

**PERCEPTION TOWARD DOMESTIC VIOLENCE
AGAINST WOMEN OF HEALTH PROVIDERS OF
THE THANH NHAN GENERAL HOSPITAL IN
HANOI, VIETNAM**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PRIMARY HEALTH CARE MANAGEMENT
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY**

2006

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was submitted to the Faculty of Graduate Studies, Mahidol University
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on
March 13, 2006



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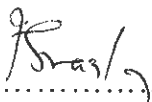
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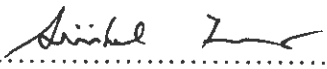
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PERCEPTION TOWARD DOMESTIC VIOLENCE AGAINST WOMEN OF
HEALTH PROVIDERS OF THE THANH NHAN GENERAL HOSPITAL IN
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ABSTRACT

This descriptive cross-sectional study was conducted to detect perception of domestic violence against women (DVAW) of health providers of the Thanh Nhan general hospital, Hai Ba Trung district, Hanoi city, Vietnam.

The subjects were 380 health providers from clinical departments of the Thanh Nhan general hospital who had direct contact with DVAW patients. They included doctors, assistant doctors, nurses, and midwives in these departments. The data was collected in January, 2006. A structured self-questionnaire was used to collect the information of this study. Data were analyzed by using percentage, mean, standard deviation, chi-square, and multiple logistic regressions.

The findings revealed that 55.5% of the experimental sample group had a positive perception toward DVAW and 44.5% had a negative perception. Health providers had positive trend but in general still supported the traditional view of the man's role as family leader. Female health providers had significantly more positive perception but less knowledge toward DVAW than male health providers ($p < 0.05$). Nurses had more positive perception than other respondents, even doctors ($p < 0.05$). Health providers of the surgery department had significantly more positive perception and better knowledge toward DVAW than health providers from other departments ($p < 0.001$). 21.1% the respondents had good knowledge of DVAW; 64.7% fair knowledge; and 14.2% poor knowledge. The results show health providers with good knowledge have a more positive perception than those with poor or fair knowledge of DVAW ($p < 0.001$). The health providers with more experience had a more positive perception toward DVAW than health providers with less experience ($p < 0.05$). Approximately 20% (37/187) of the health providers in all relevant departments revealed that they never ask DVAW patients they work with directly about DVAW. Overall, 80 percent of health providers would personally welcome training on this matter.

The main recommendation is to set up a strategy of intervention to improve the health care response to DVAW at health facilities. This response might include training courses on DVAW; establishing a counseling room in the hospital, and collaboration among local organizations in community, etc. It might also involve the development of a specific protocol on examination and treatment of DVAW victims, and Guidelines for health staff on working with DVAW victims.

