Violence against foreign-born women in Sweden

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Abstract

Violence against women (VAW) is an increasing public health concern. Prevalence of such violence may potentially be greater among foreign-born women due to lack of empowerment and other contributing factors. Research concerning violence against foreign-born women in Sweden is scarce. Thus, the general aim of this thesis was to obtain increased knowledge of exposure to interpersonal violence among foreign-born women in Sweden and to gain a better understanding of potential factors contributing to such exposure. Data was obtained from four different sources; the Scania Public Health Survey 2004 (Paper I), the Swedish Cause of Death Register 1991-2007 (Paper II), qualitative in-depth interviews with newly arrived Iraqi refugees (Paper III), and a Public Health Survey among Thai women in Sweden (Paper IV). The findings show that compared to Swedish-born women, foreign-born women are at increased risk of interpersonal violence, especially those with low disposable income, and that foreign-born women also have an increased risk of mortality due to interpersonal violence. Moreover, although information about the perpetrator was lacking in papers I and II, intimate partner violence may be implicated in some cases of interpersonal violence, due to a) significant associations with marriage/cohabitation and b) the home as a setting for such violence. Low gender equity of country of birth was also a significant determinant of mortality due to interpersonal violence. Furthermore, among Iraqi refugees in Sweden, norms governing gender roles influence perceptions of intimate partner violence. Finally, in a sample of Thai women predominantly married to Swedish men, exposure to intimate partner violence was related to poor mental health. The risk for poor mental health was greatest among abused women with perceived social isolation, and with low social trust, respectively. Thus, social trust and absence of social isolation among abused women may contribute to resilience against poor mental health. The current findings indicate the need for interventions directed towards foreign-born women, and also towards men in order to reduce VAW and its harmful effects. The potential influences of gender equity of country of birth and other determinants of violence against foreign-born women need to be further examined and taken into account in the development of preventive work. Finally, such research may help to identify the mechanisms that contribute to VAW more generally.

Key words: violence against women, foreign-born, mortality, mental health, gender equity, social isolation, Iraqi refugees, Thai women

To Jesper

"The education and empowerment of women throughout the world cannot fail to result in a more caring, tolerant, just and peaceful life for all."

Aung San Suu Kyi

Abbreviations

GHQ12	General Health Questionnaire, 12 questions
SRH	Self-rated health
OR	Odds ratio
VAW	Violence against women
WHO	World Health Organization

List of publications

I Fernbrant, C., Essén, B., Östergren, P.-O., Cantor-Graae, E. (2011). Perceived threat of violence and exposure to physical violence against foreign-born women: A Swedish population-based study. *Women's Health Issues*, 21(3), 206 -213.

II Fernbrant, C., Essén, B., Esscher, A., Östergren, P.-O., Cantor-Graae, E. Increased risk of mortality due to interpersonal violence in foreign-born women of reproductive age: A Swedish register-based study. *Manuscript submitted for publication*.

III Fernbrant, C., Essén, B., Östergren, P.-O., Cantor-Graae, E. Navigating between control and autonomy: Recently arrived Iraqi refugees' perceptions regarding honor, well-being and risk for intimate partner violence. *Journal of Immigrant and Refugee Studies* (in press).

IV Fernbrant, C., Emmelin, M., Essén, B., Östergren, P.-O., Cantor-Graae, E. Intimate partner violence and poor mental health among Thai women residing in Sweden. *Manuscript submitted for publication.*

Table of Content

Introduction

Violence against women (VAW) is prevalent all over the world, regardless of country, value system, religion, etc. The majority of the perpetrators of such violence are intimate partners or former partners (Krantz and Garcia-Moreno, 2005); thus the violence primarily takes place in the home, which makes it even more difficult to detect and prevent. VAW may have both short and long-term adverse health consequences, and the consequences are similar whether VAW concerns interpersonal violence (Flood and Pease, 2009; Krantz and Garcia-Moreno, 2005; Watts and Zimmerman, 2002) or intimate partner violence (Campbell, Jones, Dieneman, Kub, Schollenberger et al, 2002; Ellsberg, Jansen, Heise, Watts, and Garcia-Moreno, 2008; Krantz and Vung, 2009; Nerøien and Schei, 2008). The most extreme outcome of VAW is mortality (Campbell, Glass, Sharps, Laughon, and Bloom, 2007). VAW is a major public health concern as well as a violation of human rights (Campbell, 2002; Ellsberg et al, 2008; Garcia-Moreno, Jansen, Ellsberg, Heise, and Watts, 2006; Krantz, 2002; Jewkes, 2002).7

Although VAW is present in all settings and populations, previous research has shown that certain groups of women are more vulnerable than others. Such groups are less educated and less empowered women (Jewkes, Penn-Kekana, and Levin, 2002a), women with limited economic resources (Jewkes, 2002; Kasturirangan, Krishnan, and Riger, 2004), and women with subordinated positions compared to men (Abu-Ras, 2007; Chang, Shen, and Takeuchi, 2009; Krantz and Garcia-Moreno, 2005; Thapa-Oli, Dulal, and Baba, 2009). Immigrant women may have a higher concentration of such risk factors, as well as social isolation, language barriers and ignorance of facilities for seeking help, and thus an increased prevalence of VAW (Darvishpour, 2002; Raj & Silverman, 2003). Previous studies has shown that VAW, especially intimate partner violence, may be exacerbated after migration due to normative differences between the country of origin and the new country, which can enhance stress (Nilsson, Brown, Russell, and Khamphakdy-Brown, 2008), as well as lead to a change in the power dynamics within families (Jewkes, 2002; Sokoloff and Dupont, 2005). Power structures in a family and/or relationship may be altered if women who primarily acted in the private sphere before migration become an important contributor to the financial well-being of the family in the new country, thereby threatening the men's authoritative role (Carlbom, 2003; Plantin and Carlbom, 2010). An additional strain within the family may be that the men are lacking their former

networks and status from their home country, and/or may have difficulty finding employment, thus increasing the risk for intimate partner violence (Jin and Keat, 2009; Krishnan, Rocca, Hubbard, Subbiah, Edmeades et al, 2010). Also, in certain immigrant communities VAW may even be sanctioned (Abu-Ras, 2007) due to strong patriarchal values, with for example honor killings as an extreme outcome (Kulwicki, 2002).

Honor killings, the most extreme form of honor related violence, are prevalent in some group-oriented communities in order to protect or restore the honor of a family (Kulwicki, 2002). In a group-oriented society group dynamics are more important than the individuals within a group (Schlytter and Linell, 2010), and the group's reputation or honor is of utmost importance. The honor system is built on patriarchal structures and honor is primarily represented by purity and virginity among unmarried women within the group. Thus, female sexuality is owned by the group and not the women themselves. A group's honor can be damaged if a female member has pre-marital sex and thus brings shame over the group. Thus, in order to restore the honor, measures may be taken that have serious consequences for the woman, such as disowning her, abusing her, or in extreme cases killing her (Akpinar, 2003; Kandiyoti, 1988).

Sweden is one of the countries within the European Union that has received a relatively high number of refugees per capita during the last decade (UNHCR, 2013). Migration research is a growing area in Sweden, as shown in labor market studies (Bevelander, 2004; Dahlstedt, 2009) and health studies (Cantor-Graae, Zolkowska, and McNeil, 2005; Essén, Blomkvist, Helström, and Johnsdotter, 2010; Hjern and Allebeck, 2002; Sundquist, Bayard-Burfield Johansson, and Johansson, 2000). However, previous systematic research on VAW among foreign-born women in Sweden is lacking. Also, research on the prevalence of VAW in general in a Swedish context is scarce. The largest prevalence study was conducted by The Swedish Crime Victim Compensation and Support Authority in collaboration with Uppsala University, and showed that within a Swedish national-based sample of 6926 women, 12% had been exposed to interpersonal violence during the last twelve months, and 5.5% had been abused by a former or current partner during the same period (Lundgren, Heimer, Westerstrand, and Kalliokoski, 2001). However, a comprehensive report based on the material has not been published in a peer-reviewed journal. Another report, produced by The Swedish National Council for Crime Prevention (2001), showed that 80% of reported VAW in Sweden was intimate partner violence.

Other studies in Sweden have primarily focused on interpersonal violence among patients within the health care system including pregnant women, utilizing the NorVold Abuse Questionnaire (NorAQ) (Hilden, Schei, Swahnberg, Halmesmäki, Langhoff-Roos et al, 2004; Swahnberg, Thapar-Björkert, and Berterö, 2007;

Swahnberg, Hearn, and Wijma, 2009; Wijma, Schei, Swahnberg, Hilden, Offerdal et al, 2003). However, according to Campbell (2002) a higher prevalence of VAW may be found in a health care setting than in a population-based sample, because one could expect an increased number of battered women within the health care system. Interestingly, a recent study of interpersonal violence among pregnant women attending antenatal health clinics in Malmö also using NorAQ (Wangel, Schei, Östman, and Ryding, unpublished) found no differences in prevalence of abuse between Swedish-born and foreign-born women. Nevertheless, the NorAQ does not ask for the perpetrator of the violence, and thus concerns prevalence of interpersonal violence, rather than intimate partner violence. The NorAQ has also been used in smaller population-based studies on both women (n=590) and men (n= 2924) in Östergötland, Sweden (Swahnberg and Wijma, 2003; Swahnberg, Davidsson-Simmons, Hearn, and Wijma, 2012). Samelius et al (2007), also using material from Östergötland, showed further that VAW has negative somatic health effects.

Furthermore, Krantz and colleagues have investigated intimate partner violence in Sweden in different settings during the last decade, however in relatively small samples (Krantz and Östergren, 2000; Lövestad and Krantz, 2012). Recently, Krantz and colleagues have conducted pilot projects on intimate partner exposure both among women and men, in order to evaluate relevant research methods (n=173 men and n=251 women, Lövestad and Krantz, 2012; n=458 men, Nybergh, Taft, and Krantz, 2012). Finally, in 2012 the Swedish government appointed an interdisciplinary group of officials in order to map the national prevalence of intimate partner violence exposure, with primary focus on interventions and methods in preventing and decreasing such violence (Government Offices of Sweden, 2012).

In the Nordic region, a multi-site study conducted in Denmark, Norway, Iceland, Finland and Sweden (e.g. Hilden et al, 2004; Wijma et al, 2003) found high prevalence of ever in lifetime abuse among gynecology patients. However, this material also included abuse during childhood. Ever in lifetime exposure to interpersonal violence has also been studied in the Bidens multi-site study including additional Northern European countries in a population of pregnant women (Lukasse, Vangen, Øian, and Schei, 2011; Wangel et al, unpublished).

The investigation of VAW is a challenge both from a methodological and an ethical perspective. VAW is a highly complex area and requires research in numerous social contexts in order to understand the causes of such violence (Jewkes, 2002). All methods have seemingly different pitfalls: 1) Questionnaire studies can result in low response rates, and/or no response from the most severe cases; 2) Studies conducted within antenatal care settings are the most common, but such studies examine an already pre-selected group, namely pregnant women, and often foreign-born women are under-represented (Almeida, Caldas, Ayres-de-Campos, Salcedo-Barrientos, and Dias, 2013); 3) Interview studies normally have a limited number of participants and

do not provide information about prevalence, albeit the one-on-one situational context has the potential advantage of being able to explore very sensitive issues. Ethical dilemmas of VAW research include the following: that abused women may be exposed to even greater abuse due to answering a questionnaire in their home, and also that the proper help and resources may not be able to be provided to the abused woman. To our knowledge, no previous population-based research exists concerning exposure to interpersonal violence, including intimate partner violence, among foreign-born women in Sweden.

Aims

General aim

The overall aim of this thesis is to obtain increased knowledge concerning the extent to which foreign-born women in Sweden are exposed to interpersonal violence and to gain a better understanding of potential factors that contribute to such exposure.

Specific aims

1. to investigate the prevalence of exposure to interpersonal violence (Papers I, IV) and the prevalence of related mortality (Paper II) among foreign-born women in Sweden

2. to examine potential determinants of exposure to interpersonal violence (Papers I, IV) and potential determinants of related mortality (Paper II) among foreign-born women in Sweden

3. to explore how norms governing gender roles may influence perceptions of intimate partner violence among Iraqi refugees in Sweden (Paper III)

4. to examine mental health consequences of exposure to intimate partner violence and the potential protective influence of social capital among Thai women in Sweden (Paper IV)

The current thesis thus utilizes a multi-faceted approach in order to examine the phenomena of VAW among foreign-born women. Figure 1 provides an overview of the various samples utilized. Paper I is based on a regional population-based sample comparing Swedish-born and foreign-born women. In Paper II a national sample of women who died from external causes, including interpersonal violence is examined, also comparing Swedish-born and foreign-born women. Paper III is an interview study with a specific group of female and male immigrants, namely Iraqi refugees, and Paper IV examines a population-based sample of Thai women residing in Sweden, another specific immigrant group (Figure 1). See also Table 1 for an overview of the thesis.

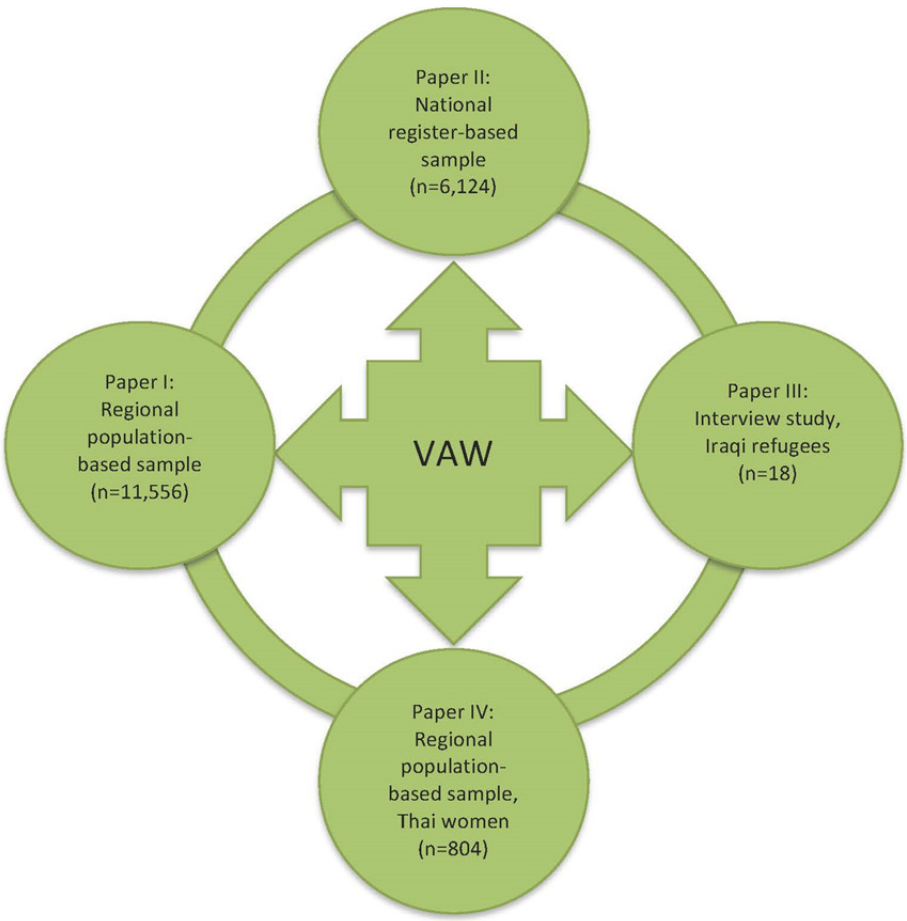

Figure 1. Study samples in the current thesis used to investigate VAW

Table 1. Overview of the thesis. Aims, study design, data sources, analytical approaches, and corresponding papers

Aims	Study design	Data sources	Informants/Information	Analysis	Paper
To investigate the prevalence of exposure to interpersonal violence and the prevalence of related mortality, respectively, among foreign-born women in Sweden	Quantitative Cross-sectional	Questionnaires	Population-based sample of female residents in Scania aged 18-64 years (n=11 556)	Descriptive and analytical analysis, multivariate logistic regression	I
			Population-based sample of Thai women residing in two regions in Sweden since 2006, aged 18-61 years (n=804)	Descriptive and analytical analysis, bi and multivariate logistic regression	IV
		Register	National register data of all deceased women with external causes of death between 1991-2007, aged 15-49 years (n=6124)	Descriptive and analytical analysis, bi and multivariate logistic regression	II
To examine potential determinants of exposure to interpersonal violence and potential determinants of interpersonal violence-related mortality, respectively, among foreign-born women in Sweden	Quantitative Cross-sectional	Questionnaires	Population-based sample of female residents in Scania aged 18-64 years (n=11 556)	Descriptive and analytical analysis, multivariate logistic regression	I
			Population-based sample of Thai women residing in two regions in Sweden since 2006, aged 18-61 years (n=804)	Descriptive and analytical analysis, bi and multivariate logistic regression	IV
		Register	National register data of all deceased women with external causes of death between 1991-2007, aged 15-49 years (n=6124)	Descriptive and analytical analysis, bi and multivariate logistic regression	II
To explore how norms governing gender roles may influence perceptions of intimate partner violence among Iraqi refugees in Sweden	Qualitative	In-depth interviews	Purposive sampling of female and male Iraqi refugees (n=18)	Manifest and latent qualitative content analysis	III
To examine mental health consequences of exposure to intimate partner violence and the potential protective influence of social capital among Thai women in Sweden	Quantitative Cross-sectional	Questionnaire	Population-based sample of Thai women residing in two regions in Sweden since 2006, aged 18-61 years (n=804)	Descriptive and analytical analysis, bi and multivariate logistic regression	IV

Violence against women

Definitions and terminology

According to the World Report on Violence and Health (WHO, 2002), violence is broadly defined as the following: (a) self-directed violence, including suicidal behavior and self-abuse, (b) interpersonal violence, and (c) collective violence consisting of social, political, and economical violence (e.g. war, terrorist acts; Figure 2). Interpersonal violence can be further sub-divided into two categories: family and/or partner violence, vs. community violence (Figure 2). Violence within family/partner settings may concern violence between family members or intimate partners. Such violence occurs primarily in the home, and may involve children, intimate partners, and the elderly. Community violence occurs outside the family/partner settings between unrelated individuals, including acquaintances or strangers, and usually takes place outside the home, e.g. in public places, in schools or at the workplace (Figure 2).

