bereaved people who voluntarily participated in my study and willingly shared their experiences, views and opinions with me on the research topics. Their contributions are invaluable and unforgettable.

This thesis is the outcome of an ongoing Vietnam-Sweden co-operation programme, 'Health Systems Research' funded by Sida/SAREC, Sweden, and co-ordinated by the Health Strategy and Policy Institute; later by Hanoi Medical University; Ministry of Health, Vietnam; and IHCAR, Department of Public Health Sciences, Karolinska Institutet and Clinical Medicine, University of Umeå; The Nordic school of Public Health, Sweden. I would like to express my great thanks to all institutions and everyone who has contributed to and helped me with my training and research.

First of all, I would like to say forever thanks and carve deeply in my heart the most sincere gratitude to my main supervisor Associate Professor Gunilla Krantz. I am very grateful for and impressed by your excellent academic teaching, tutoring and supervision that have broadened my scientific views and knowledge. You always give me your hands in my research work by the most effective way and at the same time you encourage me to go further and make me feel more confident.

I would like to express many special thanks to Professor Vinod Diwan and Associate Professor Ngo Van Toan, the second supervisors who helped me a lot with guidance, encouragement, and comments during my study and thesis writing.

I would like to express my great thanks and gratitude to Associate Professor Nguyen Thi Kim Chuc, Dr. Anna Thorson and Professor Vinod Diwan for accepting me as a research student within the Health System Research Project and for your continuous great help and encouragement during my training and research process.

My sincere thanks go to Professor Gunnel Hensing, the Head of Department and her colleagues at the Department of Community Medicine and Public Health, Sahlgrenska Academy at the University of Gothenburg, Gothenburg, Sweden, for all the support and hospitality given during the analysis phase of this study.

I would like to express many special thanks to:

Professor Per-Olof Östergren, Professor Karin Ringsberg, Mr. Robert Jonzon, my co-authors, for their support, hard work and sharing of experiences together; as well as to the anonymous reviewers for their valuable comments on my research work.

Professor Staffan Bergström, Professor Hans Rosling for accepting me as a research student and for creating an excellent academic environment at IHCAR for which I am very grateful.

Professor Stig Wall, Professor Peter Byass, Professor Lars Lindholm, Professor Cecilia Stålsby-Lundborg, and Dr. Annika Johansson, Professor Eva Johansson for their contributions in one way or the other for my research competence development.

The Ransjö-Arvidson family, especially Associate Professor Anna-Berit Ransjö-Arvidson, who is my main peer debriefing for your scientific and critical comments on my research work, your kindness and warm-hearted care and for the fact that I always feel that I am at home.

Researchers at IHCAR and the Nordic School of Public Health: Dr. Asli Kulane, Dr. Mattias Larsson, Dr. Birgitta Rubensson, Dr Marie Klingberg, Dr. Marina Clark, Prof. Bo Ericsson, and Dr. Max Petzold for your teaching and for sharing your research experiences.

Ms. Gunmaria Löfberg from the Social Medicine Department, Ms. Birgitta Linnanheimo, Ms. Anna Stina Ullrich, Ms. Kersti Rådmark, Ms. Gunilla Risberg, Mr. Lars Hedlund, Mr. Thomas Mellin, Mr. Bo Planstedt, Ms. Elizabeth Kevin, as well as all other staff from IHCAR whose names I cannot mention for taking care of and providing me with excellent working conditions. Their contributions are truly remarkable and unforgettable.

Research students at IHCAR: Grethe Fochsen, Ziad El-Khatib and Tazeen Ali, Ayesha for valuable and useful discussions, comments related to research work, as well as sharing their experiences with me in many other aspects.

I am indebted to Mr. Kai-Mikael Jää-Aro for his valuable comments, willingness and effective help with English editing.

Many thanks to my Swedish colleagues, great friends whose contribution and encouragement and support are so meaningful to me: Mr. Göran Dahlgren, Ms. Anastasia Pharris, Dr. Lena Andersson, Mr. Allan Dale, Dr. Anders Norman, and Ms. Rose Wesley Lindahl.

I also would like to express my special thanks to Prof. Nguyen Lan Viet, the Rector of Hanoi Medical University and his Deputies as well as Prof. Dao Ngoc Phong, Prof. Truong Viet Dung, Deans of the Faculty of Public Health, HMU, and their Deputies, Dr. Chu Van Thang, Head of the Department of Environmental Health and Dr. Tran Chi Liem, Head of the Department of Demography and my colleagues and friends in the Faculty of Public Health, HMU, Dr. Duong Huy Lieu, Director of the planning and finance department, former head of the health policy unit and Dr. Nguyen Hoang Long, Deputy Director of the planning and finance department, head of the health policy unit, ministry of health of Vietnam where I work, for their strong support and great encouragement in my PhD training, even during my times when the workplace was very busy.