KEY WORD(S) : DOMESTIC VIOLENCE AGAINST WOMEN

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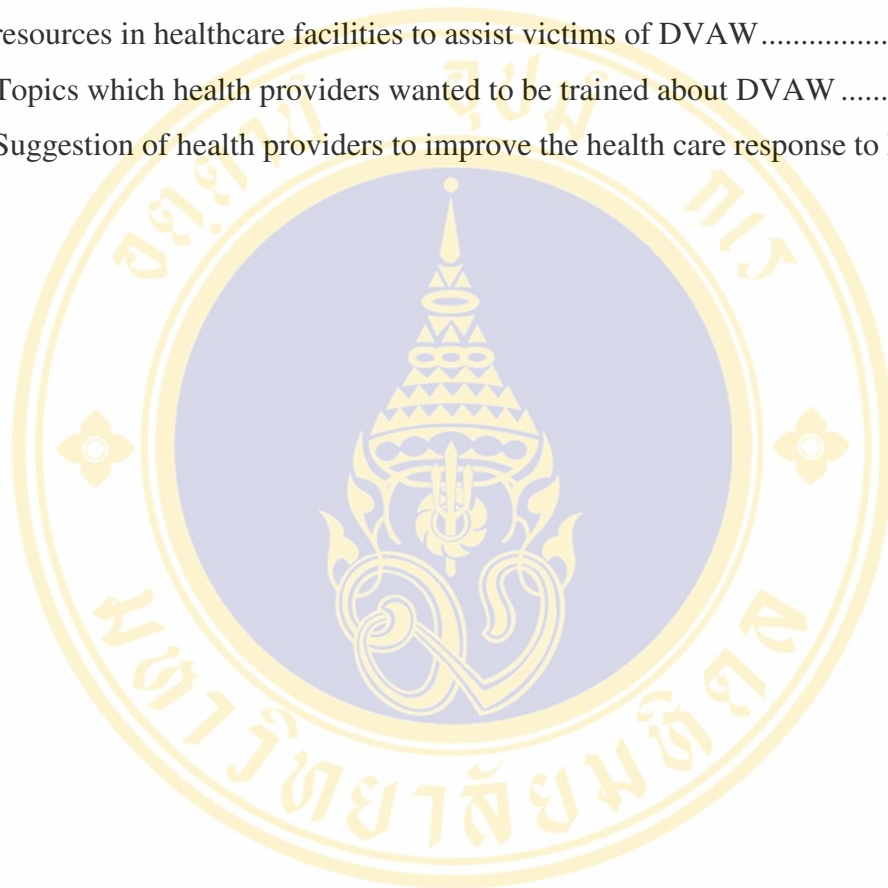
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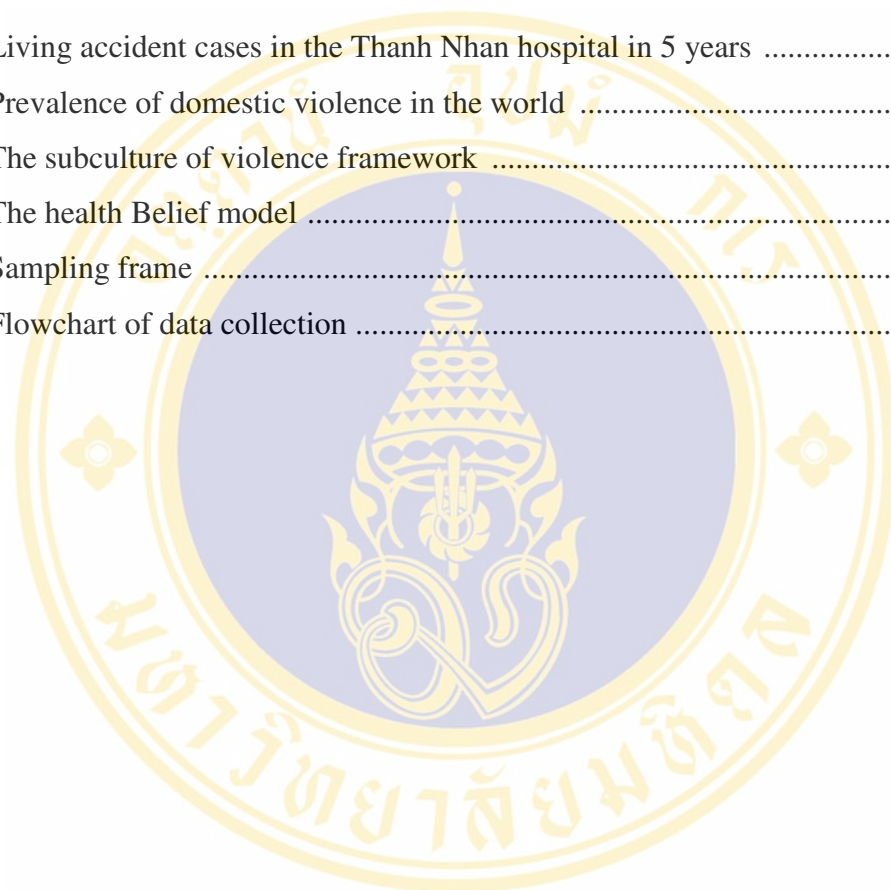
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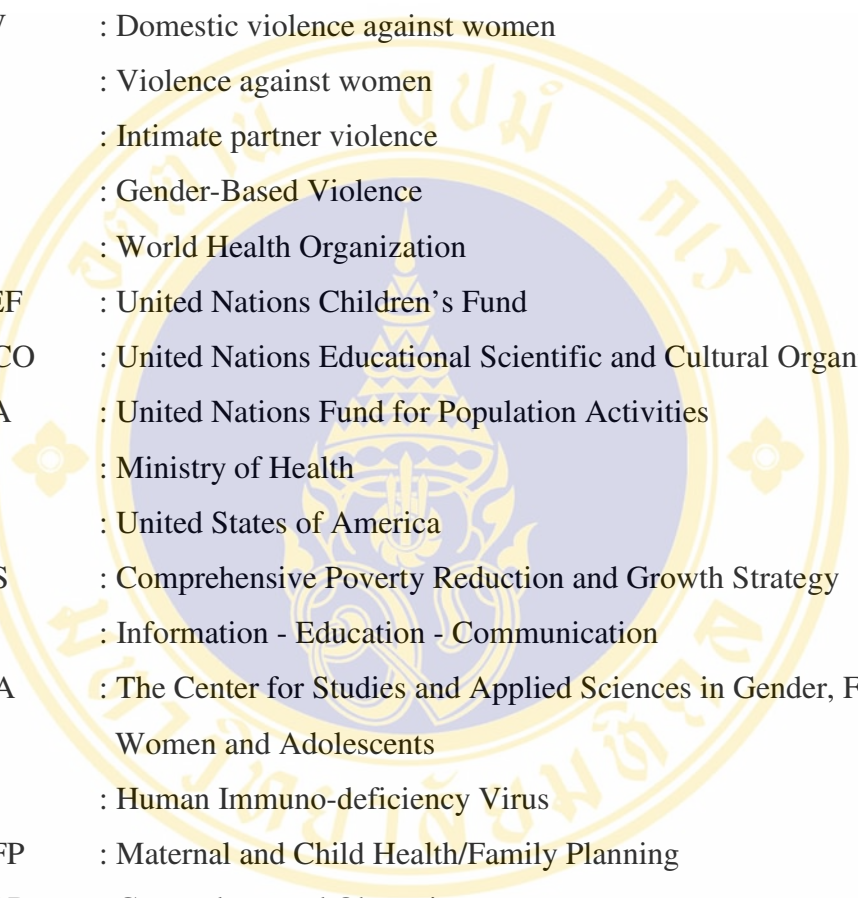


