Intimate partner violence: forms, consequences and preparedness to act as perceived by healthcare staff and district and community leaders in a rural district in northern Vietnam

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\textbf{Summary} \textbf{Objectives:} A qualitative study was conducted among healthcare staff and district and community leaders in May and June 2002 to describe their perceptions of violence occurring between intimate partners. It focused on male violence towards females, and its forms, consequences and preparedness to act in a rural setting in Vietnam.

\textbf{Methods:} Twenty men and 20 women were strategically selected for focus group discussions and a phenomenographic approach was employed.

\textbf{Findings:} Violence was described not only as physical but also, primarily, as affecting women's mental health status. Mental violence was exemplified as verbally offending, ignoring or humiliating a woman. Sexual abuse was mentioned less frequently. IPV was considered to be a private matter, occurring in the home away from relatives, neighbours and the local community. Only very serious cases would seek health care. Divorce and deteriorating family finances were reported as serious consequences, not least for the children. Local reconciliation groups, comprised of trusted community members, played a role in mediating, while health professionals were found to be uninformed about prevalence rates and reluctant to intervene.

\textbf{Conclusions:} Gender-based violence needs to receive attention from policy makers, and effective advocacy programmes are needed at all levels. In Vietnam, partner violence against women seems to be recognized at Government level. At community level, Women's Union staff and local reconciliation groups are prepared to act.
However, the subject is surrounded by silence. We found that healthcare workers exhibited a lack of understanding of violence against women as a health problem in their own working environment.

Introduction

Violence by an intimate male partner or former partner is the most common type of violence against women. It is now recognized as a public health problem that exists in all societies and among people of higher and lower social strata.1

Most violence against women takes place within families, and the perpetrators are almost exclusively men who are or who have been in a close relationship with the woman.1-4 This type of violence against women, here referred to as intimate partner violence (IPV), is also termed ‘domestic violence’, ‘battering’ or ‘wife/spouse abuse’.5

Violence is usually described as being physical, sexual, psychological or any combination of these.6 Findings from a number of recent studies from various parts of the world indicate that between 10 and 60% of women had been hit or otherwise physically assaulted by an intimate male partner at some point in their lives,7 and between 3 and 52% of women reported physical violence in the previous year.8 The range in these figures illustrates not only possible real differences in prevalence rates among settings but also differences in research methods and in definitions of violence. Furthermore, respondents’ willingness to disclose intimate partner abuse varies in different settings.

Small-scale studies of IPV in Vietnam revealed that it occurs in urban and rural settings and in all social strata.7 Loi et al.9 found that district and commune level officials estimated that verbal violence occurred in 20-50% of families and physical violence in 5-20%. They further found that all forms of violence occurred less frequently in households where husband and wife were equal income earners, and that verbal abuse was highest in households where the woman was the main income earner. Projects carried out by Vietnamese women’s organizations found that wife beating and other forms of IPV are widespread, especially in rural areas, and estimated that 30-60% of divorce cases were the result of maltreatment of women.10 From our own population-based data, comprising 1090 women, we found that 30 and 6% had been subjected to physical and sexual violence, respectively, from an intimate male partner. Of those subjected to violence, 154 (14%) were in need of hospital care due to injuries.11

Vietnam was one of the first signatories of the 1982 Convention on the Elimination of all Forms of Discrimination Against Women.12 This was followed by a Government strategy for the advancement of women, where a number of objectives to reach a higher level of gender equality, including eliminating violence against women in the family, are spelled out.13 It appears that the existence of IPV is recognized at Government level but the question remains regarding the role that healthcare providers and communities can play in this effort.

The aim of this study was to use focus group discussions to describe how female and male healthcare workers and elected representatives of district and community organizations in a rural part of Vietnam perceive violence against women in intimate relationships. The study focused on forms of violence, attitudes and consequences of it, and preparedness to act against it.

Methods

This study was conducted within the framework of the demographic surveillance site in Bavi District, Ha Tay Province in northern rural Vietnam. The field site was established in the late 1990s in a collaborative programme between Vietnamese and Swedish researchers, and a number of studies on different health-related topics are currently ongoing.14 One ongoing project in this framework deals with violence against women, of which this study is a part.