I should not forget to express my sincere thanks and to acknowledge the support and valuable contributions from my colleagues and friends: Nguyen Binh Minh, Tran Van Phuong, Nguyen Thi Bich Thuan, Viveca Larsson for their great contribution in data collection in the first phase of the study; Tran Quang Huy, Pham Thi Lan, Ho Dang Phuc, Duong Duc Thien, Hoang Van Minh, Nguyen Phuong Hoa, Le Thi Hoan, Nguyen Quynh Hoa, Kim Bao Giang, Dao Lan Huong, Tran Thanh Do, Dao Dinh Sang, Nguyen Thi Nguyet Minh, Dang Thi Tuyen, Truong Hoang Long, Hoang Truc Phong, Lam Thi Thanh Xuan, Nguyen Duy Khe, Hoang Minh Hang, Pham Thai Son, Le Thi Thanh, Le Van Hoi, Tran Mai Oanh, Do Duy Cuong, Dinh Thanh Huyen and so many others that I cannot mention all their names.

I also wish to extend my thanks to my colleagues and staff in the Department of Demography, Department of Environmental Health Faculty of Public Health, Hanoi Medical University, as well as my friends in the Health Policy Unit, MoH, where I am working, for their help, encouragement, and especially their willingness to share my work when I am away for training.

I dedicate this thesis and deepest gratitude to my father and to my mother who always encourages me to study and who believes in my success, and to my parents in law as well as to all of my family, especially to my wife, Nguyen Thi Hai, my daughters Nguyen Hai Anh and Nguyen Thuy Tien, for your love, sympathy, understanding, encouragement, patience, and your tolerance. I understand deeply in my heart that behind this thesis is my own family, without you, my dear wife and children, I cannot have enough courage and energy to go ahead. For that I am very grateful.

9. REFERENCES

ADB. (2005). Vietnam gender situation analysis**.** Hanoi: Asian development bank.

Anh, D. D. (1998). Viet nam van hoa su cuong (an outline history of Vietnamese culture). The second edition (in Vietnamese). *Nha xuat ban tong hop Dong Thap (Dong Thap General Publishing House)*.

Anh, D. N. (1991). The position of women in two rural communes. In: Liljestrom R, Lai T, editor. Sociological studies on the Vietnamese family. *Hanoi: Social Sciences Publishing House*, 165-174.

Barbour, R., & Kitzinger, J. (2000). Developing focus group research: Politics, theory and practice.

Beaglehole, R., Bonita, R., & Kjellstrom, T. (1993). Basic epidemiology.

Bélanger, D. (2002). Son preference in a rural village in north Vietnam. *Studies in Family Planning, 33*(4), 321-334.

Bélanger, D., Oanh, K., Jianye, L., Thuy, L., & Thanh, P. (2002). Are sex ratios at birth increasing in Vietnam? *Population (English Edition), 58*(2), 231-250.

Bensley, L., Eenwyk, J., & Simmons, K. (2003). Childhood family violence history and women's risk for intimate partner violence and poor health. *American Journal of Preventive Medicine, 25*(1), 38-44.

Bich, P. V. (1999). The Vietnamese family in change: The case of the Red River delta. *Richmond, Surrey, England: Curzon Press*.

Bondurant, A., Hendersson, S., & Nguyen, C. Q. (2003). Addressing reproductive health and rights of young people since icpd: The contribution of UNFPA and IPPF.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2007). Health outcomes in women with physical and sexual intimate partner violence exposure. *Journal of Women's Health, 16*(7), 987-997.

Bunck, J. (1997). Women and post-cold war socialism: The cases of Cuba and Vietnam. In C*uba in transition: Papers and proceedings of the seventh annual meeting of the association for the study of the cuban economy*. 31.

Carlson, B. E. (1984). Children observations of interparental violence. In a.R.Roberts (ed.), battered woman and their families. 147-167.

Chuc, N. T. K., & Diwan, V. K. (2003). Fila bavi: A demographic surveillance site, an epidemiological field laboratory in Vietnam. *Scand J Public Health, 31 (Suppl 62)*, 3-7.

Coker, A. L., Smith, P. H., McKeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: Physical, sexual, and psychological battering. *Am J Public Health, 90*, 553-559.

Columbus, O. H., Rose, L., Fantuzzo, J., & Lindquist, C. (1988). Violence in the home: The effects of observing conjugal violence on children. *Journal of Family Violence, 4*, 77-90.