Interpersonal may be further characterized as belonging to four types: 1) physical violence 2) sexual violence 3) psychological violence and 4) deprivation or neglect (Figure 2).

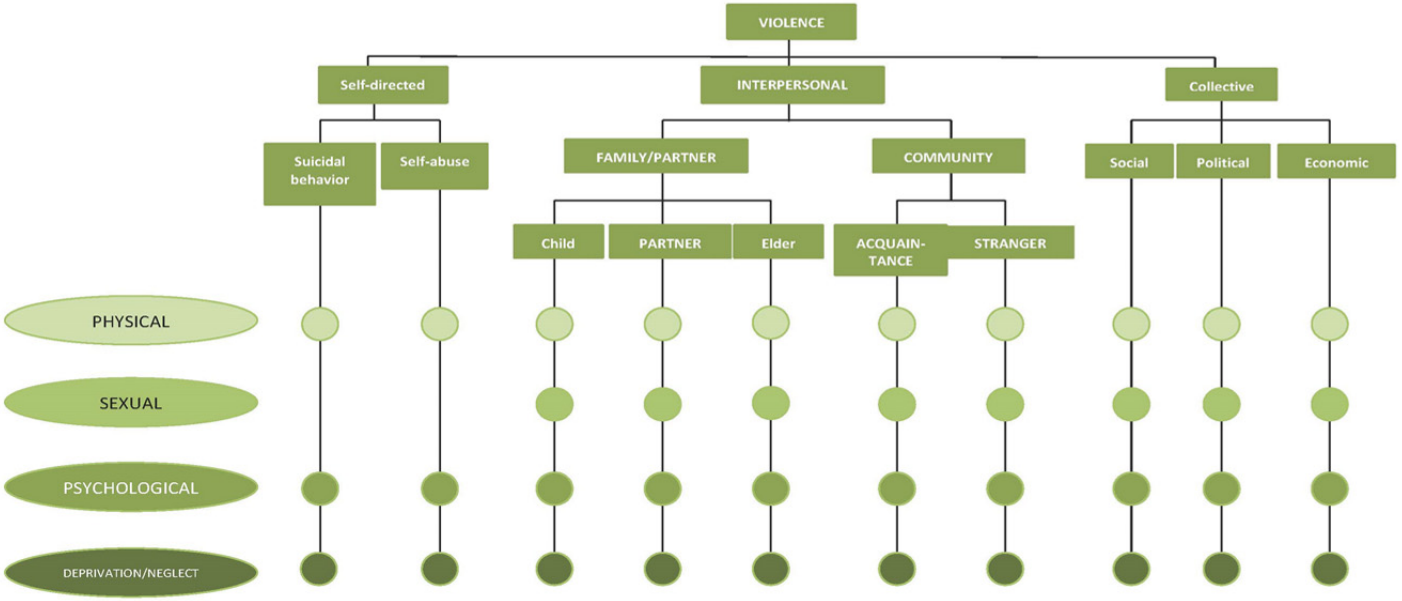

Figure 2. The typology of violence (WHO, 2002).

Physical violence is defined as an act in which one person tries to intentionally hurt another person with physical violence such as slapping, kicking or threatening with weapons, etc. (Flury, Nyberg, and Riecher-Rössler, 2010; WHO, 2005). Physical violence may lead to injuries and the most extreme forms of physical violence may result in death. In intimate partner relations physical violence is often repeated over a longer period of time, which further increases the risk for adverse somatic as well as mental health effects. Examples of physical violence are: the woman is slapped or has something thrown at her, is hit with a fist or something that could hurt her, is choked or burnt on purpose (WHO, 2005).

Sexual violence is defined as any sexual act against a person's sexuality using coercion, including comments and advances (Jewkes, Sen, and Garcia-Moreno, 2002b). Examples of such violence are: the woman is physically forced to have sexual intercourse when she does not want to or is forced to do something sexual that she finds degrading or humiliating (WHO, 2005).

Psychological violence is used by the perpetrator to humiliate, degrade and threaten the victim and in similarity to deprivation or neglect (see below) may result in making the abused person feel useless and unworthy, but also scared due to threats of physical violence. Examples of psychological violence are that the woman is insulted or made to feel bad about herself and/or the perpetrator threatens to hurt her or someone she cares about (WHO, 2005). Psychological violence will primarily be referred to as emotional violence in the current thesis.

Finally, *deprivation or neglect* is used in order to belittle the victim and restrict her individual freedom and information, with possible consequences such as damaged self-esteem and feelings of dependence in the victim. For example, the woman may be ignored and treated indifferently, her contact with family and friends may be restricted, or her partner may insist on knowing where she is all the time (WHO, 2005). Deprivation may take the form of controlling behavior. Such controlling behavior is mainly present in intimate relationships, but also for example within honor cultures.

Intimate partner violence is the most common form of interpersonal VAW (Krantz and Garcia-Moreno, 2005) and encompasses any behavior causing physical, emotional, or sexual harm or exercising power and control between partners within an intimate relationship (Heise and Garcia-Moreno, 2002). Intimate partner violence most often involves a complex system of abuse rather than any single violent event (Flury et al, 2010).

The factors that contribute to the contexts within which violence occurs are very complex and there are a number of possible scenarios and perpetrators. Interpersonal violence includes all existing or non-existing relationships between perpetrator and victim, from stranger to intimate partner, and some studies do not specify whether the

VAW was intimate partner violence or other forms of interpersonal violence. Also, a violent relationship may involve mutual abuse or the woman abusing the man, etc.

The current thesis concerns VAW hereby defined as a range of various types of interpersonal violence with the intention of causing harm. In the papers included, the definitions of violence vary according to the source material used and the purpose of the respective study. In Papers I and II the source materials do not include the identity of the perpetrator and thus the exposure to violence examined is the more general type, i.e. interpersonal violence, including family/partner violence as well as community violence. In Papers III and IV the identity of the perpetrator is known and the primary focus of both studies is more specifically intimate partner violence, rather than interpersonal violence. However, Paper III also includes exposure to other forms of violence, such as collective violence experienced during the war in Iraq (Figure 3).

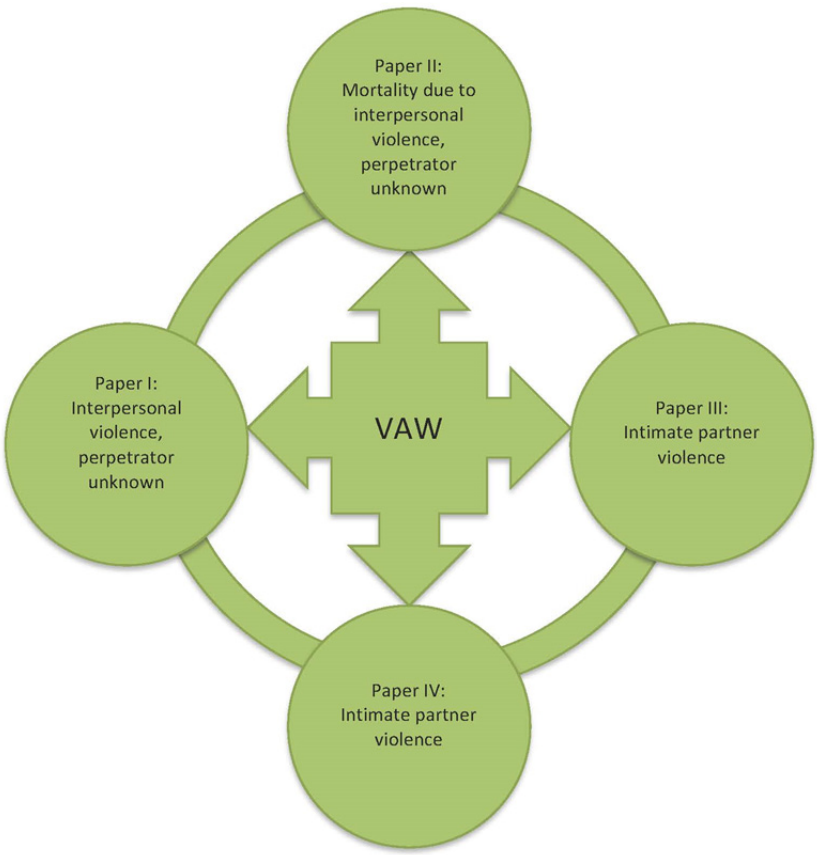

Figure 3. Definitions of violence against women used in the current thesis

Risk factors for exposure to interpersonal violence

The majority of violence against women (VAW) is gender-based, and thus, frequency and severity of such exposure are formed by gender role expectations and level of gender equity (Russo and Pirlott, 2006). According to feminist theory, patriarchal value systems are the primary cause of VAW (e.g. Dobash and Dobash, 1988; Dobash, Dobash, Cavanagh, and Lewis, 1995). In patriarchal societies fathers and older men have institutionalized power over women, children, younger men, and property, as a patriarchy usually is organized around adult male dominance. Control of the female body and its sexuality is central for the maintenance of the patriarchal power hierarchy and thus, proper behavior of the sexes is strictly controlled through values, laws, and traditions. Thus, men's loss of control over a woman or a change in the power balance in the relationship, for example due to migration to a country having a different value system or unemployment on behalf of the man may exacerbate such violence (Darvishpour, 2002; Jin and Keat, 2009; Krishnan et al, 2010). Another reason for VAW according to previous research is the normalization of violence (Jewkes et al, 2002a). Thus, experiences of abuse during childhood, either self-perceived or witnessing violence in the home, are risk factors for being in an adult abusive relationship, either as perpetrator or victim. Moreover, living in a country with prolonged periods of conflict may exacerbate and normalize interpersonal violence, including intimate partner violence. Also, the stress of a war situation may result in increased levels of daily family stressors, including intimate partner violence (Miller and Rasmussen, 2010).

Poverty has been found to be one of the main socio-demographic determinants of intimate partner violence in epidemiological research, and economic inequality within the relationship seems to be more important than the level of poverty of the family (Jewkes, 2002; Jewkes et al, 2002a). Such inequality can lead to intimate partner violence both when the man is the provider of the family, in that the woman is subordinated, and also when the woman has her own income, and hence cannot be controlled by the man. Similarly, low socioeconomic status in the woman, for example low educational level and low disposable income, are risk factors for such violence (Kasturirangan et al, 2004). Correspondingly, according to Campbell (2002) high socioeconomic status may not decrease the risk of intimate partner violence in women, but at least gives them the possibility through different resources to leave the abuser.

Female empowerment, including employment, education, and economic independence, is a protective factor for intimate partner violence in most cases (Abu-Ras, 2007), but an increase in empowerment level may also lead to increased violence especially within a relationship (Jewkes, 2002). Other risk factors are lack of social support (Wong, Tiwari, Fong, Humpreys, and Bullock, 2011) and social isolation

(James, Johnson, and Raghavan, 2004; Jin and Keat, 2009). Social support may be empowering for women in that it strengthens their self-esteem and makes it easier to find support in order to seek help. Social isolation, in contrast, is an important risk factor leading to increased control for the man and makes it difficult for the woman to seek help and leave the relationship. Social isolation may be especially prevalent among foreign-born women (Jewkes et al, 2002a; Jin and Keat, 2009).

Previous research has found that high social capital is associated with good somatic and mental health (Ahnquist, Wamala, and Lindström, 2012). However, knowledge is relatively scarce when it comes to the potential protective effect of social capital against exposure to and health consequences of VAW, including intimate partner violence (but see Goodman, Smyth, Borges, and Singer, 2009; Perez, Johnson, and Wright, 2012). Social capital has been defined in various ways but for this thesis the focus is on social trust in others and on social participation (Putnam, 2000).

Alcohol consumption is another risk factor for VAW (Messman-Moore, Coates, Gaffey, and Johnson, 2008), including intimate partner violence (Abramsky, Watts, Garcia-Moreno, Devries, Kiss et al, 2011; Foran and O'Leary, 2008; Jewkes, 2002). Male consumption may lead to aggressive behavior, poor judgment, and lack of boundaries, whereas female consumption may result in inability to assess a dangerous situation and lesser capacity to defend herself (Testa and Livingston, 2009).

The most extreme outcome of VAW is mortality, and most of the female victims of assault are killed by a current or former intimate partner (Campbell, Webster, Koziol-McLain, Block, Campbell et al, 2003). Risk factors for such mortality are previous exposure to intimate partner violence, pregnancy, being stalked by a current or former partner, and leaving the abuser (Campbell et al, 2007). When a woman leaves her abuser, the risk of mortality is especially elevated during the first months after the separation, although there are no studies comparing the risk of mortality associated with staying in a relationship (Campbell et al, 2007).

Leaving an abusive relationship is difficult for many reasons. The woman needs to have financial means to provide for herself and perhaps her children. Many abusive men exercise their control of the woman by restricting her to work within the home, which leaves her without an income (Morash, Bui, Zhang, and Holtfreter, 2007). Another reason for staying in a violent relationship is the fear of losing custody of the children and many immigrant women fear having to leave the country. Also, some women do not want their children to grow up without a father, and others are emotionally attached to the abuser (Morash et al, 2007).

The ecological model as a tool for further understanding

The ecological model (Bronfenbrenner, 1977) has previously been used in research in order to understand the complex interaction between factors influencing men's VAW (Heise, 1998). Such factors interact on and between different levels of society, namely personal history, individual, community, and society level (Figure 4). The first level pertains to personal history factors affecting a person's behavior and relationships, such as experiences of abuse as a child or witnessing abuse as a child, and having an absent or rejecting father. The next level is the individual level characterized by actual exposure to violence, within the family or by an intimate partner, encompassing experiences such as male dominance in the family, alcohol use, and marital conflict. The third level is that pertaining to the near community, i.e. social institutions and social structures, and risk factors that influence VAW, including low socio-economic status, unemployment, and social isolation of the woman. Finally, norms and legislation at the society level may influence the prevalence and severity of exposure to VAW. Factors at this level that influence VAW include norms that sanction male ownership/control of women, rigid gender roles, and acceptance of interpersonal violence and physical chastisement (Heise, 1998).

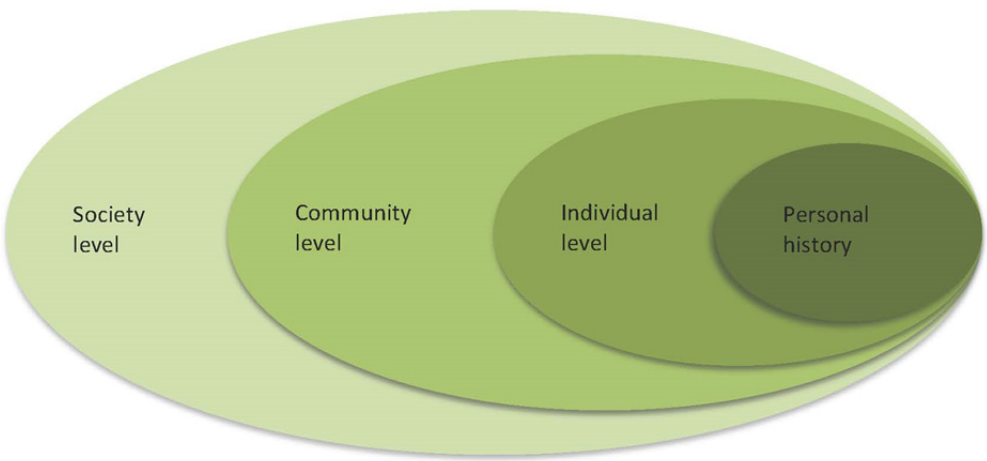

Figure 4. The ecological model: society level, community level, individual level, and personal history (Belsky, 1980; Bronfenbrenner, 1977)

Foreign-born women

Foreign-born women, i.e. first-generation immigrants or refugees born in another country than Sweden, are a very diverse group. In 2011, 15% of the Swedish population was foreign-born and the largest of these groups in Sweden were from Finland, Iraq, Former Yugoslavia, Poland, and Iran (Statistics Sweden, 2013). The concept "foreign-born" may be considered a proxy measure for low socioeconomic status, low gender equity in the country of origin, social isolation, and internalized norms sanctioning VAW, i.e. some of the key factors that may contribute to exposure to VAW.