In Bavi District, agricultural production and livestock breeding are the main economic activities of the local people (81%).14 Illiteracy is low (0.4%), but considerably higher among women than among men. About 70% of the adult population has completed primary school, 21% secondary level, 9% high school and 0.6% higher education. The higher the educational level, the lower the number of females.15

Informants

In all, 40 people (20 men and 20 women) participated in five focus group discussions, conducted during May and June 2002. The informants were strategically selected with respect to gender
and occupation, i.e. they were either healthcare staff or people that held positions at the district or local community level which entitled them to be part of so-called reconciliation groups. These groups, existing mainly at village and commune levels, are established for the purpose of reconciling couples when there is violence in the family, and usually consist of four to five people.

The selection of informants was made with the support of the deputy director of the district health centre, who is well acquainted with local conditions. Table 1 shows the characteristics of the informants.

The assistant physicians, with 2 years of medical training at a medical school, all worked at commune health stations (CHS), as did the village health workers. The physicians and the nurse worked at the district hospital and were specialized in paediatrics, gynaecology, emergency care and general medicine, respectively. The participating district officers were chairpeople or directors of their respective associations. The men-only group and the women-only group consisted of farmers and heads of local associations, and were members of local reconciliation groups.

### Analysis

A qualitative research approach was applied, and phenomenography was used for data collection and analysis. Phenomenography aims to capture people’s perceptions of different aspects of a problem.16

Five focus group discussions were held. These were semi-structured, informal in style and lasted for approximately 90 min.17 The moderator for the mixed-sex groups (G1-G3) was male (TVP), assisted by a female co-moderator (NTBT). The moderator for the exclusively male focus group was TVP assisted by a male co-moderator; the moderator for the exclusively female group was NTBT assisted by a female co-moderator. The discussions were conducted in Vietnamese. The guiding questions were comprehensive, such as: When you hear about intimate partner violence, what comes to mind? What kind of actions can be judged as violence
against a woman in an intimate relationship? What in your view are the consequences of intimate partner violence? What in your opinion would improve the situation? Please give examples.

The discussions were tape-recorded and transcribed verbatim in Vietnamese and thereafter translated into English. Two of the authors, independent of each other, identified codes related to the areas under study. The findings were then agreed on and brought together into categories and themes. The results that evolved were discussed continuously between all the authors. A co-examiner was assigned to test the intersubjective agreement of the findings in the following way: the themes and the selected quotations were presented separately to the co-examiner, who matched quotations with themes. There was almost a full level of agreement between the researchers and the co-examiner. To secure the validity of the translation, an independent Vietnamese person, proficient in English, read all the selected quotations from the Vietnamese original transcript and re-translated them into English. The quotations given are intended to facilitate the reader’s evaluation of the credibility of the results.

The findings were reported back to the informants 1 year later in a formal meeting in Bavi; 28/40 informants were present and they affirmed the findings.

Ethical considerations

The Ministry of Health in Vietnam, the Local Health Authority in Vietnam and the Research Ethics Committee at Göteborg University approved the study. All participants were informed about the project verbally and in writing in Vietnamese. They were clearly informed of their opportunity to withdraw at any stage of the project.

Findings

The findings relate to three main themes covered in the interviews: forms of violence, consequences and preparedness to act.

The participants considered that IPV is the violation of a woman by a man, although it was pointed out that the reverse also exists, albeit to a much smaller extent. It was also underlined that the whole family (i.e. children, parents, siblings and other relatives) is involved when IPV occurs. Furthermore, IPV was described as a private matter that takes place in the home, away from relatives, neighbours and the local community. It was said that only very serious cases would seek health care.

Forms of violence against women in intimate relationships

Violence was described not only as physical but also, primarily, as affecting women’s mental health status. Sexual abuse was mentioned less frequently than physical violence and mental abuse.

Most informants considered that physical violence occurred mainly among rural and poorly educated people. More educated people were believed chiefly to abuse women verbally. This was referred to as maltreatment. It was viewed as less serious than physical violence by some, and as serious as physical violence by others.

"To say it frankly, I mention here violence relating to using hands—that can be seen more often in the country villages, while there is maltreatment in educated families." (Female assistant physician).

Some were of the opinion that violence against women had decreased considerably as living conditions had improved and women become more independent.

Physical violence

The informants described physical harm as all actions violating the woman’s body that caused physical injury or harm. Examples given included such acts as blows, kicking, beating with force, hitting with objects, pouring hot water, using knives or sticks, and burning.

"[…] while the wife was talking, the husband took the water thermos on the table to pour hot water on her head. Of course such deed causes trauma, it is just that they do not go to the hospital.” (Female assistant physician).