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LIST OF ABBREVIATIONS



DV	: Domestic violence
DVAW	: Domestic violence against women
VAW	: Violence against women
IPV	: Intimate partner violence
GBV	: Gender-Based Violence
WHO	: World Health Organization
UNICEF	: United Nations Children's Fund
UNESCO	: United Nations Educational Scientific and Cultural Organization
UNFPA	: United Nations Fund for Population Activities
MOH	: Ministry of Health
USA	: United States of America
CPRGS	: Comprehensive Poverty Reduction and Growth Strategy
IEC	: Information - Education - Communication
CSAGA	: The Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents
HIV	: Human Immuno-deficiency Virus
MCH/FP	: Maternal and Child Health/Family Planning
GYN/OB	: Gynecology and Obstetrics

CHAPTER 1

INTRODUCTION

1.1 Rationale and justification

Around the world at least one woman in every three has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often the abuser is a member of her own family. One woman in four has been abused during pregnancy. Increasingly, gender-based violence is recognized as a major public health concern and a violation of human rights. Millions of women require medical attention or otherwise suffer the impact of gender-based violence (1).

Domestic violence against women is a world-wide problem, occurring in developed and developing countries alike and in families across all layers of society. It is not a new problem, but recognition of its extent and serious impact is new and growing. Domestic violence against women is a matter of public health. Violence debilitates women physically, psychologically and socially, sometimes with lifelong results (2).

According to data of the United Nations Children's Fund (UNICEF, 2000), the rate of women that suffered from violence in United States of America (USA) is 28%, United Kingdom is 25%; Japan is 59%; Cambodia is 16%; India is 45%; Korea is 38%; Thailand is 20% (10). Through studies of women's right on violence to women, the domestic violence against women (DVAW) is commonly and most severe. Of which almost cases, defendants are husbands.