The norm system of the country of birth is deeply rooted within a person, and even though a person migrates to a new country, such norms may stay with the person for the rest of her life. The age of a person may influence the capacity and perhaps even willingness to change one's attitude towards certain norms, with children being most adaptable. Duration of residence is another important factor that may influence integration into a society; however duration is most often not the only necessary factor in a successful integration. The size of the gap between the norm systems of the country of birth and that of the new country is another important factor to take into consideration with regard to any individual's integration process.

Previous research has shown that gender norms are of great importance with regard to exposure to interpersonal violence (Jewkes, 2002; Morash et al, 2007; Russo and Pirlott, 2006). Gender norms differ between countries and the extent to which a clash may arise between two norm systems/sets of traditions after migration may differ depending on one's personality, perceptions, and attitudes. Compared to Sweden, most countries have more patriarchal gender norms, as Sweden is one of the most gender equal societies globally (Hausman, Tyson, and Zahidi, 2011; Social Watch, 2012). Thus, many foreign-born women in Sweden originate from countries where women have a subordinated position compared to Swedish-born women. Moreover, the majority of foreign-born women also find themselves in a low socioeconomic position after migration compared to Swedish-born; thus being foreign-born may involve being at increased risk for several factors that contribute to VAW. In addition to these risk factors as well as the ones mentioned above, foreign-born women experience the challenges of language barriers, lack of knowledge of laws and rights in the new country, and ignorance of where to seek help for abuse (Morash et al, 2007; Raj and Silverman, 2003).

Specific groups of foreign-born women

Iraqi and Thai women are two specific groups of foreign-born women that were chosen for further investigation in this thesis. Little is known about VAW in foreign-born women from Iraq and Thailand. These two groups of women were chosen based on the notion that both groups originate from countries where women have a subordinated role to men and that VAW, including intimate partner violence, is socially accepted (Amowitz, Kim, Reis, Asher, and Iacopino, 2004; WHO, 2005), making them risk groups for such violence also after migration to Sweden. However, the two groups differ greatly with regard to traditions, norms, and reasons for migration.

Iraqi women

Iraqis are the second largest group of immigrants in Sweden, consisting of 125 499 persons (1.3% of the Swedish population), of which 45.9% are women (Statistics Sweden, 2013). Previous research concerning prevalence of intimate partner violence among immigrant Iraqi women in the USA has shown that intimate partner violence levels are high also after migration (80%) (Barkho, Fakhouri, and Arnetz, 2011). Furthermore, experiences of prolonged periods of conflict and severe human rights abuse in Iraq before migration contribute to poor health status among Iraqi refugees, both with regard to self-rated health and mental health, including depression and anxiety (Jamil, Farrag, Hakim-Larson, Kafaji, Abdulkhaleq et al, 2007; Lecerof and Stafström, 2011). Iraq is generally regarded as a strongly patriarchal society (Donahue, 2008), and has low gender equity, including low female empowerment (Hausmann et al, 2011). Women in Iraq have limited access to education and employment, and legislation with regard to intimate partner violence and marital rape is lacking (Amowitz et al, 2004). Iraq is a group-oriented society and has, together with several other countries such as Turkey and Jordan, a very strong and conservative honor culture (Kandiyoti, 1988; Kulwicki and Miller, 1999). Thus, in some communities within Iraq, women as well as in some cases men are punished for breaking such honor codes, with the most extreme consequence being honor killings (Kulwicki and Miller, 1999). After migration most Iraqi women are still married to Iraqi men, in contrast to Thai women of whom the majority are married to Swedish men. However, exposure to Swedish gender norms may have very different implications for Iraqi men and women, with a risk for marital conflict, due to increasing opportunities for women in contrast to diminished self-esteem and feelings of powerlessness among men (Carlbom, 2003).

Thai women

The female Thai population residing in Sweden is relatively young and in good health, but the majority have low labor market and social integration. In Sweden there are 33,613 Thai persons (0.4% of the Swedish population), of whom 78.1% are

women (Statistics Sweden, 2013). Thus, foreign migration among Thai women is mainly due to family reasons, e.g. marriage abroad. Previous research on Vietnamese immigrant women in the United States has shown that so-called "picture brides", i.e. women who have not met their husbands before marriage abroad, have an increased risk for all types of abuse compared to other Vietnamese women (Morash et al, 2007). According to Swedish legislation, Thai women who are married to a Swedish citizen receive a two-year temporary permit of residence, after which permanent residence may be granted if the woman is still married. During these two years the woman is economically dependent on the Swedish citizen, in most cases an intimate partner, and thus the woman is in a vulnerable position. Previous research has shown that uneducated and less empowered women, e.g. economically dependent on their partners, have an increased risk of intimate partner violence (Jewkes et al, 2002a). Some women with poor language skills and low social capital may endure in an abusive relationship for the sake of receiving permanent residence.

Health consequences of exposure to interpersonal violence

Previous research has shown that exposure to violence, especially intimate partner violence that normally encompasses repeated incidences of abuse during a period of time, often leads to adverse health consequences (Campbell, 2002; Ellsberg et al, 2008; Krantz and Östergren, 2000; Nerøien and Schei, 2008). These health consequences may be both physical, e.g. injury, chronic pain, gastrointestinal disorders, and psychological, e.g. depression, post-traumatic stress disorder (PTSD). Studies have shown that health consequences due to intimate partner violence can have long-term effects and endure long after the abuse has stopped, and thus result in increased health care seeking, poorer health status, and lower quality of life (Campbell, 2002; Campbell et al, 2002).

Campbell (2002) has identified three areas of physical health effects: 1) gynecological problems encompassing vaginal infections, urinary tract infections, and sexually transmitted diseases; 2) central nervous system problems, e.g. chronic pain, fainting, and seizures; and 3) chronic stress-related symptoms due to for example fear, including loss of appetite and hypertension. In addition, sexual violence may lead to unintended pregnancies, which may have adverse health effects for mother and infant, especially in low-income countries (Pallitto, Campbell, and O'Campo, 2005). Also, mortality due to interpersonal violence is the most extreme outcome of physical harm and an actual risk factor for women exposed to physical or sexual violence and/or living in an abusive relationship (Campbell et al, 2007).

In previous research, strong associations have been found between adverse mental health consequences and interpersonal violence (Bohn and Holz, 1996; Humphreys

and Lee, 2009; Evans-Campbell, Lindhorst, Huang, and Walters, 2006; Watts and Zimmerman, 2002), including intimate partner violence (Ellsberg et al, 2008; Fischbach and Herbert, 1997; Golding, 1999; Haj Yahia, 2000; Saif el Dawla, 2001), both among women in high- and low-income countries. Both emotional intimate partner violence (Vizcarra, Hassan, Hunter, Munoz, Ramiro et al, 2004) and physical and/or sexual intimate partner violence (Bonomi, Anderson, Rivara, and Thompson, 2007; Ellsberg et al, 2008; Campbell, 2002) may have poor mental health outcomes. The most common consequences are depression (Bonomi et al, 2007; Ratner, 1993; Wong et al, 2011) and post-traumatic stress disorder (Golding, 1999; Woods, Hall, Campbell, and Angott, 2008). Other mental health outcomes are anxiety (Ratner, 1993), substance abuse (Golding, 1999), and suicide (Bergman and Brismar, 1991; Golding, 1999).

The frequency/chronicity and severity of exposure to violence may influence the impact on the abused person's health (Resnick and Acierno, 1997). However, all experiences are subjective and thus perceived differently by different persons irrespective of the frequency and/or severity of such violence (Samelius et al, 2007).

Materials and methods

The set of different studies in this thesis represents a multi-faceted approach towards gaining a deeper understanding of violence against foreign-born women. Thus, various samples, data sources, and analytic methods are used across the four studies in order to explore the prevalence and correlates of such violence.

Data sources

The Scania Public Health Survey, 2004 (Paper I)

The Scania Public Health Survey is a comprehensive public health questionnaire distributed by post every fourth year to randomly selected persons between the ages of 18 and 80 years residing in Scania, a region in Southern Sweden. The self-reported information collected by the questionnaire (130 questions) pertains to health-related issues, including somatic and mental health, alcohol use, smoking, living conditions, exposure to violence, and socio-demographic background factors, including socioeconomic status and country of birth. Respondents choose their answers from among several structured alternatives. Paper I is a cross-sectional study based on data obtained from the 2004 Public Health Survey sent out to a total of 27,963 persons (50.4% women, 49.6% men) in Scania, born between 1919 and 1981 (Rosvall, Khan, Nilsson, and, Östergren, 2005). All persons included in the survey received three postal reminders, unless they had already answered the questionnaire. Respondents were guaranteed that their answers would remain anonymous. The final response rate was 57.4%.

The Swedish National Cause of Death Register, 1991-2007 (Paper II)

The Swedish National Cause of Death Register is a register of all deceased Swedish residents. Persons lacking a Swedish personal identification number are not included in the register, for example asylum seekers and temporary residents. The information recorded in the register is based on death certificates, completed by the attending physician, or in cases of violent or unclear death, the coroner conducting the forensic

examination. The register includes information on age at death, date of death, causes of death, and gender. For Paper II information on country of birth and duration of residence in Sweden (for foreign-born women) was obtained through record linkage with the Swedish Population Register by means of each person's unique personal identification number. Also, additional information concerning demographic and socioeconomic measures for each deceased woman regarding marital status, educational level, employment, and disposable monthly income was obtained by linkage with the Longitudinal Integration Database for Health Insurance and Labor Market Studies (LISA), at Statistics Sweden.

The IMHAd project, 2009-2011 (Paper III)

The data source was derived from a collaboration project between Lund University, Malmö University, Uppsala University, and a number of municipalities and county councils in Sweden, and financed by the European Refugee Fund. The IMHAd project comprised four studies aiming to examine the well-being of Iraqi refugees in Sweden, with focus on their health situation. An additional aim of the project was to evaluate the effect of the information they received from Multicultural Health Advisors (immigrants with health education informing recently arrived countrymen in their mother tongue). The studies included in the IMHAd project were 1) a public health questionnaire study of a random sample of recently arrived refugees in eight municipalities in Sweden (Lecerof, Westerling, Moghaddassi, and Östergren, 2011), 2) an observational study with focus on methods used by the Multicultural Health Advisors, 3) a qualitative study based on focus groups discussions with Iraqi young adults, and 4) a qualitative study based on in-depth interviews with recently arrived female and male Iraqi refugees in Scania. Paper III is based on the fourth study within the project. Participants were recruited from schools where they were studying Swedish by means of purposive sampling. All interviews (n=18) were conducted by the same person (CF) and followed an interview guide with various topics, such as life as an Iraqi woman/man in Sweden; roles and rules within the family; perceptions/attitudes towards marriage and sexual relations; the importance of virginity and the code of honor; attitudes and experiences towards threat of violence and physical violence.

The HELMI project, 2010-2012 (Paper IV)

The data source was derived from a project financed by the European Integration Fund, the HELMI project. The project was a collaboration between Lund University, Malmö University, Uppsala University, The Swedish Institute for Communicable Disease Control, and seven municipalities in Sjuhäradsbygden in Sweden. The overall

aim of the HELMI project was to investigate the well-being of Thai and Somali women in two regions in Sweden, with focus on health and empowerment. The study populations were chosen based on the notion that both groups have low levels of labor market integration and social participation in the Swedish society. A public health questionnaire in Thai (the Thai Survey) was distributed by post to all Thai women residing in Scania and Sjuhäradsbygden since 2006 (n=1291). The questionnaire contained 98 questions pertaining to health-related issues, such as self-rated somatic and mental health, exposure to violence, alcohol use, living conditions, social participation, and other background factors, including marital status, employment, and socioeconomic status. The same questionnaire, translated into Somali, was used in face-to-face structured interviews conducted with Somali women in the same regions. However, Paper IV reports the results solely from the Thai women. All persons included in the Thai Survey received three postal reminders, unless they already had answered the questionnaire. Respondents were guaranteed that their answers would remain anonymous. The final response rate of the Thai Survey was 62.3% or 804 Thai women.

Measures

Outcome measures

Exposure to threat of violence and/or physical violence (Paper I)

In Paper I the outcome measures were defined as exposure to threat of violence and/or physical violence. Exposure was based on the responses to two questions from the Scania Public Health Survey 2004: 1) “Have you at any time during the last 12 months been exposed to threat of violence dangerous or serious enough to scare you?”, and 2) “Have you at any time during the last 12 months been exposed to physical violence?” Possible answers were “yes” and “no” to both questions. These questions were followed by another question, asking where such violence had occurred, with the following options: in the home, in another home/the neighborhood, at work/at school, in a public place (i.e., in an amusement park, train, bus or metro), or other place.

External causes of death (Paper II)

In Paper II the outcome measure was defined as the external cause of death that was reported in the Swedish Cause of Death Register for each woman in the study population. The study covered the period 1991-2007, and thus the causes of death were coded according to both ICD-9 (until 1996) and ICD-10 (from 1997, WHO, 2010). Causes of death used in this study were external causes of morbidity and

mortality: transport accident injury (ICD-9: E800-E849; ICD-10: V01-V99), other external causes of accidental injury, e.g. falls, accidental drowning, accidental poisoning (ICD-9: E850-E928; ICD-10: W00-X59), intentional self-harm, including suicide (ICD-9: E950-E959; ICD-10: X60-X84), assault, including homicide (ICD-9: E960-E969; ICD-10: X85-Y09), and event of undetermined intent (ICD-9: E980-E989; ICD-10: Y10-Y34). For the purpose of data analysis, the code "death due to assault" (ICD-9: E960-E969; ICD-10: X85-Y09) was operationally chosen to represent death due to interpersonal violence. Assault was defined in the register as homicide, including manslaughter, or other death by assault, by a spouse or a partner, a parent, an acquaintance or a friend, official authorities, or other specified and unspecified persons (WHO, 2010). Two categories of external cause of death were excluded, complications of medical and surgical care (n=17) and sequelae of external causes of causes of morbidity and mortality (n=24), due to few individuals in these categories. Also, causes of death not included in the study were internal causes of death, such as disease and other health related problems.

Exposure to intimate partner violence (Paper IV)

Exposure to intimate partner violence by a current partner was one of two outcomes studied in Paper IV. Exposure to emotional intimate partner violence and exposure to physical and/or sexual intimate partner violence were based on four questions developed for the purpose of the study: 1) "Have you ever been insulted or humiliated by anyone?", 2) "Have you ever been exposed to threat of violence to the extent that you became frightened?", 3) "Have you ever been slapped, kicked or in any other way exposed to physical violence?", and 4) "Have you ever been forced to have sexual intercourse or other sexual activity against your will?" Possible answers were "yes" and "no" to all four questions. Questions 1, 3, and 4 were derived from selected items used in the WHO's multi-country study (WHO, 2005) and question 2, was based on an item used in the Scania public health survey (Rosvall et al., 2005). The questions also included alternatives for whether the perpetrator of the violence was a "current partner", "previous partner", "other person in the family", and "other person", as well as the country where such violence occurred: "Thailand" and/or "Sweden" and/or "other country".

Poor mental health (Paper IV)

Poor mental health as a potential consequence of exposure to intimate partner violence was the other outcome measure used in Paper IV. Poor mental health was assessed by the General Health Questionnaire 12 items (GHQ-12, Goldberg, 1978). The GHQ-12 was included in the Thai Public Health Questionnaire and has 4 answer alternatives for each item: "worse than usual", "much worse than usual", "better than usual", "same as usual". For the purpose of obtaining a summary score, answer alternatives were aggregated as 1=low (worse than usual/much worse than usual) and 0 = high (better than usual/same as usual). Thereafter, a mean summary score was

calculated in order to designate persons having "poor" vs. "good" mental health. For the purpose of data analysis, "poor" mental health was defined as a mean summary score of 2 or more, based on an examination of the frequency distribution, whereby these scores represented the upper quartile. Also, this cut-off point corresponds to the sample mean, which is generally recommended as the appropriate cut-off point (Goldberg, et al, 1998). The GHQ-12 has shown good validity across a broad variety of samples (Goldberg et al., 1998), and has previously been utilized in a study of University students in Thailand (Kunadison and Pitanupong, 2010).