Counts, D. A., Brown, J., & Campbell, J. (1992). Sanctions and sanctuary: Cultural perspective on the beating of wifes.

Dahlgen, L., Emmelin, M., & Winkvist, A. (2004). Qualitative methodology for international public health, Umeå. Umeå University.

Dong, D. T. (1991). Modification of the traditional family in the south of Vietnam. In: Liljestrom R, Lai T, editor. Sociological studies on the Vietnamese family. *Hanoi: Social Sciences Publishing House*, 69-83.

Drummond, L., & Rydstrom, H. (2004). Gender practices in contemporary Vietnam. Singapore. Singapore University Press.

Duc, N. T. H. (2004). Center for reproductive and family health in Hanoi, personal communication.

Dunkle, K. L., Jewkes, R. K., Brown, H. C., Yoshihama, M., Gray, G. E., McIntyre, J. A., et al. (2004). Prevalence and patterns of gender-based violence and revictimization among women attending antenatal clinics in Soweto, South Africa. *Am J Epidemiol, 160*(3), 230-239.

Ellsberg, M., Pena, R., Herrera, A., Liljestrand, J., & Winkvist, A. (2000). Candies in hell: Women's experiences of violence in Nicaragua. *Soc Sci Med, 51*(11), 1595-1610.

Forsstrom-Cohen, B., & Rosenbaum, A. (1985). The effects of parental marital violence on young adults: An exploratory investigation. *Journal of Marriage and the Family, 47*, 467-472.

Franklin, B. A. K. (2000). Expanding horizons: Changing gender roles in Vietnam. A report on the audience research & analysis and the media campain for gender, hanoi.

Garcia-Moreno, C. (1999). Violence against women, gender and health equity.

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the who multi-country study on women's health and domestic violence. *Lancet, 368*(9543), 1260-1269.

Gil-Gonzales, D., Vives-Cases, C., Ruiz, M. T., Carrasco-Portino, M., & Alvarez-Dardet, C. (2007). Childhood experiences of violence in perpetrators as a risk factor of intimate partner violence: A systematic review. *J Public Health*, 1-9.

GSO. (2005). Population change and family planning survey. *General Statistics Office, Hanoi, Vietnam*.

Haj-Yahia, M. M. (2001). The incidence of witnessing interparental violence and some of its psychological consequences among Arab adolescents. *Child Abuse & Neglect, 25*, 885-907.

Hamberger, L. K., Lohr, J. M., Bonge, D., & Tolin, D. F. (1997). An empirical classification of motivations for domestic violence. *Violence against women, 3*, 401-423.

Hegarty, K., Hindmarsh, E. D., & Gilles, M. T. (2000). Domestic violence in australia: Definition, prevalence and nature of presentation in clinical practice. *Med J Aust, 173*(7), 363-367.

Heise, L. (1998). Violence against women: An integrated, ecological framework. *Violence against women, 4*, 262-290.

Heise, L., Ellsberg, M., & Gottermoeller, M. (1999). Ending violence against women. *27*(11), 3-8.

Henning, K., Leitenberg, H., Coffey, P., Turner, T., & Bennett, R. T. (1996). Long-term psychological and social impact of witnessing physical conflict between parents. *J Interpersonal Violence, 11*, 35-51.

Hotalling, G. T., & Sugarman, D. B. (1990). A risk marker analysis of assaulted wives. *J Fam Violence, 5*, 1-12.

Hudson, W. W., & McIntosh, S. R. (1981). The assessment of spouse abuse: Two quantifiable dimensions. *Journal of Marriage and the family, 43*, 873-885.

Huong, D. L. (2006). Mortality in transitional Vietnam. *Doctoral Dissertation, Department of Public Health and Clinical Medicine, Umeå University*.

Huy, TQ. (2007). Mortality in rural Vietnam: Validity of routine reporting and experiences from a surveillance system. Doctoral dissertation. Department of public health sciences, Karolinska Institutet, Stockholm.

Jaffe, P., Wolfe, D., & Wilson, S. (1990). Children of battered women.

Jewkes, R. (2002). Intimate partner violence: Cause and prevention. *Lancet, 359*, 1423-1429.

Johansson, A. (1998). Dreams and dilemmas, women and family planning in rural Vietnam. *Doctoral Dissertation, Department of Public Health Sciences (IHCAR), Karolinska Institutet, Stockholm*.

Johansson, E. (2000). Emerging perspectives on tuberculosis and gender in Vietnam. Dissertation. Umeå: Umeå university, dept of public health and clinical medicine.