According to the report of UNESCO in conference of World Health Organization about violence prevention activities (2005), each year, 1.6 million people worldwide die from violence. Suicides account for 800,000 of these deaths; 500,000 are homicides and 300,000 are war-related. Males aged 15 - 44 years are at

highest risk of violent death. For each of the nearly 200,000 homicides in people aged 10 - 29 years, there are 20 - 40 injuries requiring hospital treatment. Where data are available, studies show that 10 - 69% of women are physically abused by an intimate partner at some point in their lives; Victims often suffer major non-injury health consequences too, such as depression, anxiety disorders and post-traumatic stress disorder. In the last ten years the World Health Organization has devoted substantial attention to addressing violence as a major public health problem (4).

Approximately 1.5 million women experience physical or sexual violence from a current or former intimate partner each year in the United States. Lifetime intimate partner violence (IPV) prevalence rates against women range between 25 and 31%. In addition to injuries, IPV has been associated with other medical problems including gastrointestinal disorders, depression, anxiety, chronic pain syndromes gynecological problems, sexually transmitted diseases, increased substance abuse, and suicidal ideation. Studies of female homicide victims reveal that between 30 and 60% of murdered women are killed by a current or former intimate partner. IPV victims also incur 2 - 2.5 times the health care costs as non-victims (36).

One study in U.S. showed that 30% of women presenting with injuries in an Emergency Department were identified as having injuries caused by battering. Pregnancy is a risk factor for battering. Several studies indicate a range of incidence from 8 - 15% of pregnant women in public and private clinics to 17% to as much as 24 - 26%. The level of injury resulting from domestic violence is severe: of 218 women presenting at a metropolitan emergency department with injuries due to domestic violence, 28% required admission to hospital for injuries, and 13% required major medical treatment. 40% had previously required medical care for abuse. 30% of women murdered in the U.S. in 1992 were murdered by a husband or boyfriend (5).

In Vietnam, DVAW is often concealed because it is a sensitive issue concerning the private lives of women. Recently there has been significant media attention given to unreported DVAW in Vietnam. Like many countries, official data on DVAW in Vietnam is not available. However, alternative sources of data suggest a

possible increase in the number of cases of violence against women. Women from all social strata can be victims of various forms of violence: mental, sexual, economic and social, which may continue throughout their married life (6).

The study on domestic violence carried out by the Vietnam Women's Union in 1997 in the northern provinces of Hanoi, Ha Tay, and Thai Binh, revealed the widespread nature of family-based violence in the region. Another report from 1997 found that the most common form of domestic violence in Vietnam was physical or psychological violence perpetrated on a woman by her husband and that this accounted for 65 - 70% of all cases of family based violence (7).

In 1999, a comprehensive study of domestic violence in Vietnam was undertaken by a team of researchers working within the framework of the World Bank's Policy Research Report on Gender and Development. The study, which was based on qualitative and a limited amount of quantitative data received from focus groups, questionnaires and interviews with key district and commune-level authorities, found domestic violence to be a "very real and widespread issue in Vietnam, affecting women from all social and geographical groupings."

There is evidence that there has also been an increase in recent years in the number of cases of domestic violence resulting in the murder of the victim. Prior to 1993, family-based violence ending in murder accounted for 14 - 15% of the total number of murders. In the period 1994 - 1997, domestic violence related murders comprised 17 - 20% of all murders (8).

The study of the People's Supreme Court of Hanoi in 3 years 1998 - 2000 showed the DVAW is an important cause leading to divorce (52.62%) (49). At the Center for Studies and Applied Sciences in Gender, Family, Women and Adolescent (CSAGA), during the period of 4 years (1997 - 2000), handled 106,991 consulting cases through telephone for customers mainly living in Hanoi; in which, the rate of consulting cases relating to family relationship, mainly maltreatment, disagreement, divorce, adultery, accounted for 32.8%, in 2000, this rate was 42.2%. This showed that

contradiction in family has tendency to increase (39). The study of Le T. Phuong Mai conducted in GiaLam hospital (Hanoi, Vietnam) showed that injuries of DVAW victims are diverse; complex that is listed in 5 injury groups: 41.2% trauma of four limbs, 27.2% trauma at head face neck areas, 13.6% trauma at abdominal area, 9% poly trauma, and 9% osseous trauma (6).