Explanatory measures and/or determinants

Country of birth and level of development (Paper I and II)

In papers I and II, country of birth was considered a possible determinant of VAW and was dichotomized as Swedish-born vs. foreign-born based on information concerning birthplace. The foreign-born women in Paper I originated from 98 different countries and 85 different countries in Paper II. However, due to small numbers in some of the subgroups when divided by country, all foreign-born women were aggregated into one group in the respective studies. In Paper I foreign-born country of birth was further classified into groups based on the country's development level, as defined by the World Bank (2009). The categories were high-income countries (30.8%) and middle/low-income countries (69.2%), and the latter category was aggregated due to small numbers in the separate categories middle- and low-income countries.

Gender Equity Index/level (Paper II)

In Paper II country of birth was further classified according to gender equity level, in an attempt to further explore the extent to which country of birth could be an indicator of level of empowerment. Information on the countries' gender equity levels was obtained from the Gender Equity Index, which is based on data from UNESCO (GEI, Social Watch, 2012). The GEI is a highly valid system for evaluating both socioeconomic and political aspects of gender equality in any given country (Mills, 2010). The GEI score is based on three measures of gender gaps between men and women in each country: education, economic activity, and political empowerment. Literacy rate and enrollment rate in primary, secondary, and tertiary education are measures for gaps in education. Economic activity also includes estimated perceived income. Women's political empowerment is based on the following indicators: % of women in technical positions, % of women in management and government positions, % of women in parliament, and % of women in ministerial level positions (Social Watch, 2009). The average of these measures yields the GEI score and possible categories are "acceptable", "medium", "low", "very low", and "critical" levels of gender equity. For Paper II the final categories, including the total sample (both

Swedish-born and foreign-born women), were “medium” gender equity (90.1%), “low” gender equity (6.2%), and “very low/critical” gender equity (3.0%). The categories “very low” and “critical” were aggregated due to small numbers. According to Social Watch (2012) no countries are currently regarded as having “acceptable” GEI.

Duration of residence (Paper I, II, and IV)

Information on duration of residence for the various foreign-born populations was obtained and utilized in Papers I, II and IV. Immigration year was defined as the year the woman received residence permit in Sweden. In Paper I duration of residence was dichotomized as 10 years or less vs. more than 10 years of residence. In Paper II, the dichotomization of duration of residence was based on changes in immigration patterns in Sweden, whereby prior to 1980 labor-market immigrants predominated, and thereafter immigrants with refugee status predominated (Bevelander, 2004). Thus the two groups in Paper II were: residence by the years 1954-1979 and residence by the years 1980-2007. The dichotomization of duration of residence for Paper IV was based on the Swedish legislation regarding family immigration of a third country citizen (e.g. a Thai person) whereby such person must be married to a Swedish citizen for two years before they can receive permanent permit of residence. The groups in Paper IV were: years 2006-2008 and 2009-2011, and thus women in the latter group would not yet be eligible for permanent residence.

Self-rated health (Paper IV)

In Paper IV self-rated health was included as an explanatory measure for exposure to intimate partner violence and poor mental health as a potential consequence of intimate partner violence, based on the question “"How do you rate your general health status?" and dichotomized as "neither good nor bad/bad/very bad health" (poor self-rated health) and "good/very good health". Self-rated health has shown good validity across a broad variety of samples and in different ethnic groups (Abdulrahim and Asmar, 2012; Chandola and Jenkinson, 2000). However, the validity of self-reported health among Thai women residing in Sweden is currently unknown.

Social isolation (Paper IV)

In Paper IV social isolation was included as an explanatory measure for exposure to intimate partner violence and poor mental health as a potential consequence of intimate partner violence. Social isolation was based on the response to the question: “Have there been periods during the last year when you have felt isolated or excluded from the society?” with the possible answers “yes” and “no” (Rosvall et al, 2005).

Social capital variables (Paper IV)

In Paper IV, social capital was examined in relation to exposure to intimate partner violence and to poor mental health. Social capital was defined as social trust and social participation, respectively. Social trust was based on the responses to four statements on general interpersonal trust, i.e. 1) "Most people would take advantage of you if they got the chance", 2) "Most people try to be fair", 3) "You can trust most people", and 4) "You cannot be too careful in dealing with other people", with four potential responses ranging from "Agree completely" to "Do not agree at all". Social trust was dichotomized, with low social trust defined as agreeing completely/agreeing to questions 1 and 4 and disagreeing completely/disagreeing to questions 2 and 3.

Social participation was based on reported participation in the activities of formal or informal groups and was assessed by 13 questions regarding participation in the following activities during the last year: study circle/course at workplace, union meeting, meeting of other organizations, meeting of Thai organizations, theatre/cinema, arts exhibition, religious event, sports event, letter to the editor of a newspaper/journal, demonstration, night club/entertainment, large gathering of relatives, and private party. Based on an examination of the frequency distribution, persons with attendance at two or less of the activities were considered to have low social participation and persons with attendance at >3 were considered to have medium/high participation.

Demographic and socioeconomic measures (Paper I, II, and IV)

In Papers I, II, and IV age, marital status, educational level, employment status, and disposable income were all considered potential confounders and adjusted for in the multivariate analyses. Age was dichotomized as two groups: 18-44 years and 45-64 years (Paper I), 15-29 years and 30-49 years (Paper II), and 18-29 years and 30-61 years (Paper IV). The rationale for the age groupings is further described below, under Study populations and designs. For the remaining variables the same definitions of groups were utilized in all three papers, i.e. married/divorced/widow or married/cohabitating, <9 years of education or >9 years of education, employed or not employed, high disposable monthly income (>9,000 SEK ≈ >1,300 US$) or low disposable monthly income (<9,000 SEK ≈ <1,300 US$). However, with regard to the stratification of marital status, registered partnership was included in the latter category in Paper II and partnered women were included in the same category in Paper IV. Also, in Papers I and II the disposable monthly income concerns the household income, whereas in Paper IV disposable monthly income concerns the woman's income.

Quantitative data analyses (Papers I, II, and IV)

All statistical tests in this thesis were two-sided and statistical significance was assumed at <0.05.

In Paper I, SPSS computer software for Macintosh 14.0 was used for statistical analyses. Independent t-tests were used for the analysis of numeric measures (mean age) and chi^2 tests were used for the analysis of categorical variables. Associations between categorical variables were analyzed by logistic regression and expressed as odds ratio with 95% confidence intervals. Confounding by differences in age, marital status, educational level, employment status, disposable income was controlled for in multivariate analyses and by stratification.

In Paper II, SPSS computer software for Macintosh 20.0 was used for statistical analyses. Independent t-tests were used for the analysis of numeric measures (mean age) and chi^2 tests were used for the analysis of categorical variables. Age-standardized incidence rates for external cause of death were calculated separately for Swedish-born and foreign-born women, using the female population of Sweden for the year 2000 as the reference group. Calculated incidence rate ratios were expressed in terms of relative risk (RR) with 95% confidence intervals (CI). Associations between categorical variables were analyzed by bivariate and multivariate logistic regression analysis and expressed as odds ratios with 95% confidence intervals. Confounding by differences in age, marital status, educational level, employment status, disposable income was controlled for in multivariate analyses and by stratification. Finally, an interaction analysis (2-way interaction terms) was conducted in order to examine the extent to which a potential interaction between marital status and foreign-born status increased the risk for death due to interpersonal violence.

In Paper IV, SPSS computer software for Macintosh 20.0 was used for statistical analyses. Descriptive statistics were used to calculate mean age. Associations between categorical variables were analyzed by bivariate and multivariate logistic regressions and expressed as odds ratios with 95% confidence intervals. Confounding by differences in age, marital status, educational level, disposable income, social isolation, social participation, and social trust was controlled for in multivariate analyses and by stratification. A synergy analysis was also performed in order to examine the potential combined effect on mental health outcome of intimate partner violence exposure by a current partner and social isolation, and that of intimate partner violence by a current partner and low social trust.

Qualitative content analysis (Paper III)

Paper III utilized qualitative in-depth interviews, whereby the interview texts were transcribed and analyzed using a combination of manifest and latent qualitative content analysis (Graneheim & Lundman, 2004). Transcribed interviews were coded and codes were grouped into categories illustrating the manifest meaning of the text. Further, on the basis of the categories four themes were developed capturing the latent meaning; these were "the limbo of arrival"; "violence as personal baggage"; "clashing gender norms"; and "the overriding importance of honor". In addition, one over-arching theme was developed that related to all four themes. The overarching theme was "navigating between control and autonomy". The same person (CF) who conducted the interviews also coded them after transcription. In order to enhance data analysis quality, a random sample of the interviews was coded several times. The last author of Paper III (ECG) also independently coded several interviews, and the first and last author reached consensus on data coding.

Study populations and designs

Population-based cohort study (Paper I)

Paper I is a study of 11,556 women residing in Scania, in Southern Sweden, in 2004. Foreign-born women represented 17.8% (n=2,054) of the final sample and originated from 98 different countries. The study population was restricted to women in the cohort between the ages of 18 and 64 years, in order to examine women in the workforce, and thus not restrict violence to that which occurs in the home. The overall aim of Paper I was to investigate exposure to perceived threat of violence and physical violence among women (18-64 years) in Scania in relation to country of birth. The rationale of the study was to use exposure to threat of violence and/or physical violence in the home as a proxy indicator for partner and/or family violence.

National register-based study (Paper II)

Paper II is a study of 6,124 women who were identified as having external cause of death during the period 1991-2007. Of the study population, 16.2% (n=995) women were foreign-born and they were born in 85 different countries. The study population was restricted to women aged 15-49 years, in order to examine women in reproductive age, as such women are more prone to be in a relationship and thus at increased risk for intimate partner violence. The aim of Paper II was to examine the

risk of mortality due to interpersonal violence in relation to other external causes of death among women of reproductive age (15-49 years), with focus on country of birth. The rationale of the study was to utilize death due to assault as a proxy indicator for the most extreme possible consequence of interpersonal violence.

Qualitative interview study (Paper III)

In-depth interviews were conducted with 18 newly arrived Iraqi refugees, nine women and nine men. After 14 interviews the data was analyzed, and four additional interviews were done, in order to confirm the findings from the previous interviews. The majority of the interviews were conducted in Arabic (n=11), with telephone interpreter. The rest of the interviews were performed in Swedish (n=5) and English (n=2). The aim of Paper III was to explore recently arrived male and female Iraqi refugees' experiences of migration to Sweden with particular focus on their well-being, and perceptions of gender role differences and norms governing relationships between men and women. The rationale for choosing this specific study population was that newly arrived Iraqi refugees are regarded as a group with potential previous exposure to interpersonal violence, both due to the prolonged conflict situation in Iraq and also due to the strong patriarchal norms that may sanction VAW.

Survey of Thai women in two regions in Sweden (Paper IV)

Paper IV is a study of 804 Thai women residing in Scania and Sjuhäradsbygden, in Sweden, since 2006. The questionnaire was distributed to the total population of Thai women in these two regions (n=1291). The study targeted women in the age range 20-61 years old in order to examine women in the work force. The aim of Paper IV was to investigate poor mental health in relation to exposure to intimate partner violence among Thai women (18-64 years) residing in Sweden. The association between intimate partner violence and mental health outcome was further examined with regard to the potential influence of social isolation and social capital measures. The rationale was to include social capital as potential modifiers of adverse mental health outcome.

Main findings

Background characteristics of the study populations (Papers I-IV)

In Paper I concerning 11,556 women residing in Scania, the mean age did not differ between Swedish-born (40.86 years) and foreign-born women (40.54 years). However, the age distribution differed significantly between foreign-born and Swedish-born, with fewer older (vs. younger) women among foreign-born women (χ^2=12.99, p<0.001). Marital status did not differ between the groups, but foreign-born women had significantly lower educational levels (χ^2=30.23, p<0.001), higher prevalence of unemployment (χ^2=46.55, p<0.001), and lower disposable income (χ^2=442.84, p<0.001) compared to Swedish-born women.

In Paper II, concerning deceased women in Sweden (n=6,124), the mean age at time of death was approximately 35 years and did not differ between Swedish-born (34.29 years) and foreign-born women (35.96 years). However, the age distribution differed significantly between Swedish-born and foreign-born with fewer younger (vs. older) women among foreign-born women (χ^2=32.9, p<0.001). Also, foreign-born women were more frequently married or cohabiting at their time of death (χ^2=56.5, p<0.001), had lower educational level (χ^2=10.9, p= 0.001), higher prevalence of unemployment (χ^2=4.2, p=0.04), lower disposable income (χ^2=17.0, p<0.001), and lower levels of gender equity (χ^2=3344.5, p<0.001) than Swedish-born women.

In paper III, concerning Iraqi women and Iraqi men in Scania (n=18), the women had a mean age of 38 years and were 20-51 years old. Seven of the women were married, one unmarried, and one a widow, and six were Muslims and three Mandeans. Four women had less than six years of school, four had finished secondary school, and one had higher education. The men had a mean age of 32 and were between the ages of 22-51 years. Five were unmarried, four married, and six were Muslims and three Mandeans. Two of the men had primary school, five had secondary school education, and two had higher education.

In Paper IV concerning Thai women residing in Sweden, (n=804), the mean age was 37 years and 82.8% were in the older age group (30-61 years). Most of the women were married or cohabitating (85.4%) and approximately 75% of these women who

were married/cohabiting had a Swedish partner. In the sample, 52.1% had low or middle educational level, 39.3% worked full or part time, 83.3% had low disposable income and 31.1 % had resided in Sweden for less than two years. One-third of the women reported poor self-rated health and 19.8% reported poor mental health. Finally, 39.9% reported being socially isolated, almost as many reported low social trust, and half of the women had low social participation.

Prevalence of exposure to interpersonal violence (Papers I, IV) and related mortality (Paper II)

Do Swedish-born and foreign-born women differ in exposure to perceived threat of violence and physical violence? (Paper I)

In Paper I the prevalence for perceived threat of violence was 6.5% in Swedish-born and 9% in foreign-born women, and for exposure to physical violence the prevalence was 3.7% in Swedish-born and 4.7% in foreign-born women (Figure 5). The bivariate logistic regression analyses showed that foreign-born women reported significantly increased exposure to both perceived threat of violence (χ^2=15.73, p=0.001) and physical violence (χ^2=4.73, p=0.03) compared to Swedish-born women (Figure 5). Also, foreign-born women from middle/low-income countries had significantly increased exposure to physical violence (χ^2=5.06, p=0.03), but not for threat of violence (χ^2=3.37, p=0.07) compared with women born in high-income countries.

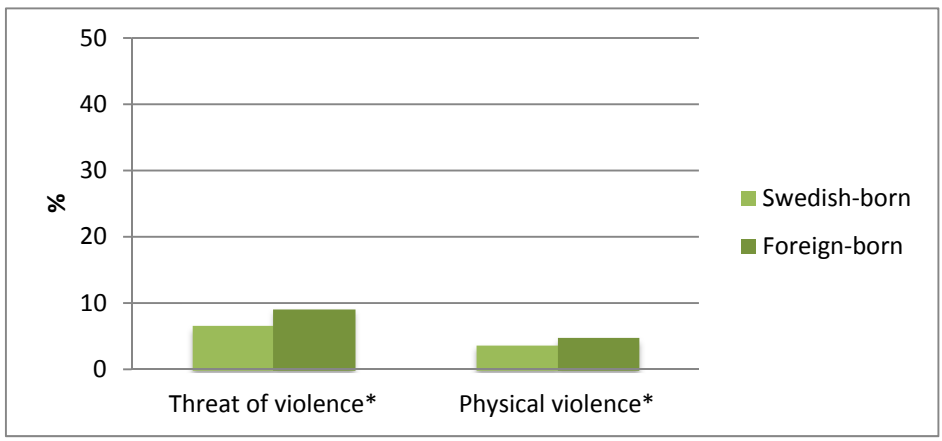

Figure 5. Prevalence of interpersonal violence among Swedish-born and foreign-born women in Scania (n=11,556, *p<0.05, group differences foreign-born vs. Swedish-born)

Do Swedish-born and foreign-born women differ in mortality due to interpersonal violence? (Paper II)

In Paper II the prevalence for mortality due to interpersonal violence was 4.2% in Swedish-born women and 10.9% in foreign-born women (Figure 6). Foreign-born women also had a higher prevalence of mortality due to intentional self-harm (48.3% vs. 46.4%) and mortality due to undetermined intent (14.1% vs. 12.9%). Swedish-born women had higher mortality due to transport accidents (21.6% vs. 15.4%) and other accidents (14.9% vs. 11.4%). A comparison of age-standardized mortality rates showed an overall increased risk for mortality due to external causes of death among foreign-born women (RR, 1.15, 95% CI, 1.08-1.23) compared to Swedish-born. The bivariate logistic regression analyses showed that by far the greatest differences in mortality rates between foreign-born vs. Swedish-born women were those obtained for interpersonal violence (RR, 2.97, 95% CI, 2.36-3.74). Foreign-born women also had significantly increased risk for death due to intentional self-harm and events of undetermined intent, and significantly decreased risk for mortality due to transport accidents.