Kabeer, N., Van Anh, T., & Loi, V. (2005). Preparing for the future: Forward-looking strategies to promote gender equity in Vietnam. A united nation/world bank thematic discussion paper.

Kaye, D., Mirembe, F., & Bantebya, G. (2002). Risk factors, nature and severity of domestic violence among women attending antenatal clinic in mulago hospital, kampala, uganda. *Cent Afr J Med, 48*(5-6), 64-68.

Khe, N. D. (2004). Socioeconomic differences in a rural district in Vietnam: Effect on health and use of health services. *Doctoral Dissertation, Department of Public Health Sciences (IHCAR), Karolinska Institutet, Stockholm*.

Kinnear, P., & Gray, C. (2001). *Spss for windows made simple. Release 10.* Aberdeen: University of Aberdeen.

Koenig, M., Ahmed, S., Hossain, M., & Khorshed Alam Mozumder, A. (2003). Women's status and domestic violence in rural bangladesh: Individual- and community-level effects. *Demography, 40*(2), 269-288.

Krantz, G. (2002). Violence against women: A global public health issue! *J Epidemiol Community Health, 56*(4), 242-243.

Krantz, G., & Garcia-Moreno, C. (2005). Violence against women. *J Epidemiol Community Health, 59*(10), 818-821.

Krantz, G., & Ostergren, P. (2000). The association between violence victimisation and common symptoms in Swedish women. *J Epidemiol Community Health, 54*, 815-821.

Krantz, G., Van Phuong, T., Larsson, V., Thuan, N., & Ringsberg, K. C. (2005). Intimate partner violence: Forms, consequences and preparedness to act as perceived by healthcare staff and district and community leaders in a rural district in northern Vietnam. *Public Health, 119*(11), 1048-1055.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). The world report on violence and health. *Lancet, 360*(9339), 1083-1088.

Lepp, M., & Ringsberg, K. (2002). Phenomenography-a qualitative research approach. In: Hallberg LM, editor. Qualitative methods in public health research-theoretical foundations and practical examples: Lund: Studentlitteratur.

Liljestrom, R. (1991). Family, gender and kinship in Vietnam. In: Liljestrom R, Lai T, editor. Sociological studies on the Vietnamese family. *Hanoi: Social Sciences Publishing House*, 13-25.

Loi, V., Huy, V., Minh, N., & Clement, J. (2000). Gender-based violence: The case of Vietnam.

Long, L., Hung, L., Truitt, A., Mai, L., & Anh, D. (2000). Changing gender ralations in Vietnam ‘s post doi moi era: Gender and development working paper series no. 14. The world bank development research group.

Long, N. H. (2000). Gender specific epidemiology of tuberculosis in Vietnam. *Doctoral Dissertation, Department of Public Health Sciences (IHCAR), Karolinska Institutet, Stockholm.*

Malcoe, L. H., Duran, B. M., & Montgomery, J. M. (2004). Socioeconomic disparities in intimate partner violence against native American women: A cross-sectional study. *BMC Med, 2*, 20.

McDonald, R., & Jouriles, E. (1991). Marital aggression and child behaviour problems: Research findings, mechanisms, and intervention strategies. *Behavior Therapist, 14*, 189-191.

Moshiro, C., Heuch, I., Astrom, A. N., Setel, P., & Kvale, G. (2005). Effect of recall on estimation of non-fatal injury rates: A community based study in Tanzania. *Inj Prev, 11*(1), 48-52.

OMCT. (2001). Violence against women in Vietnam: Report prepared for the committee on the elimination of discrimination against women.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health, 15*(5), 599-611.

Piquero, A. R., Brame, R., Fagan, J., & Moffitt, T. E. (2006). Assessing the offending activity of criminal domestic violence suspects: Offense specialization, escalation, and de-escalation evidence from the spouse assault replication program. *Public Health Rep, 121*(4), 409-418.

Que, T. T., Uyen, N. V., & Bang, N. (1999). Gender basic concepts and gender issues in Vietnam. *Hanoi: Statistical Publishing House*.

Quy, D. T. (2000). Domestic violence in Vietnam, Asia pacific forum on women, law and development.

Reviere, S. L., Farber, E. W., Twomey, H., Okun, A., Jackson, E., Zanville, H., et al. (2007). Intimate partner violence and suicidality in low-income African American women: A multimethod assessment of coping factors. *Violence against women, 13*(11), 1113-1129.

Romedenne, M., & Loi, V. (2006). Domestic violence: The Vietnamese shift. Findings and recommendations from the UNFPA/SDC project.

Rothman, K. J. (2002). Epidemiology-an introduction.