In the group of district officers, acts such as pouring petrol on the woman and setting her on fire, or shaving the woman’s head and painting it were mentioned as ways of violating the ideal of beauty.

Psychological violence

Psychological violence was described in terms of ignoring a woman, verbally offending or humiliating her. This was exemplified by generally treating the woman badly, being silent and not talking to her, preventing her from taking part in social activities
at home or outside, and using bad language for the purpose of offending her.

“There are words that can truly hurt the dignity and pride of a woman [...]. This has a deeper effect. I have seen such a case [...] the woman suffered this psychological violence continuously and in the end she committed suicide.” (Female deputy director).

Examples of humiliating behaviour were given, such as driving the woman out of the house to live in the pigsty, openly keeping a mistress or forcing the woman to have sex the day before she prepares to go to pray in the pagoda, thus forcing her to break the taboo of being ‘clean’.

In the district officers’ group, psychological violence was also exemplified by the man thinking that it was his right to make decisions about the family, decide about an abortion or force the woman to give birth to sons under the threat that he would divorce her otherwise.

It was emphasized that psychological violence was present in almost all cases, either alone or linked to physical or sexual abuse.

**Sexual abuse**

Sexual abuse, which was discussed mainly among the healthcare staff, was described as when a man uses force to have sexual intercourse, either because the woman does not want to or because she is not feeling well or is tired. Sexual abuse during pregnancy was also mentioned.

The opinion was that abused women do not talk to family members or friends about the abuse and that it was rarely discussed with village or commune health workers. At district hospital, located far from home, the female patients occasionally talked about it. A female physician reported that she had met women who complained about sensitive sexual problems and asked for support in this matter. However, the physician hesitated:

“A woman came to my home asking me to make up a prescription with a note that she had to abstain from sexual intercourse. I told her that this was their family problem. I as a doctor have no right to get involved in it.” (Female assistant physician).

Sexual abuse was a sensitive matter, and while it was regarded as unacceptable, it was considered to be an internal family problem.

**Consequences of IPV**

The consequences of IPV in women were related to health effects, both physical and psychological, such as depression and inability to work, although limited information was given on this. More extensive descriptions were given about how violence affects the family, including the children and the family economy. Divorce was considered to be a serious consequence and a male officer stated:

“It is because the parents cannot handle their problems that children drop out of school. Nowadays, many street children have divorced parents.” (Male officer).

A male farmer commented that violence between intimate partners makes an already hard life even worse and this might be difficult to redress. Furthermore, a badly treated woman was said not to be strong enough to maintain good relationships with neighbours and society at large, and this would worsen the situation for the entire family. It was feared that violence between parents would result in the children not listening to them, but learning to use violence themselves. A female health worker commented that when a husband takes a mistress, this not only hurts the wife emotionally but also affects the family economy.

Some informants stressed that they had met cases where violence had become a part of ‘normal’ behaviour and living without it would create a feeling of strangeness.

**Attitudes and preparedness to act**

All participants mentioned local reconciliation groups as acting bodies in relation to violence in the home, although there were different opinions about their benefit. The male physicians stated that they were generally not impressed with the type of mediation that these groups achieved. The female physicians considered it a duty to intervene in any case of violence and supported the formation of reconciliation groups. All other informants regarded these groups as important in the struggle against violence between intimate partners. It was described how representatives of the reconciliation group went into a couple’s home and discussed the situation, and how the husband and wife later felt ashamed and reconciled. Among the assistant physicians, it was proposed that reconciliation groups should be formed on all levels, i.e. also at village and hamlet levels.

The physicians did not find mediation successful; instead, there was a tendency towards shifting the responsibility to intervene over to local authorities.

“...parents, brothers and sisters, aunts and uncles would help to ease the violent situation
if they consider it serious [...]. In a case when these people themselves cannot solve it, they should report the problem to the local authority." (Male physician).

A male assistant physician who had been part of a reconciliation group described how dangerous it could be to work with violence in the family as that violence could suddenly be turned against the mediators. It was proposed that legislation should be clearer in this matter.

The physicians were reluctant to admit that there were cases of IPV in their own environments. They acknowledged that violence victims turned up at the surgery and emergency departments, as well as in the obstetrics department, but they had no idea about the magnitude of the problem.

"Have not made any statistics, a small number, have not done statistics." (Male assistant physician).

"Very rare in the emergency department." (Female physician).