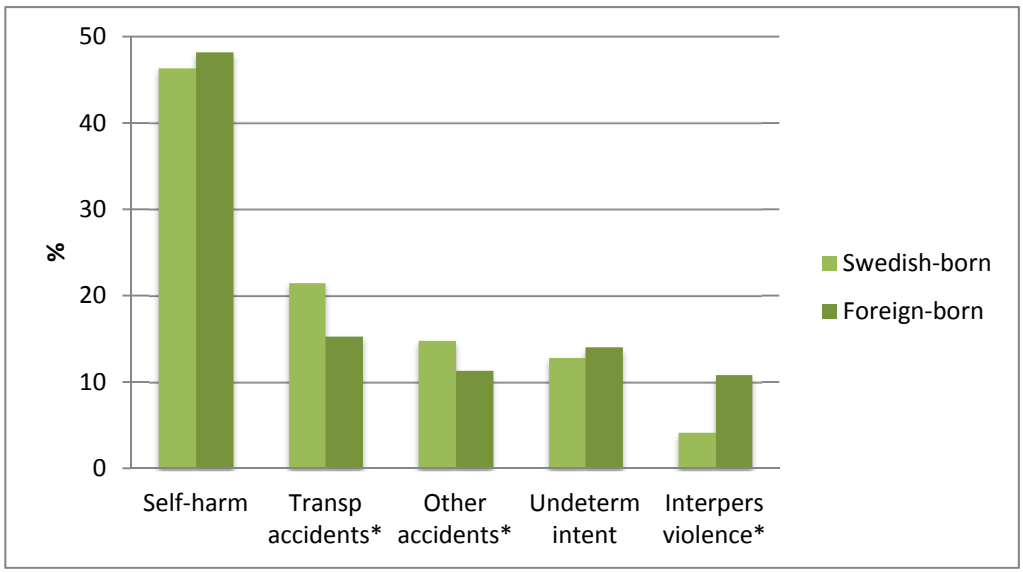

Figure 6. Mortality due to external causes among Swedish-born and foreign-born women (n=6,124, *p<0.05, foreign-born vs. Swedish-born)

What is the prevalence of intimate partner violence among Thai women residing in Sweden? (Paper IV)

In the total sample of Thai women (n=804), 22.1% (n=178) women reported exposure to emotional and/or physical and/or sexual intimate partner violence ever, i.e. by previous or current partner, in Sweden or elsewhere. Exposure to intimate partner violence, including emotional violence, by a previous partner was reported by 23.0% (n=165) and exposure by a current partner was reported by 6.7% (n=54). Exposure to emotional intimate partner violence by previous partner was reported by 14.3% and by current partner 6.1%, and 13.9% reported exposure to physical and/or sexual violence by a previous partner and 2.4% by current partner (Figure 7). Of the 178 women exposed to intimate partner violence ever, 41 had been abused by both previous and current partners and there was a strong association between exposure to intimate partner violence by current and previous partners ($p<0.001$). The majority of women with current intimate partner violence exposure had a Swedish partner. Among women with previous or current exposure to intimate partner violence, 28.7% reported physical and/or psychological injuries, 13.1% had sought health care for their injuries, and 25.7% had told someone about the abuse, most often a close friend or a relative.

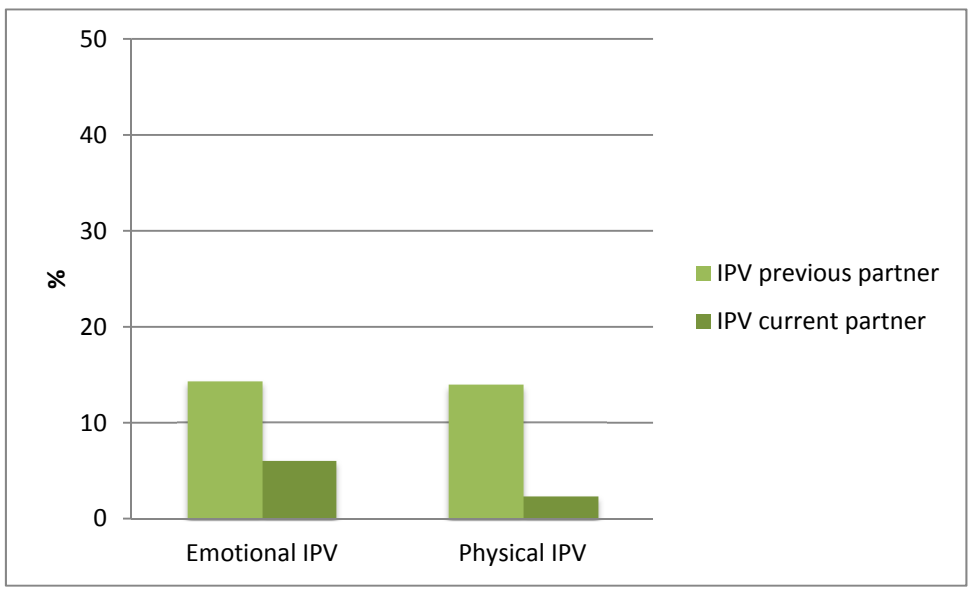

Figure 7. Prevalence of intimate partner violence among Thai women in Sweden (n=804)

Determinants of exposure to interpersonal violence (Papers I, IV) and related mortality (Paper II)

Are perceived threat of violence and exposure to physical violence significantly related to foreign-born status after adjustment for demographic and socioeconomic determinants? (Paper I)

Paper I showed that foreign-born women had significantly greater exposure to interpersonal violence than did Swedish-born women. Thus, multivariate analyses showed significantly increased odds ratios for exposure to threat of violence among foreign-born women in the crude model (OR, 1.43; 95% CI, 1.19–1.70), which also remained significant in the fully adjusted model (OR, 1.27; 95% CI, 1.05–1.54), after stepwise adjustment for the potential confounders represented by age, marital status, educational level, unemployment, and disposable household income. Exposure to physical violence was also significantly increased among foreign-born women compared to Swedish-born women in the crude model (OR, 1.30; 95% CI, 1.03–1.64), but the relationship was no longer significantly increased after adjustment. In contrast, exposure to physical violence was significantly related to marriage/cohabitation (OR, 2.36; 95% CI, 1.91–2.90) and low disposable income (OR, 1.85; 95% CI, 1.48–2.31). Finally, exposure to violence in the home was significantly more frequent among foreign-born women than Swedish-born (χ^2=15.73, p=0.001).

Is mortality due to interpersonal violence significantly related to foreign-born status after adjustment for demographic and socioeconomic determinants? (Paper II)

In Paper II significantly increased odds ratios for mortality due to interpersonal violence (vs. other external causes) were found among foreign-born women compared to Swedish-born women, both in the crude and fully adjusted models (OR, 2.45; 95% CI, 1.88-3.20, Figure 8). Potential confounders that were stepwise adjusted for were age, marital status, educational level, employment, and disposable household income. Marriage/cohabitation, low educational level, and unemployment were significantly related to mortality due to interpersonal violence as well as was later year of migration, i.e. foreign-born women who had migrated to Sweden in 1980 or later (compared to foreign-born women with earlier migration dates). Also, a statistically significant interaction was found between foreign country of birth and marriage/cohabitation, in the fully adjusted model (p=0.007). The interaction indicates that married/cohabiting foreign-born women are at greater risk of mortality due to interpersonal violence than unmarried foreign-born women and Swedish-born women, whether married or not.

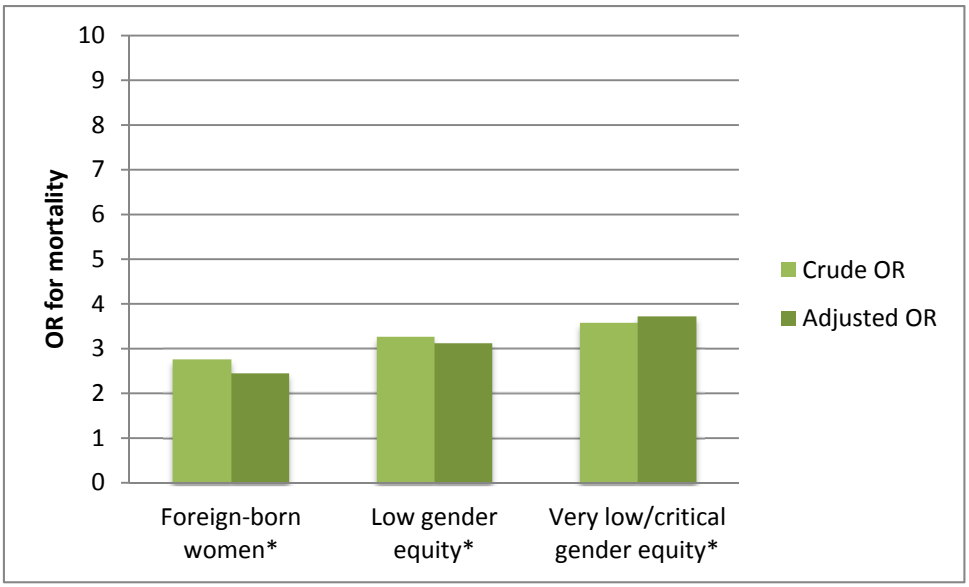

Figure 8. Odds ratios for crude and adjusted mortality due to interpersonal violence in relation to country of birth (Swedish-born (ref) vs. foreign-born) and equity level (medium (ref) vs. low, medium (ref) vs. very low/critical, *p<0.05)

Significantly increased odds ratios were obtained for mortality due to interpersonal violence (vs. other external causes) in women with low and very low/critical levels of gender equity in the crude model and remained significant after adjustment for potential confounders in both groups (OR, 3.14; 95% CI, 2.20-4.49), (OR, 3.72; 95% CI, 2.31-6.00, Figure 8), respectively, compared to women with medium level of gender equity (incl. Swedish-born). Also, low educational level was significantly associated with mortality due to interpersonal violence. An interaction analysis between GEI level and marital status in relation to mortality due to interpersonal violence yielded a significant interaction between low GEI level of country of birth and marriage/cohabitation (p=0.03) and between very low/critical GEI level country of birth and marriage/cohabitation (p=0.006, both analyses after adjustment). Thus, the results indicated that married/cohabitating women with low GEI level and very low/critical GEI level of country of birth respectively, were at greater risk of such mortality than unmarried women with low/very low/critical GEI levels and married women with medium GEI level.

Finally, bivariate analyses of mortality due to intentional self-harm, transport accidents, other accidents, and events of undetermined intent did not show any significantly increased odds ratios for women from countries with low or very low/critical levels of gender equity compared to women with medium GEI levels. However, odds ratios for mortality due to transport accidents (OR, 0.75; 95% CI,

0.56-0.98) and other accidental injuries (OR, 0.82; 95% CI, 0.48-0.95) were significantly decreased for women with low GEI levels compared to women with medium GEI levels.

What potential determinants are related to exposure to intimate partner violence by current partner among Thai women residing in Sweden? (Paper IV)

In Paper IV investigating intimate partner violence among Thai women in Sweden, no significant relationships were found between intimate partner violence by previous or current partners and the women's socio-demographic background characteristics. However, women with social isolation had significantly greater odds ratios for intimate partner violence by current partner (OR, 3.37; 95% CI, 1.82-6.24), and intimate partner violence by previous partner (OR, 2.17; 95% CI, 1.50-3.13), compared to women without social isolation. Also, women with low social trust had significantly increased odds ratios for intimate partner violence by previous partner compared to women with high social trust (OR, 1.58; 95% CI, 1.08-2.30, Figure 9).

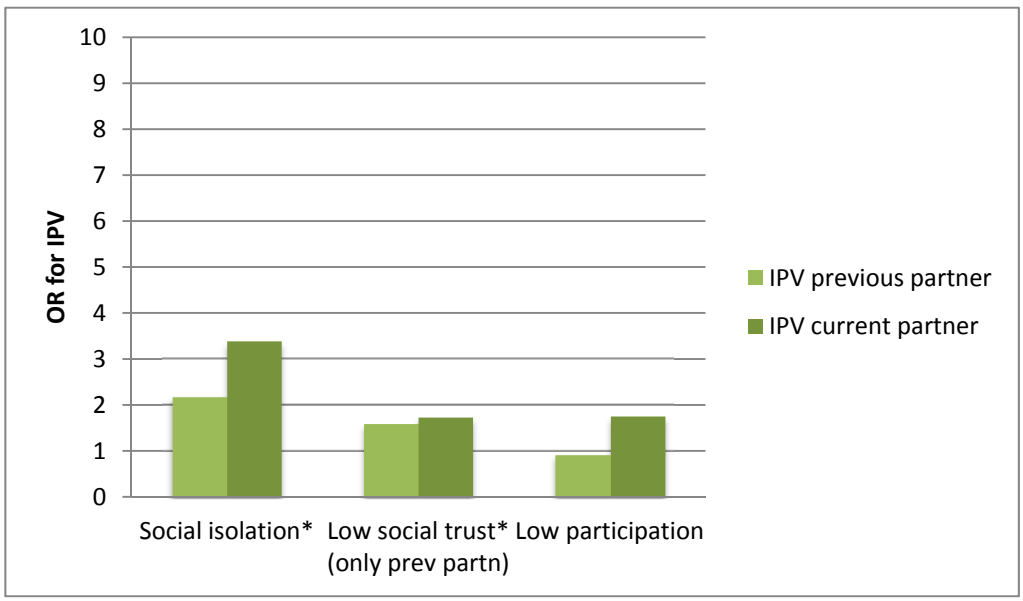

Figure 9. Odds ratios for exposure to intimate partner violence (yes vs. no) by previous and current partners in relation to social isolation (yes vs. no), low social trust (yes vs. no), and low social participation (yes vs. no) among Thai women residing in Sweden, (*p<0.05).

Perceptions regarding intimate partner violence among Iraqi refugees (Paper III)

What norms and experiences influence the perceptions of intimate partner violence among Iraqi refugees? (Paper III)

Manifest and latent qualitative content analysis was used for data analysis. In the latent analysis four themes, as well as an over-arching theme, were extracted from the interviews based on the various categories derived from the manifest content analysis. The first theme "the limbo of arrival" was based on the following categories: unfulfilled basic needs, lonely and worried, psychological distress due to migration, lack of network and support, and security, freedom, and rights. "The limbo of arrival" describes the sense of being lost and trapped at the same time as a newly arrived refugee in Sweden. Many of the participants felt psychological distress, social isolation, and lack of support. Some even expressed feelings of hopelessness and meaninglessness. The primary concerns of the participants, especially the men, were their perceived high level of unmet basic needs and loss of identity and social networks. Although most of the women suffered from psychological distress and feelings of dependency, they emphasized the differences between Sweden and Iraq concerning human rights, including women's rights, and anticipated increased levels of individual freedom.

The second theme, "violence as personal baggage", was based on the following categories: involuntary left Iraq due to the war, oppressed, threatened, and abused, abused in school, threatened and abused by partner in Iraq, and verbally abused by partner in Sweden. "Violence as personal baggage" illustrates a combination of exposure to war-related violence and family violence described by the participants. Approximately half of the women had been exposed to intimate partner violence while living in Iraq. Such violence was, according to the participants, frequent in Iraq, due to patriarchal structures preventing women from having equal rights with men, e.g. regarding forced marriages, intimate partner violence, and honor-related violence. Most of the participants did not believe that moving to a new context would decrease abusive behavior, although the type of violence might change for some, from physical to emotional, due to the less accepting legislation and norm system regarding intimate partner violence in Sweden. Also, some women described that a loss of status in the man, together with an increase in empowerment in the woman, could lead to marital conflict after migration.

"Clashing gender norms" was the third theme that was developed and the categories included here were: subordination of women in Iraq, men head of household, different opportunities due to gender, increased opportunities for women in Sweden, and too much freedom for women in Sweden. The theme describes great differences in gender norms between Iraq and Sweden. All participants regarded Sweden as a more gender equal society. Thus, in Iraq the man is family provider and head of the

household. Fewer rights for women than for men contribute to different opportunities for women in Iraq, with such limitations arising already during childhood. Some female participants emphasized the human rights-based Swedish legislation as an explanation for female empowerment in Sweden. Although male and female participants agreed that there was increased gender equity in Sweden, their attitudes regarding gender equity diverged, in that the women were hoping for more autonomy, while the men were afraid of losing power. Most of the women were hoping for increased autonomy and control over their own lives, but also felt dependent on their husband's views and wishes. Clashing gender norms aroused fear and suspicion in the men, but also even in some of the women, who disliked the thought of increased opportunities and control for women.