Rubensson, B. (2005). *Working children's experiences and their right to health and well-being.* Doctoral dissertation, Karolinska institutet, Stockholm.

Rydstrom, H. (2003). Encountering "hot" anger. Domestic violence in contemporary Vietnam. *Violence against women, 9*(6), 676-697.

Rydström, H. (1998). Girls' socialisation in a north Vietnam commune. *Doctoral Dissertation, Linköping University*.

Saltzman, L., Fanslow, J., McMabon, P., & Shelley, G. (1999). *Intimate partner violence surveillance: Uniform definitions and recommended data elements, version 1.0.* Atlanta: National Center for Injury Prevention and Control.

Saso, M. (1990). Blue dragon, white tigers. Taoist rites of passage. *Hawaii: University of Hawaii Press, 16*.

Sjöström, B., & Dahlgren, L. (2002). Applying phenomenography in nursing research. *J Adv Nurs, 40*, 339-345.

Straus, M. A. (1992). Children as witnesses to marital violence: A risk factor for lifelong problems among a nationally representative sample of American men and women. In D.F. Schwarz (Eds), children and violence: Report on the 23rd cross round table on critical approaches to common pediatric problems. 98-104.

Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). Behind closed doors. New - York: Doubleday.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales. Development and preliminary psychometric data. *Journal of Family Issues, 17*, 283-316.

Swahnberg, K., Wijma, B., Schei, B., Hilden, M., Irminger, K., & Wingren, G. B. (2004). Are sociodemographic and regional and sample factors associated with prevalence of abuse? *Acta Obstet Gynecol Scand, 83*(3), 276-288.

Thinh, H. B. (2001). Vietnamese laws and domestic violence.

Tjaden, P., & Thoennes, N. (2000). Extent, nature, and consequences of intimate partner violence: Finding from the national violence against women survey. *NIJ*.

Tuyet, L. T. N., & Thu, M. T. (1978). Women of Vietnam. *Hanoi: Foreign Language Publishing House.*

UN. (1995). Beijing declaration and platform for action. Paper presented at the fourth world conference on women: Action for equality, development and peace.

Valladares, E. (2005). Partner violence during pregnancy psychosocial factor and child outcomes in Nicaragua. Doctoral disseration, department of public health and clinical medicine, Umea university, Umea, Sweden.

Valladares, E., Pena, R., Persson, L. A., & Hogberg, U. (2005). Violence against pregnant women: Prevalence and characteristics. A population-based study in Nicaragua. *Bjog, 112*(9), 1243-1248.

Werner, J., & Belanger, D. (2002). Gender, household and state: Doi moi in Vietnam. Cornell Southeast Asia programme.

WHO (2000). Who multi-country study on women's health and life experiences questionnaire.

WHO (2001). Putting women first. Ethical and safety recommendations for research on domestic violence against women.

WHO (1997). Violence against women: A priority health issue.

WHO (2002). *World report on violence and health*. Geneva: World Health Organization.

WHO (2005). Who multi country study on women's health and domestic violence against women. In who multi country study on women's health and domestic violence against women. Garcia-Moreno C, Jansen H, Watts C, Ellsberg M (Eds). 204.

Winslow, C. (1926). Public health at the crossroads. *Am J Public Health, 16*, 1075-1085.

WMA (1964). World medical association declaration of Helsinki. Ethical principles for medical research involving human subjects. Adopted by the 18th WMA General Assembly, Helsinki.

Wolak, J., & Finkelhor, D. (1998). Children exposed to partner violence. In Jasinski JL & William LM (eds). Partner violence: A comprehensive review of 20 years of research. *Sage Publication*, 73-112.

WU (1989). Vietnamese women's union and the centre for family and women's studies, Vietnamese women in the eighties. In violence against women in Vietnam: Report prepared for the committee on the elimination of discrimination against women, OMCT, 25th session. June 2001. 8.

Xu, X., Zhu, F., O'Campo, P., Koenig, M. A., Mock, V., & Campbell, J. (2005). Prevalence of and risk factors for intimate partner violence in China. *Am J Public Health, 95*(1), 78-85.

Yllo, K. (2005). Through a feminist lens "gender, diversity, and violence: Extending the feminist framework" in current controversies on family violence. Loseke DR, Gelles RJ, Cavanaugh MM (eds). *Sage Publication*, 19-34.

Yllo, K., & Straus, M. A. (1990). Patriarchy and violence against wives: The impact of structural and normative factors. In: Straus, MA, Gelles, RJ. (eds). Physical violence in American families: Risk factors and adaptations to violence in 8145 families., 383-399.