Legal actions were discussed extensively among the district officials, especially the role of the local courts in relation to divorce. The local courts also have a reconciliatory function, and a female director claimed that these were successful in about 50% of cases.

Discussion

This study recruited professionals and key stakeholders in focus group discussions to capture perceptions of intimate partner violence, its forms and consequences, and preparedness to act upon it.

It was found that psychological abuse was considered to be the dominant and most serious form of violence in intimate relationships. Some healthcare informants expressed how such treatment aimed to emphasize the woman’s feeling of inferiority and described how she would eventually regard violence as part of normal behaviour. This way of interpreting a violent situation is a well-known phenomenon, commonly referred to as the ‘normalization process’, i.e. a process where the woman starts punishing herself for not being good enough.19

Furthermore, the acts of physical violence described were of varying seriousness. Acts such as kicking, beating or slapping could be understood as occurring due to individual male factors, such as personal shortcomings and feelings of inferiority.20 However, more serious acts that would lead to long-lasting injuries and disfiguring of the woman, such as pouring oil on her and setting her on fire to ‘violate the ideal of beauty’, could be understood as intended to ‘teach’ the woman how to behave, mirroring a sense of ownership over the woman. This was also commented on by the district officials.

Present day Vietnamese society is often described as a combination of old patriarchal traditions, emphasizing the subordinate role of women, and Communist party ideology instating equality by law.21–23 This was also reflected in our findings as, on one hand, behaviour serving to maintain power hierarchies and inequalities was viewed as violent acts, while on the other hand, some female informants pointed at obedience and women’s behaviour as reasons for violence.

Consequences such as financial problems, a deterioration of social networks and support, risk of divorce, and children dropping out of school were reported. Consequences of this type have also been recognized in other studies.3,24

As in most societies, violence between intimate partners is surrounded by silence in Vietnam. Institutionalised settings at the local level are rarely prepared to interfere in the case of violence in families. In Vietnam, however, there are reconciliation groups at the commune and, in some cases, the village level. No professional training is required to become a member of such a group, and about half of the informants were active members. They described interventions that had pulled the partners together without violence as well as cases that ended in divorce; they believed in this type of intervention and were proud of their own contributions.

The medical doctors seemed more reluctant to act, even though they acknowledged the presence of violence and condemned it. However, they seemed uninformed about its prevalence in their own catchment area and had not themselves seen many cases. The same situation is reported in most countries where research has been done on IPV,25 and reflects shortcomings among professionals due to inadequate training and lack of experience in diagnosing and treating such cases. Moreover, it reflects shortcomings in policy and legislation.

Strengths and weaknesses of the study

Focus group discussions, capturing perceptions and attitudes,17 carry certain advantages and disadvantages. It is possible to reach a large number of informants in a short period of time and to reach a higher level of understanding amongst the participants as they influence each other by listening and
discussing. We believe our focus group discussions challenged the participants’ own attitudes and we found this technique to be productive for interviewing officials. However, if victims were to be approached, in-depth interviews should be the method of choice as the violence would be a personal experience and therefore a sensitive subject.

As with qualitative studies in general, these findings cannot be generalized to a broader population but may serve as an ‘eye-opener’ that helps to generate new hypotheses and ideas about how to combat violence between intimate partners.

Gender equity is on the political agenda in Vietnam today and there is a risk of obtaining only politically correct opinions. However, in this particular study, the informants belonged to different social strata and the discussions were held in sex-disaggregated groups as well as in mixed groups, with a male and a female moderator, which allowed contrasting opinions to emerge. The interviews were held in Vietnamese, which allowed for nuances that are difficult to capture in a foreign language. Two of the Swedish researchers were present, one of them with good knowledge of Vietnamese.

Conclusions and implications

Gender-based violence needs to receive attention from policy makers, and effective advocacy programmes are needed at all levels. In Vietnam, partner violence against women seems to be recognized at Government level. At community level, Women’s Union staff and local reconciliation groups are prepared to act. However, the subject is surrounded by silence. Healthcare staff lack understanding of violence against women as a serious health problem, and intervention does not seem to be considered as a duty.

In relation to the findings in this study, we believe that counselling services need to be improved and training programmes need to be made available to healthcare personnel, local Women’s Union staff, other officials and local reconciliation groups. There is also a need for sectors to collaborate. The healthcare sector should take the lead in this and be responsible for raising the issue with individual patients, monitoring gender-based violence, spreading the information, and assisting in improving skills and awareness among local officials and others involved.

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