The final theme, "the overriding importance of honor" describes how the family honor, according to the participants, was permeating all their actions, as well as all aspects of the Iraqi society. The theme was based on the following categories: honor is everywhere, pre-marital sex prohibited for women, pre-marital relationships allowed for men, control and violence to protect honor, and punishment for honor crimes. Women and men shared the same view of honor, which was a characteristic that was primarily embodied in the women and protected by their purity and virginity. The rules concerning male honor and virginity were not as clear to the participants, i.e. whether men were allowed to have pre-marital relationships or not. The participants agreed that the woman's virginity often is controlled in order to protect the family honor and if damaged, it may result in the killing of the woman in order to restore the honor. Honor killings were, according to the participants, frequent in Iraq and usually handled by the family or the community.

The overarching theme "navigating between control and autonomy" describes the difficulties of balancing between two different set of norms, in Iraq and Sweden. But it also reflects women's struggle to gain more autonomy without changing the power balance within the relationship in a way that might initiate or exacerbate partner violence.

How do Iraqi refugees perceive their situation and conflicting gender norms on different levels of the Swedish society? (Paper III)

The themes were further analyzed with reference to the ecological model, in which the four themes were viewed as corresponding to the four different levels of the model: society, the community, the individual, and the personal history level. In the ecological model a person's actions are considered to be consequences of the interaction between different levels in society (Bronfenbrenner, 1977). Thus, in Paper III the model was used to explore how newly arrived refugees are able to navigate between two sets of values, those concerning their country of origin and those concerning Sweden, and to explore the interrelationships between the factors that influence this navigational process (see Figure 10).

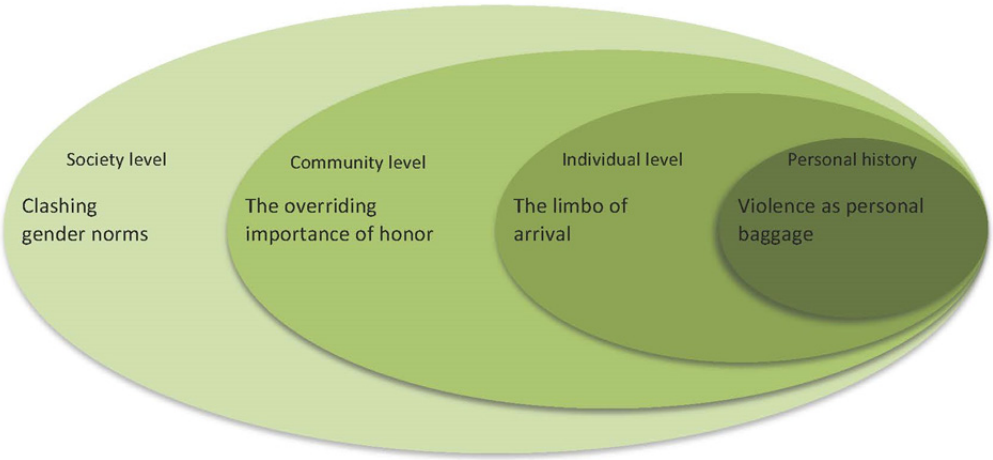

Figure 10. The ecological model: society level, community level, individual level and personal history

The results of the analysis showed that the theme "Clashing gender norms" corresponded to the society level (Figure 10), as it is on this level that values and beliefs are set that influence the other three levels. The participants were in the process of sorting out how to combine the two very divergent gender norm systems inherent in Iraq and Sweden. Most of the women were looking forward to gaining increased autonomy in Sweden, however fully aware of that the final decisions on her level of autonomy as well as in general were made by her husband. The community level refers to the social structures, both formal and informal and corresponded to the theme "the overriding importance of honor" (Figure 10). The participants were mainly group-oriented with a strong honor code and thus had not internalized the more individually based Swedish norms yet. The extent to which these Iraqi refugees would be willing to adopt Swedish gender norms depends somewhat on their perceptions of the importance of the honor culture. However, on the individual level strong adherence to the honor culture may have a variety of adverse consequences, including low level of integration.

On the individual level the theme "limbo of arrival" reflects the participants' individual situation and perceptions with regard to migration and well-being (Figure 10). Poor health, somatic and/or mental, reported by most of the participants is an important limitation regarding the integration of newly arrived refugees, thus, resulting in difficulties in participating in Swedish language education and other introductory activities. Inability to participate in such activities may lead to poor labor market and social integration. Many female participants emphasized their husbands' well-being and adaptation process as important determinants for their whole families'

quality of life in Sweden. Finally, the influence of personal history is applicable to the theme "violence as personal baggage" describing the participants experiences of both war-related violence and intimate partner violence. Due to the participants' internalized gender norms sanctioning intimate partner violence and also their previous experiences of different types of violence, the participants seemed to have normalized such exposure to violence to some degree, and thus did not appear to problematize or reflect to a greater extent on causes or behavior leading to VAW (Figure 10). Results on a sub-sample from the current material have been reported elsewhere (Fernbrant and Cantor-Graae, 2011).

Mental health consequences and social capital among abused Thai women (Paper IV)

Is intimate partner violence related to poor mental health relate and how might social capital play a role among Thai women residing in Sweden? (Paper IV)

Bivariate logistic regression analyses showed that odds ratios for poor mental health were significantly elevated among Thai women who reported any type of intimate partner violence exposure, i.e. emotional intimate partner violence by a previous partner (OR, 2.36; 95% CI, 1.52-3.68), physical/sexual intimate partner violence by a previous partner (OR, 1.85; 95% CI, 1.17-2.94), emotional intimate partner violence by a current partner (OR, 5.06; 95% CI, 2.72-9.42), and physical/sexual intimate partner violence by a current partner (OR, 5.36; 95% CI, 2.08-13.83), compared to women who did not report such abuse. Thus, odds ratios for poor mental health were significantly elevated among Thai women experiencing intimate partner violence by a current partner vs. those with previous or without any experience of intimate partner violence. Moreover, odds ratios for poor mental health were also significantly elevated among women who were not in a relationship (OR, 1.78; 95% CI, 1.10-2.86). Finally, odds ratios for poor mental health were also significantly elevated among women with poorer self-rated health (vs. good self-rated health, OR, 4.30; 95% CI, 2.96-6.26), women with perceived social isolation (vs. women who did not feel socially isolated, OR, 3.94; 95% CI, 2.68-5.79), and women with lower social trust (vs. high social trust, OR, 2.85; 95% CI, 1.93-4.19).

The multivariate logistic regression analysis showed significantly elevated odds ratios for poor mental health in relation to women who had been exposed to intimate partner violence by current partner, compared to unexposed women, both in the crude model (OR, 4.86; 95% CI, 2.69-8.79), and the fully adjusted model (OR, 3.29; 95% CI, 1.39-7.79). Potential confounders stepwise adjusted for were the following: intimate partner violence by a previous partner, age, marital status, educational level, disposable income, social isolation, and social capital measures (social trust and social participation). In the fully adjusted model, perceived social isolation (OR, 5.15;

95% CI, 3.18-8.33), and low social trust (OR, 2.43; 95% CI, 1.53-3.85) were also significantly related to poor mental health. Exposure to intimate partner violence by a previous partner was no longer significantly associated with poor mental health in the fully adjusted model.

A synergy analysis between intimate partner violence by current partner and social isolation with regard to the outcome measure poor mental health showed a more than additive effect ($p<0.001$, fully adjusted model, Figure 11). Similarly, a more than additive synergy effect was found between intimate partner violence exposure by a current partner and low social trust ($p<0.001$, fully adjusted model, Figure 12) with regard to poor mental health. The lower odds ratios for poor mental health among women exposed to intimate partner violence but who were not socially isolated as well as those shown for women with high social trust indirectly suggest a greater resilience to adverse mental health consequences of intimate partner violence among women in these two subgroups (Figures 11, 12).

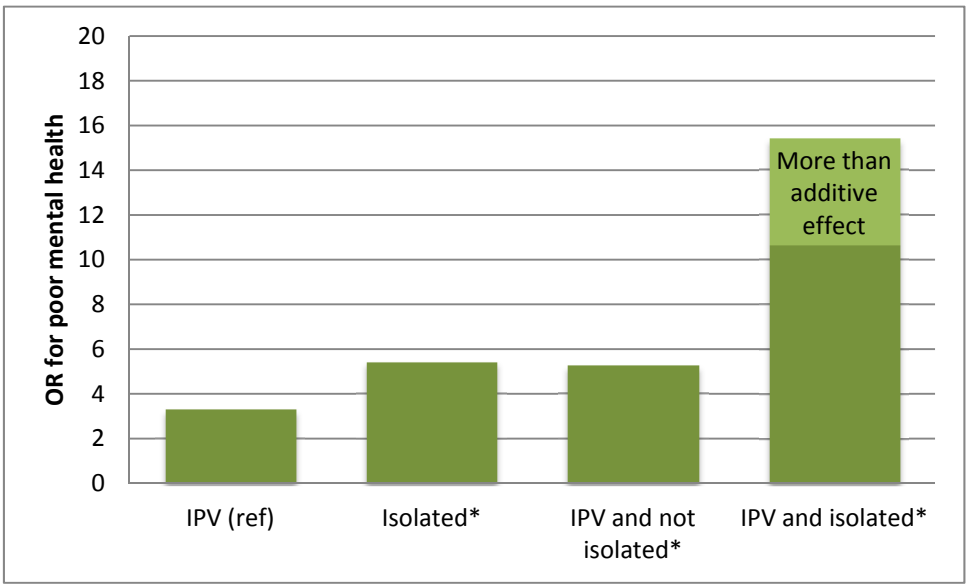

Figure 11. Synergy effect between intimate partner violence by current partner and social isolation with regard to poor mental health (*$p<0.05$, significant synergy effect)

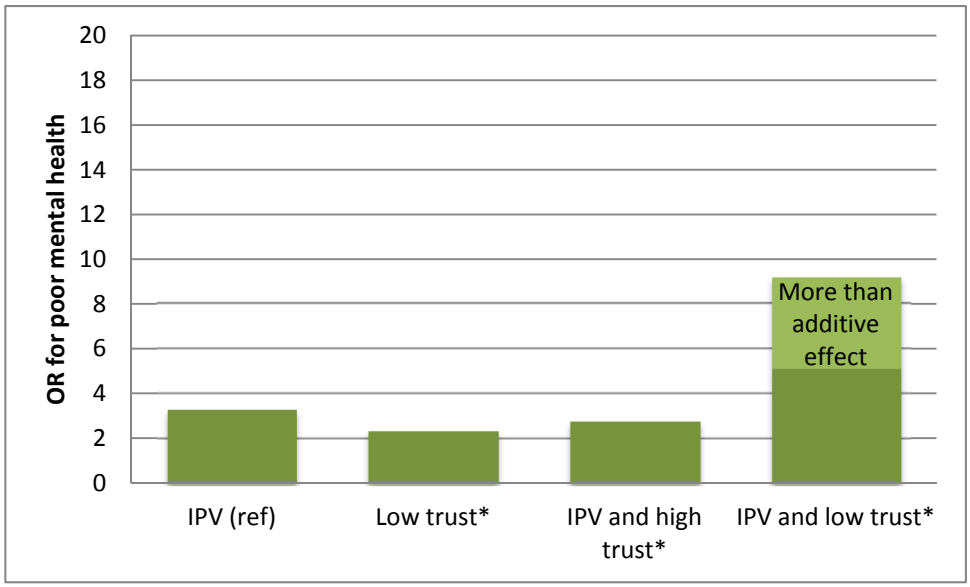

Figure 12. Synergy effect between intimate partner violence by current partner and low social trust with regard to poor mental health (*p<0.05, significant synergy effect)

General discussion

The results of this thesis showed that foreign-born women in Sweden have a significantly increased exposure to interpersonal violence in the home and a significantly increased risk of mortality due to interpersonal violence, compared to Swedish-born women. Women from low and middle-income countries reported greater exposure to physical interpersonal violence than women from high-income countries. Moreover, women originating from countries with low and very low/critical gender equity had an increased risk of being killed by another person. Finally, the results showed that exposure to intimate partner violence among Thai women residing in Sweden is related to poor mental health. In addition to foreign country of birth, determinants for interpersonal violence included the following: marriage/cohabitation, low disposable household income (Paper I) and low disposable woman's own income (Paper IV), social isolation, and low social trust. Determinants for mortality due to interpersonal violence were marriage/cohabitation, low educational level, and unemployment. The findings from the qualitative study also showed that legislation and value systems from the country of origin with regard to gender roles influence perceptions of intimate partner violence among Iraqi persons in Sweden, and that different factors such as gender, current well-being, and previous exposure to violence, interacted in creating such perceptions.

These findings agree with previous research from other settings showing that foreign-born women are at increased risk of interpersonal violence (Colorado-Yohar, Tormo, Salmerón, Dios, and Ballesta, 2012), including intimate partner violence (Golden, Perreira, and Durrance, 2013) and related mortality (Azziz-Baumgartner, McKeown, Melvin, Dang, and Reed, 2011), compared to majority populations. Note that most previous studies concern ethnic minorities but that ethnic minorities often contain a sizeable proportion of foreign-born persons. Previous studies has also shown that low socioeconomic status (Jewkes et al, 2002a; Kasturirangan et al, 2004), low gender equity (Abu-Ras, 2007; Chang et al, 2009; Thapa-Oli et al, 2009), and social isolation (James et al, 2004; Morash et al, 2007; Raj and Silverman, 2003) are determinants for such violence among foreign-born women. To our knowledge no previous studies have investigated prevalence of interpersonal violence among foreign-born women in Scania, mortality due to interpersonal violence among foreign-born women in Sweden, or prevalence and determinants for intimate partner violence among Thai women in Sweden. Thus, this thesis contributes new evidence to the general body of

existing knowledge concerning violence against foreign-born women and its determinants.

The multifaceted approach

The multifaceted approach utilized in this thesis, whereby different methods and materials were incorporated, provided the opportunity to examine violence against foreign-born women in Sweden from different approaches. These were: the survey data approach (Papers I, IV), the register-based data approach (Paper II), and the in-depth exploratory approach (Paper III), that is, the use of quantitative (Papers I, II, IV) as well as qualitative (Paper III) study designs. In line with the overall aim of the thesis, the survey approach provided information on the prevalence of interpersonal violence, both in a regional population (Paper I) and in a specific population, namely Thai women (Paper IV). Also, the survey approach provided information on determinants for such exposure and thus helped to gain a better understanding of contributing factors. Access to register-based data on cause of death among women in Sweden provided the opportunity to examine the prevalence of the worst outcome of exposure to interpersonal violence, i.e. assault leading to death. Thus, mortality due to interpersonal violence represents the most adverse health outcome of VAW. Potential determinants of interpersonal violence leading to death were examined within this population of deceased women, as a further complement to the determinants that were examined in the survey studies. Finally, the in-depth exploratory approach provided the opportunity to discuss perceptions and experiences of VAW in a group of individuals originating from a culture that sanctions the use of such violence, namely Iraqi refugees.

Moreover, the current thesis utilized both samples of highly heterogeneous foreign-born women (Papers I and II) and samples with specific focus on one country of origin, i.e. Iraq and Thailand (Papers III and IV). The latter two samples represent two very different types of migration history. The Iraqis are refugees who have fled from a war situation and the Thai women have mainly migrated for family reasons, that is, in order to marry Swedish men. Also, these two groups of foreign-born women come from different types of societies; they have different religions, and different value systems, etc. Common denominators for the two groups are that both Iraqi and Thai women are subordinated men in their countries of birth, and also that their labor market and social integration in Sweden is relatively low. All in all, the various approaches used in this thesis served as a complement to one another in terms of the type of information that could be accessed.

Prevalence across samples

The current thesis includes three prevalence studies of VAW (Papers I, II, IV). Prevalence studies are often difficult to compare due to divergent definitions of VAW and also varying periods of exposure. With regard to the survey data studies in the thesis (Papers I and IV), both definitions of type of VAW and periods of exposure differ. In Paper I we investigated exposure to interpersonal violence without knowledge of the identity of the perpetrator, while Paper IV is concerning intimate partner violence. Also, the measures of VAW used in Paper I were perceived threat of violence and exposure to physical violence, and in Paper IV they were: emotional intimate partner violence (including insulting/humiliating behavior and threat of violence), and exposure to physical and/or sexual intimate partner violence. The divergent measures of VAW used in Papers I and IV was due to the fact that we had the opportunity to develop our own questionnaire in Paper IV and thus could include questionnaire items concerning different forms of violence as well as the identity of the perpetrator. Furthermore, the period of exposure in Paper I was regarding the last 12 months, whereas in Paper IV, the exposure to intimate partner violence was by current or former partner, rather than a specific time period. The reason for choosing a different approach for measuring the time period in Paper IV was to increase the chance of collecting as much information as possible about intimate partner violence among Thai women, rather than solely during the past year. Nevertheless, the prevalence for perceived threat of interpersonal violence in foreign-born women during the last 12 months (Paper I) was higher than the prevalence for emotional intimate partner violence by current partner among Thai women (9% vs. 6.1%). The same patterns were found in comparing exposure to physical interpersonal violence in foreign-born women (Paper I) and physical intimate partner violence by current partner in Thai women (4.7% vs. 2.4%). Apart from slightly different definitions and that the foreign-born women included in Paper I represented a broad variety of nationalities, the higher prevalence of interpersonal violence reported by foreign-born women may possibly be explained by the fact that intimate partner violence is essentially a narrower definition than interpersonal violence, and thus probably includes fewer cases of exposure.

The prevalence of exposure to interpersonal physical violence in the total sample (Swedish-born and foreign-born women) during the last 12 months in Paper I (8.4%) and exposure to such violence during the same period of time as used in Lundgren et al's study (2001, 12%), did not differ to a great extent. Other previous Swedish prevalence studies were not comparable due to reporting only lifetime exposure (Swahnberg and Wijma, 2003), intimate partner violence (Lövestad and Krantz, 2012), or examining purposive samples, such as only abused women (Samelius et al, 2007) or patients (Wijma et al, 2003).

To our knowledge there are no previous studies on Thai women's exposure to intimate partner violence in Sweden; however Thailand was one of the sites in WHO's Multi-Country Study on Women's Health and Domestic Violence (2005). The prevalence for exposure to physical and/or sexual intimate partner violence ever in lifetime in WHO's study was 41.1% and can be compared to our findings of Thai women's exposure to such violence by previous partner and/or current partner of 15.0%. The lower prevalence in our study may possibly be due to decreased exposure to violence in the study population after migration compared to before migration to Sweden. Also, the discrepancy between the results might be explained by the differing methods used for data collection in the two studies, as the WHO study was collected by structured interviews while we used postal questionnaires, and thus the extent to which the current participants fully understood the questions is unknown. Also, even though our questions were derived from the WHO questionnaire, the questionnaires used in the respective studies differed in exact content.

In Paper II, the overall rate of mortality due to interpersonal violence among foreign-born women was 10.9% during the period studied, i.e. 15 years. Thus, the yearly prevalence among foreign-born women was 0.73%, which can be compared to the 4.7% of foreign-born women who reported exposure to physical interpersonal violence in Paper I. Hence, as expected the prevalence of exposure to interpersonal violence was greater than the mortality, which is the most severe health outcome. Previous Swedish reports on fatal violence were based on the same register as Paper II and thus, showed the same prevalence, however not stratified as Swedish-born and foreign-born women (The Swedish National Council for Crime Prevention, 2012).

Determinants of violence against foreign-born women

Violence against women (VAW) has many contributing factors, and these may vary across countries and also on an individual level. The increased risk of interpersonal violence among foreign-born women compared to Swedish-born women found in this thesis raises the question as to whether their increased risk is due to a greater concentration of the same factors that contribute to interpersonal violence in Swedish-born women, or whether there are unique aspects associated with being foreign-born that contribute to this increased vulnerability. Our findings indicated that marriage/cohabitation (Papers I, II), low disposable household income (Paper I), low educational level (Paper II), unemployment (Paper II), social isolation (Paper IV), low development level of country of origin (Paper I), and low level of gender equity in country of origin were significant determinants of increased risk for interpersonal violence among foreign-born women. All of these factors have previously been associated with VAW in general, and these factors are presumably more concentrated

among foreign-born women on a group basis. Thus, the answer to the question is that foreign-born women generally share the same determinants for VAW as majority populations, but may differ from Swedish-born women concerning gender equity level of their country of origin and also, the ability to make themselves understood in Swedish. Foreign-born women may have less familiarity with the Swedish laws and the health care system and may not know where to seek help for abuse. Moreover, foreign-born women may be especially fearful of contact with authorities due to either previous adverse experience in their homeland or due to fear for their residential status.

Gender equity

The findings of the current thesis showed that even in a country with high gender equity, such as Sweden, VAW does occur, and especially among foreign-born women. However, access to education and employment among women may lead to economic independence and also to increased empowerment, and female empowerment could be a protective factor against such violence. Thus, the risk factors represented by low disposable household income (Paper I), low educational level, and unemployment (Paper II) are similar to the measures that are assessed in the Gender Equity Index (GEI), although in the current context no information was available on the gap between the woman and the other household members. The thesis used two classification systems for country of birth: the country's development level in Paper I (high-income countries and middle/low-income countries, World Bank, 2009), and in Paper II the GEI (Medium gender equity, low gender equity, and very low/critical gender equity, Social Watch, 2012). Foreign-born women from countries with low levels of development may also have had fewer educational opportunities. However, the GEI gives a more refined classification of measures that might be more directly related to VAW, as it captures a country's gender gap with regard to educational level, economic activity, and also political empowerment.

It is interesting to note that the findings in Paper II that showed a significant relationship between mortality due to interpersonal violence and low gender equity of country of birth, are in agreement with previous research showing that women originating from countries with low gender equity and strong patriarchal norms are at increased risk of VAW (Abu-Ras, 2007; Chang et al; 2009; Jewkes, 2002; Jewkes et al, 2002a; Krantz and Garcia-Moreno, 2005). Countries with low gender equity are presumably countries where women have fewer rights and VAW may be sanctioned. Previous research showed that women from such countries may have a higher tolerance for exposure to interpersonal violence, including intimate partner violence, due to a normalization of such violence (Morash et al, 2007; Uthman, Lawoko, and Moradi, 2010). The findings in the qualitative paper of the thesis were well in line with these findings, and showed that Iraqi refugees in Sweden had internalized the

norms concerning gender roles from their country of origin and thus, some of the informants (both men and women) were against equal rights for the sexes and reported the necessity of VAW in some situations. Also, abused women who tolerate or normalize such violence may be less likely to seek help or care, and consequently may be at risk for further violence and at risk for death as the worst outcome.

Hence, male dominance seems to be an important explanation for the high prevalence of VAW in societies with low gender equity. However, it should be noted that far from all men in strongly patriarchal societies abuse women. Also, since VAW is prevalent in countries with higher gender equity levels, as supported by the findings of this thesis that also Swedish-born women and Thai women married to Swedish men are exposed to VAW, a country's gender equity level per se may not necessarily reflect gender equity levels on an individual basis.

Finally, it may be noted that low disposable household income, used in Paper I and II as a measure for socioeconomic status, was significantly related to exposure to interpersonal violence in Paper I, but not to mortality due to interpersonal violence in Paper II. The discrepancy in these findings may be explained by the fact that household income need not necessarily reflect the woman's actual access to resources, since she may be disadvantaged and/or impoverished within the household. Thus, in Paper IV we used the woman's disposable income, which may well be a better measure of women in relationships with high levels of gender inequity. Nevertheless, low disposable income was not significantly related to exposure to intimate partner violence in Thai women, and neither was employment. This might suggest that there are other more important contributors to exposure to intimate partner violence among Thai women in Sweden than socioeconomic "empowerment". Such contributors may include previous experiences of violence and lack of contact with the majority society.

Marriage and cohabitation

Marriage/cohabitation was a risk factor for interpersonal violence in Papers I and II. Information on the identity of the perpetrator was lacking in both studies, but marital status was reported and could serve as a proxy indicator for women who were in a relationship, and thus at risk of intimate partner violence specifically, rather than interpersonal violence in general. In Paper II the results of the interaction analysis showed that foreign-born women who were married/cohabitating had the highest risk of exposure to mortality due to interpersonal violence compared to unmarried foreign-born women, unmarried Swedish-born women, and married/cohabitating Swedish-born women, thus indicating that at least some of the cases of mortality may be attributable to exposure to intimate partner violence.

Furthermore, in Paper I the results showed that foreign-born women were primarily exposed to violence in the home, which also may indicate intimate partner violence. However, as there is no information on the perpetrator of the violence, the perpetrator might also be another family member or an acquaintance. Honor-related violence may be prevalent in some immigrant families in order to control the women (Schlytter and Linell, 2010). Thus, marriage in such families also includes a new extended family, which may increase the risk of violence in the home from other members than an intimate partner. Thus, such an explanation may be applicable to some of the women in both Papers I and II; however previous research has shown that the most common type of VAW is intimate partner violence (Campbell, 2002; Garcia-Moreno et al, 2006; Jewkes, 2002). Also, a Swedish report on fatal violence showed that 85% of the women knew their perpetrator and in half of the cases the perpetrator was an intimate partner (The Swedish National Council for Crime Prevention, 2007). Also, a previous study on intimate partner homicide from the United States reported that in 50% of the cases the perpetrator was an intimate partner (Campbell et al, 2003). Thus, one might infer that the majority of perpetrators of interpersonal violence in Papers I and II nevertheless were intimate partners, despite the lack of information concerning the identity of the perpetrator.

The majority of Thai women in Paper IV had come to Sweden in order to marry a Swedish man. However, marriage/cohabitation was not significantly related to exposure to intimate partner violence, which may indicate that the abused women were not married or cohabitating with their intimate partners at the time they answered the questionnaire.

Social isolation

Social isolation is a risk factor for intimate partner violence among foreign-born women, according to previous research (Raj and Silverman, 2003). This is in line with our findings concerning Thai women exposed to intimate partner violence in Paper IV. Social isolation can be used as a form of controlling behavior either by a partner or by other family members, and in families with patriarchal structures, including honor cultures. Social isolation among foreign-born women may lead to lack of contact with the family in the country of origin, low social participation in the new country, low social trust in others, poor language skills due to lack of opportunity to learn Swedish, and poor mental health, all of which can make the women less able to cope with interpersonal violence should it arise. Also, social isolation can be a further consequence of interpersonal violence (James et al, 2004; Morash et al, 2007) and thus, foreign-born women exposed to violence may be restricted from activities outside the home, may avoid social contact and/or to report such violence due to fear of increased abuse, or have lack of knowledge with regard to where to seek help, etc. Social isolation can thus become a vicious circle with regard to exposure to

interpersonal violence, as it may lead to an inability to cope with and report violence, which in turn may lead to increased vulnerability towards such exposure.

In Paper IV social isolation turned out to be an important contributor to poor mental health, and also to exposure to intimate partner violence. However, among foreign-born women in Sweden, Thai women differ in the sense that most of them migrate in order to marry Swedish or Scandinavian men, in contrast to most other female immigrants in Sweden. During recent years the majority of female immigrants to Sweden are refugees and thus either migrate together with their families, or have family members already living in Sweden. Also, many immigrants in Sweden who are married/cohabitating, are married to/cohabitating with a person from the same country of birth, and consequently would share similar gender norms. Hence, Thai women may not be representative of the larger group of immigrants in Sweden but they represent an interesting group with regard to intimate partner violence, due to the fact that they are married to Swedish men who, according to the GEI, would have high levels of gender equity on a national basis (Social Watch, 2012).

Moreover, the findings in Paper IV showed that Thai women exposed to intimate partner violence who were less socially isolated and had high social trust were seemingly resilient to poor mental health. Social trust in others is founded during childhood and affected by norms and risks in the surrounding society. Previous experiences of interpersonal violence may influence social trust, which is supported by findings in Paper IV where previous exposure to intimate partner violence was significantly associated with low social trust. Other factors that also may affect the individual level of social trust among foreign-born women are migration and adverse interpersonal experiences in the new country. Moreover, low social trust may lead to social isolation and thus may be an indirect risk factor for intimate partner violence. Also, although perceived social isolation was found to be a risk factor for poor mental health in abused Thai women, similar associations were not found for low social participation. The divergent results for these two measures may be explained by the fact that Thai women might be socially active within their group but at the same time feel socially isolated from the majority population.

Finally, VAW is a complex phenomenon due to the interplay between different factors and levels of society. This thesis is based on data on the aggregate level and thus the extent to which any of these factors are operating on the individual level cannot be determined. Although factors such as gender inequity and social isolation have been shown to be important contributors to violence against foreign-born women, there are also other strains on the individual level that may lead to abuse, including previous exposure to abuse, as shown in Paper IV, and conflicts within the relationship based on daily stressors, and not necessarily on gender inequity.

Adverse health consequences of violence against foreign-born women

Poor mental health

Poor mental health was chosen as the primary indicator of adverse health consequences of exposure to intimate partner violence (Paper IV) for a number of reasons. Firstly, mounting evidence of previous research has shown that poor mental health is a common consequence of exposure to both emotional (Vizcarra et al, 2004), and physical and/or sexual (Bonomi et al, 2007; Ellsberg et al, 2008; Campbell, 2002) intimate partner violence. Secondly, poor mental health is a good indicator of short-term consequences, such as post-traumatic stress disorder and anxiety, of exposure to interpersonal violence, in contrast to many somatic health consequences caused by such violence that rather develop in a long-term perspective (Campbell, 2002; Pallitto et al, 2005). Thirdly, self-reported mental health was a health measure deemed suitable for a postal survey distributed to Thai women.

The findings of this thesis that poor mental health is an important consequence for both emotional and physical/sexual intimate partner violence (Paper IV) are supported by previous research (Bonomi et al, 2007; Ellsberg et al, 2008). Previous studies have also shown that foreign-born in general have poorer self-rated health (Nielsen and Krasnik, 2010), and also poorer mental health than majority populations (Cantor-Graae et al, 2005; Hjern and Allebeck, 2002; Sundquist et al, 2000). This is in agreement with the findings of Paper III, where Iraqi refugees reported high levels of psychological distress and poor well-being, due to migration-related reasons such as loss of identity, loss of status, and loss of social networks, and also due to previous and current exposure to emotional and physical collective violence, as well as intimate partner violence.

Mortality

Mortality was also chosen as an outcome for one of the studies in this thesis in that it represents the most severe consequence of interpersonal violence. Previous research has shown that persons with a low level of education and low socioeconomic status were more exposed to disease and injuries and thus at increased risk for premature death, i.e. mortality occurring before life expectancy at birth (Marmot, 2005; Wilkinson and Pickett, 2008). A recent Swedish report showed that external causes of death, such as suicide, injuries, and interpersonal violence, were the second most common causes of premature death among women in Sweden (National Board of Health and Welfare, 2012). The findings in Paper II, focusing on mortality due to

assault, showed that foreign-born women and women originating from countries with low gender equity were at greater risk of mortality due to interpersonal violence than other women. This is in agreement with previous research from the United Kingdom also reporting a higher mortality risk due to interpersonal violence among immigrants (Marmot, Adelstein, and Bulusu, 1984).

To our knowledge previous research from a Swedish perspective concerning mortality among women due to interpersonal violence is lacking. It may be noted that Esscher, Haglund, Högberg, and Essén (2012), using material from the Swedish Cause of Death Register, examined all causes of death (internal and external), in Swedish-born and foreign-born women, albeit over a different period of years and using a different study design than in Paper II. Esscher et al (2012) not specifically examine mortality due to interpersonal violence vs. other non-somatic external causes of death.

An implication from the findings in Paper III concerning Iraqi refugees is that women may normalize interpersonal violence due to previous experiences and also due to norms sanctioning such violence. In those cases, or if exposure to interpersonal violence is perceived as something that is handled within the family, help-seeking behavior may be affected in a negative direction. Abused women who do not seek help may be at risk for mortality due to interpersonal violence (Paper II).

Methodological considerations

The current thesis has a number of strengths. This is the first thesis conducted in Sweden concerning violence against foreign-born women, and more specifically among Iraqi and Thai women. Another strength is the multifaceted approach with four different data sets and two different methods (quantitative and qualitative) used in order to examine VAW from different perspectives, and thus, the results may be regarded as complementary to one another. For example, the same determinants are shown in a national and a regional sample, increasing the validity of the findings. A further strength is that two of the studies present population-based general prevalence of exposure to VAW and related mortality comparing foreign-born and Swedish-born women, while the other two papers report perceptions, experiences (Paper III), and prevalence (Paper IV) of VAW in two specific groups of foreign-born women.

The Swedish Cause of Death Register, utilized in Paper II, holds an internationally high standard, uses the same classification system as WHO (Nyström, Larsson, Rutqvist, Lindgren, Lindqvist et al, 1995; Johansson, Björkenstam & Westerling, 2009), and has shown good validity in other contexts (Nyström et al, 1995). This register is an unusual data source in research on VAW, and Paper II is the first study

investigating cause of death due to assault among foreign-born women in Sweden. Another strength of the thesis is the relatively large participation rates in the survey studies, 57.4% (Paper I) and 62.3% (Paper IV). Other national or regional public health surveys targeting Swedish-speaking populations had participation rates of 49% (Swedish National Institute of Public Health, 2012) and 54% (Region of Västra Götaland, 2011). Also, although the results from the sample in Paper IV pertain to Thai women, the results are potentially generalizable to other foreign-born women who have migrated due to family relations and have a Swedish partner, in that social isolation may contribute to poor mental health and intimate partner violence even in such groups.

Furthermore, the questions on exposure to violence in Paper IV were derived from the Scania Public Health Survey (Rosvall et al, 2005) and selected items in WHO's Multi-Country Study (2005). The WHO study was originally conducted at ten different sites and has shown good validity. The questionnaires sent out to Thai women in Sweden (Paper IV) were in Thai, with the intention to hopefully include women both with good and poor Swedish language skills in order to secure a high participation rate. Furthermore, asking about exposure to violence by using a questionnaire sent to the home of potentially abused women might increase the risk of intimate partner violence for such women. Therefore, in Paper IV regarding Thai women who mostly are married to Swedish men, the information letter was both in Swedish and Thai to avoid suspicion from the men, but the questionnaire was solely distributed in Thai in order to try to protect the abused women against exacerbated abuse.

Furthermore, the use of qualitative methods in Paper III enabled the informants to describe their situation and points of view in their own words, and thus serves as a complement to the other quantitative studies. Utilizing a sample of recently arrived Iraqi men and women in Sweden with varied background characteristics enhanced the credibility of the study, in that a heterogeneous sample with different genders, educational levels, religions etc. was obtained. The diversity of backgrounds represented in the study enhanced the transferability of the current findings to other newly arrived Iraqi refugees residing in Sweden. However, the findings may not be relevant for Iraqi refugees' experiences in other international settings where gender norms are less liberal, or for Iraqi refugees with longer duration in Sweden. The use of four additional interviews after data analysis served as an indication that saturation had been achieved, as these four interviews did not contribute any new information.

Although it was not possible to discuss the findings with the participants, the extraction of relevant themes is thought to be adequate due to the fact that the first and last author independently achieved consensus in data coding. Using a checklist for the interview guide enhanced dependability, such that all participants were asked

to discuss the same topics, albeit they were free to form the interviews according to their needs.

The studies included in this thesis also have a number of limitations. An important limitation in Papers I and II is that the identity of the perpetrator is entirely unknown. In Paper I information on the type, severity, and frequency of violence is also lacking. Thus, exposure to violence in these two papers concerns the more general concept, i.e. interpersonal violence, rather than intimate partner violence specifically. Another limitation is the fact that Papers I, III, and IV are based on self-reported data, questionnaires and interviews, and thus the information is of subjective nature. Nevertheless, as mentioned above, the studies are based on questions that have shown good validity in the past, and to enable women to admit to and report abuse is an inherent problem in VAW research. A number of reasons for why women do not report abuse can be listed, such as perceptions sanctioning VAW, fear of reprisal of the perpetrator who is most likely an intimate partner, the likelihood that women exposed to the most severe abuse and control are prohibited to answer, and that women who suffer from the most severe health consequences are unable to answer. Furthermore, the questionnaire in Paper I was distributed in Swedish and hence women with poor Swedish language skills, and possibly also women who are to a greater extent socially isolated and/or in abusive relationships, were excluded from the sample. Thus, those women who might have been especially at risk for exposure to violence may have been under-represented. In Paper IV the questionnaire was distributed in Thai in order to avoid the same issue of language barriers.

A possible limitation in Paper II is the risk of misclassification errors with regard to the accuracy with which causes of death are reported, due to insufficient information on the fatal event. Thus, there might be an underreporting of interpersonal violence due to the uncertainty of the surrounding circumstances, especially in cases concerning fall accidents and other accidents in the home. It should be noted however that the outcome of the police investigations of the deceased women in the current study do not affect the results of this study, since cause of death in the register is a medical assessment rather than a judicial decision. Additionally, although the register has a high standard and level of accuracy, it is unknown whether mortality among foreign-born women due to external causes is more likely to be reported as due to interpersonal violence than other causes. Another potential limitation is the extent to which the foreign-born population in Sweden may be over-estimated, due to that some do not report to the registration authorities when they emigrate (Weitoft, Gullberg, Hjern, and Rosen, 1999). An overestimation of the foreign-born population in Sweden would result in an underestimation of the population-based risk of mortality due to interpersonal violence associated with being foreign-born. The net effect of these two sources of bias, i.e. differential reporting of mortality due to interpersonal violence and a possible over-estimation of the foreign-born population of Sweden, cannot be determined.

In Paper III, a possible methodological limitation is that the interviewer was a Swedish woman, thus posing cultural and language barriers. Due to language barriers, telephone interpreters were used for 11 of the 18 interviews. As different interpreters were used, the quality of the interpretation might have varied, and it would have been optimal to have only one interpreter. However, the use of telephone interpreters who were not residing in the same region made it possible to avoid a third party in the room and for the participants to remain anonymous to the interpreter. Furthermore, all interpreters worked for the same company, and had the same gender as the participants. Also, participants were interviewed only once, and repeated interviews might have given further insights of their views and/or led to greater trust.

In Paper IV a possible limitation is that there is no information on the country of origin of the non-Scandinavian partners, but these were relatively few. The majority (75%) of the women who reported country of origin of their partner reported Sweden or another Scandinavian country. An additional limitation is the lack of information concerning the severity and the frequency of intimate partner violence, i.e. whether it was repeated abuse or a single occurrence. Also, it is unknown whether intimate partner violence in Thailand occurred only prior to migration to Sweden or also after, for example during a vacation in Thailand. The fact that this is a cross-sectional design prevents some inferences regarding the direction of causality, and there is no way of knowing if mental health problems were present before or after exposure to intimate partner violence. Women suffering from poor mental health are often in a more vulnerable situation and may be at greater risk for abuse than women with good mental health (Ellsberg et al, 2008). Also, the study lacked a comparison group, either Swedish or other foreign-born women, with regard to prevalence of intimate partner violence. Finally, it should be noted that the current study only concerns intimate partner violence and that other types of interpersonal violence also may contribute to poor mental health.

Each research method has intrinsic limitations and while qualitative studies are limited in size compared to survey studies, it is unknown to what extent an informant has understood the questions in a survey questionnaire. The use of a postal questionnaire to assess sensitive subjects such as exposure to VAW, may potentially yield untruthful answers or result in exacerbated abuse. Thus, a multifaceted approach with different methods and materials is advantageous, in order to better understand the phenomena of VAW and its contributing factors.

Implications for prevention and future research

Although resilience was studied solely in Paper IV, the implications of those findings, in addition to the findings in the other papers point to a number of factors that may protect foreign-born women against violence, that may potentially be important for prevention. Previous research has shown that resilience occurs primarily when there are aggregated protective factors involved in both promoting well-being and protecting against risk (Zautra, Hall, and Murray, 2010). Such factors or processes leading to resilience are the result of the interaction between an individual and the surrounding society, rather than a characteristic of the individual herself (Leadbeater, Dodgen, and Solarz, 2005; Zautra et al, 2010).

The protective factors regarding exposure to interpersonal violence against foreign-born women that emerged in the current thesis are presented in Figure 13. The figure indicates that gender equity is a core protector operating on all levels of society. Gender equity on society and community levels can help to diminish the impact of those internalized gender norms that might sanction VAW on an individual level. Thus, gender equity acts to empower women through access to education, employment and political roles. Increased female empowerment among foreign-born women may also in the long-term perspective lead to increased gender equity in the entire family, and thus lead to more gender equal norms with a less subordinated role for women and less VAW.

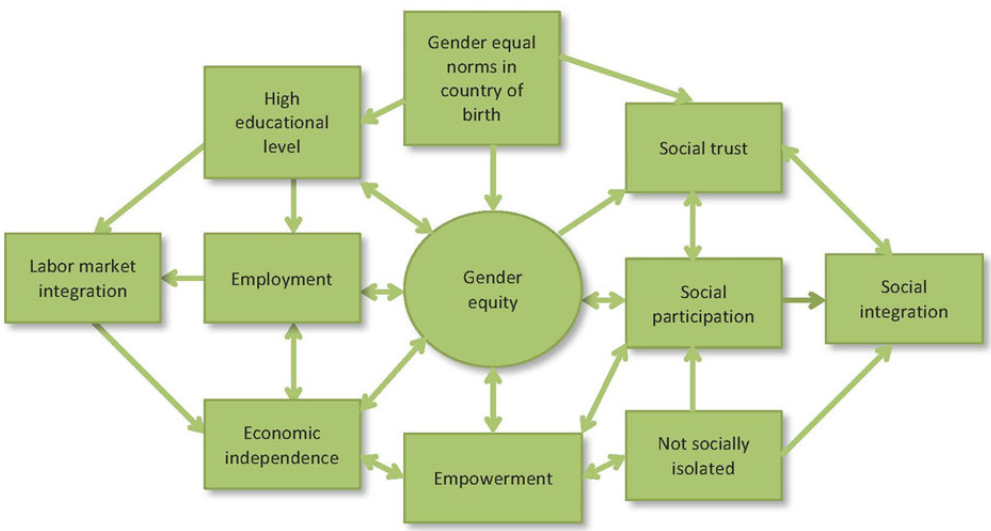

Figure 13. Factors of resilience for violence among foreign-born women in Sweden

Furthermore, labor market integration for women is both an important contributor to and a consequence of gender equity. For foreign-born women such integration is essential in order to be able to interact with, and become a part of the Swedish society, and to learn the Swedish language. Greater opportunities for education and employment for foreign-born women in Sweden compared to their country of origin may increase their economic independence and thus level of empowerment. However beneficial such increased empowerment might be for foreign-born women in the long-term perspective, in the short-term perspective, increased empowerment for women may threaten the male identity and thus exacerbate intimate partner violence (Darvishpour, 2002; Jin and Keat, 2009; Krishnan et al, 2010).

Social isolation is, as discussed above, an important risk factor for exposure to VAW among foreign-born women and an obstacle for social integration. Women's social integration is, in the same manner as labor market integration, important for the gender equity level of a country and especially important for foreign-born women, as they as newly arrived often lack social contacts and networks, particularly within the majority population. Thus, absence of social isolation on the one hand, and social participation and social trust in others on the other hand, may lead to empowerment and increased resilience against VAW (Figure 13).

Factors protecting against exposure to VAW may also promote increased well-being among foreign-born women. Gender equity is according to previous research a fundamental contributor to well-being and good health (Tesch-Römer, Motel-Klingebiel, and Tomasik, 2009). Although women biologically live longer than men, in some societies women do have shorter life expectancy than men at birth, due to gender-based discrimination (WHO, 2009). High levels of gender equity in a country give for example equal access to health care, legal rights for women to report exposure to intimate partner violence including marital rape, and opportunities for paid parental leave, making it possible for women in reproductive age to enter the labor market.

In order to prevent and decrease VAW among foreign-born women in Sweden, both foreign-born women and men need to be empowered on an individual basis, with access to Swedish language courses, the labor market, and social activities. The men are an important group to include in preventive work against VAW. Effective interventions, whether targeting women or men, should be evidence-based. Moreover, interventions targeting foreign-born women need to be directed to specific groups, with their contexts and risk factors for VAW taken into consideration. Early identification of women at risk for violence, for example socially isolated and/or controlled women, would be relevant for Swedish-born as well as foreign-born women. In this regard health care givers should be encouraged to ask questions concerning possible exposure to interpersonal violence when the context suggests that such questions are relevant. Furthermore, descriptive research continues to be crucial

in order to fully understand the magnitude and importance of VAW, both in the total population and in specific risk groups, and to be able to evaluate the impact of various types of interventions on the societal, group and individual level. Finally, although both descriptive and intervention research in Sweden concerning VAW is increasing, such efforts are still scarce.

Conclusions

- Foreign-born women in Sweden, especially those with low disposable income, are at increased risk of exposure to interpersonal violence compared to Swedish-born women.

- Foreign-born women in Sweden are at increased risk of mortality due to interpersonal violence compared to Swedish-born women.

- Women from countries with low and very low/critical levels of gender equity are at increased risk of mortality due to interpersonal violence compared to women from countries with higher levels of gender equity.

- Norms governing gender roles influence perceptions of intimate partner violence among Iraqi refugees in Sweden.

- Among Thai women residing in Sweden exposed to intimate partner violence, those without social isolation and those with high social trust have greater resilience with regard to poor mental health.

- Potential influence of gender equity of country of birth as well as other determinants of violence against foreign-born women needs to be further researched and taken into account in the development of preventive work.

- Further research on violence against foreign-born women may help to identify the mechanisms that contribute to VAW more generally.

Summary in Swedish

Mäns våld mot kvinnor är ett allt mer uppmärksammat folkhälsoproblem. Kvinnor utsätts för våld i alla länder oberoende av utbildningsnivå och ekonomiska tillgångar. Partnervåld av en nuvarande eller tidigare partner är den vanligaste formen av våld som kvinnor utsätts för. Våld mot kvinnor leder till både negativa mentala och fysiska hälsoeffekter, och i värsta fall till förtidig död.

Det finns olika faktorer som kan öka risken för att bli utsatt för våld, såsom låg inkomst och social isolering. Även låg jämställdhet i en relation eller i det omgivande samhället har visat sig vara en betydande faktor. Sådana riskfaktorer är desamma över hela världen, men kan variera något mellan länder och på individnivå. Utlandsfödda kvinnor i Sverige har troligtvis en ökad koncentration av riskfaktorer, men det saknas forskning inom området. Fokus för denna avhandling är därför att ta reda på om utlandsfödda kvinnor utsätts för mer våld än svenskfödda kvinnor, och i så fall vilka faktorer som bidrar till sådant våld.

Informationen som de fyra studierna i avhandlingen bygger på, kommer från fyra olika källor: Folkhälsoenkäten i Skåne (arbete I), Dödsorsaksregistret (arbete II), djupintervjuer med irakiska flyktingar (arbete III) och en folkhälsoundersökning bland thailändska kvinnor i Sverige (arbete IV). Resultaten av studierna (I, II) visade att utlandsfödda kvinnor, speciellt de med låg inkomst i hushållet, i högre grad riskerade att bli utsatta för våld av en annan person och även att bli dödade av en annan person, jämfört med svenskfödda kvinnor. De våldsutsatta kvinnornas relation till förövarens var okänd i dessa arbeten, men utlandsfödda kvinnor som var i en relation hade högre risk för att bli utsatta för våld än kvinnor som var ensamstående, och hemmet var den vanligaste platsen för våldet. Bland de kvinnor som blivit dödade till följd av våld av en annan person, var det också en riskfaktor att vara i en relation och att komma från ett land med låg jämställdhet. Dessa resultat tyder på att ett ovisst antal av kvinnorna i båda studierna blivit utsatta för partnervåld.

Intervjustudien med irakiska flyktingar, både män och kvinnor (arbete III), visade att de värderingar som formar könsroller påverkar inställningen till partnervåld. Dessutom menade deltagarna att den ökade jämställdheten i Sverige jämfört med Irak kan ha en negativ påverkan på maktbalansen och relationerna i familjen, och i värsta fall leda till ökat våld. I den thailändska studien (arbete IV) hade de flesta av kvinnorna kommit till Sverige för att gifta sig med en svensk man. Majoriteten av de kvinnor som blivit utsatta för partnervåld i Sverige hade tidigare erfarenheter av våld

och rapporterade att våldet hade minskat sedan de kom till Sverige. Trots detta fanns det en grupp kvinnor utan tidigare erfarenheter av våld som hade hamnat i våldsamma relationer med svenska män och män från andra europeiska länder efter att de kommit till Sverige. Därmed är det viktigt att påpeka att avhandlingens resultat även visade att kvinnor gifta med svenska män var utsatta för våld. Slutligen visade studien att frånvaro av social isolering och hög social tillit till andra skyddade mot dålig mental hälsa bland våldsutsatta thailändska kvinnor.

Låg jämställdhet i födelselandet, språksvårigheter och kunskap om svenska lagar och rättigheter samt var man kan söka hjälp, är riskfaktorer för våld mot utlandsfödda kvinnor som skiljer sig från riskfaktorer bland svenskfödda kvinnor. Dock varierar nivån av jämställdheten mellan olika individer, och även om Sverige i en global jämförelse anses vara ett samhälle med hög jämställdhet, finns det relationer med låg jämställdhet även bland svenskfödda personer. Social isolering visade sig också vara en viktig riskfaktor och även en konsekvens av våld som kan förvärras bland utlandsfödda, på grund av brist på arbetsmarknads- och social integration.

Resultaten från denna avhandling visar på ett behov av insatser riktade till utlandsfödda kvinnor och även till män för att kunna minska förekomsten och de skadliga hälsoeffekterna av våld mot kvinnor. Ytterligare forskning behövs för att vidare undersöka inflytandet av låg jämställdhet i födelselandet och andra riskfaktorer för våld mot utlandsfödda kvinnor och för att kunna utveckla effektiva och målgruppsanpassade insatser. Sådan forskning kan även användas för att identifiera faktorer/mekanismer som bidrar till våld mot kvinnor i allmänhet.

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Appendix