Until recently, DVAW was considered to be primarily a social or criminal-justice problem and therefore not in the purview of the health professional. Unfortunately, in many areas of many countries, this attitude continues to prevail despite the fact that victims of DVAW are routinely seeking care for medical complaints related to battering. Lacerations are sutured, broken bones are set, and emotional problems are medicated without an attempt to uncover or address their underlying cause. As a result, the medical community misses the opportunity to intervene in many hundreds of thousands of cases of DVAW and many, many victims continue to suffer the adverse health consequences of physical and emotional abuse (3).

Despite the fact that health practitioners see many victims of DVAW in their clinical practices and despite the fact that the impact on the health care system is enormous, many health professionals fail to recognize the problem because they don't routinely inquire about or document abuse as the cause of their patient's symptoms (3).

The Forty-ninth World Health Assembly Resolution (WHA 49.25, 1996) declared the prevention of violence, including gender-based violence, to be a public health priority. The Assembly asked: Recognizing the growing consequences of violence for health care services everywhere and its detrimental effect on scarce health care resources for countries and communities; Recognizing that health workers are frequently among the first to see victims of violence, having a unique technical capacity and benefiting from a special position in the community to help those at risk (9).

The WHO's Plan of Action emphasizes the need "to promote, as part of the curriculum for training and the continuing professional development of health professionals at all levels, the incorporation of an understanding of violence and its health consequences, as well as the requirements for the provision of sensitive services". A WHO report on violence and health emphasizes that health personnel are key to help women who are victims of violence. Unfortunately, in practice women fail to receive support or appropriate health services, partly due to the lack of hospitals' policy, procedures or reporting formats for women who have been assaulted (9).

The Government of Vietnam has recognized that the issue of physical and psychological family violence deserves more attention. The reduction of the vulnerability of women against family violence is a specific objective of the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) 2001–2010 and of the Plan of Action for the Advancement of Women by 2005. Although the DVAW has been considered a health problem in general and reproductive health in particular, but there is not yet any health regulation on identification as well as examination, treatment of disease for women who are victims of DVAW.

This study conduct to study the perception toward DVAW of health providers of Thanh Nhan hospital, Hai Ba Trung district, Hanoi city, Vietnam aim to set up the Hanoi Department of Health's regulations and guidance for health providers on supporting DVAW victims at health facilities and submit to Ministry of Health, Hanoi People's Committee the strategy of intervention to improve the health care response to domestic violence at health facilities of Hanoi.

Hanoi is the capital of Vietnam with on area of 927.3km² and population of 3,100,000 persons (2004) comprising 9 inner districts and 5 suburb districts. Hanoi city is a prominent metropolis of the nation in terms of politics, cultures, economics, science and technology, a national exchange point in term of international trade and cooperation, a vital component of Northern Main Economic Region and a fourth among the most populous city in the nation. The Hanoi Public Health System includes 15 hospitals (5 general hospitals and 10 specialist hospitals), 14 district medical centers and 232 communes' health centers.

The Thanh Nhan hospital is the biggest general hospital belong the public health system of Hanoi capital. It lies in South-east area of Hanoi with on area of 32,000m². The Thanh Nhan general hospital has 450 patient beds with 524 health providers (155 Doctors, 33 doctor assistant, 210 nurses, 15 midwives and another). There are 31 departments: 17 clinical departments, 7 Para clinics, and 7 functional departments. Clinical departments divide: Examination Rooms (include internal, surgery, and special clinics); Emergency; Obstetrics and Gynecology; General Internal (include Internal, Cardiology, Mental, Gastro Entorology, Genito Urinary); General Surgery (include Traumatology Orthopedics-Brain trauma); Specialties (Ophthalmology, Odonto-Maxillo-Facial, Oto-Rhino Laryngology); Physical therapy-Rehabilitation; Traditional medicine; Pediatrics; Occupation diseases; Tumor; Operating ward-Anesthesiology and Recuperation.

According to statistical data of the Thanh Nhan hospital, during 5 years (2001 - 2005) there were 33,324 accident cases. Of there, 15,597 cases were caused by living accident accounting relating to women. In 2005, there are 11 accident cases with DVAW causes (Figure 1).

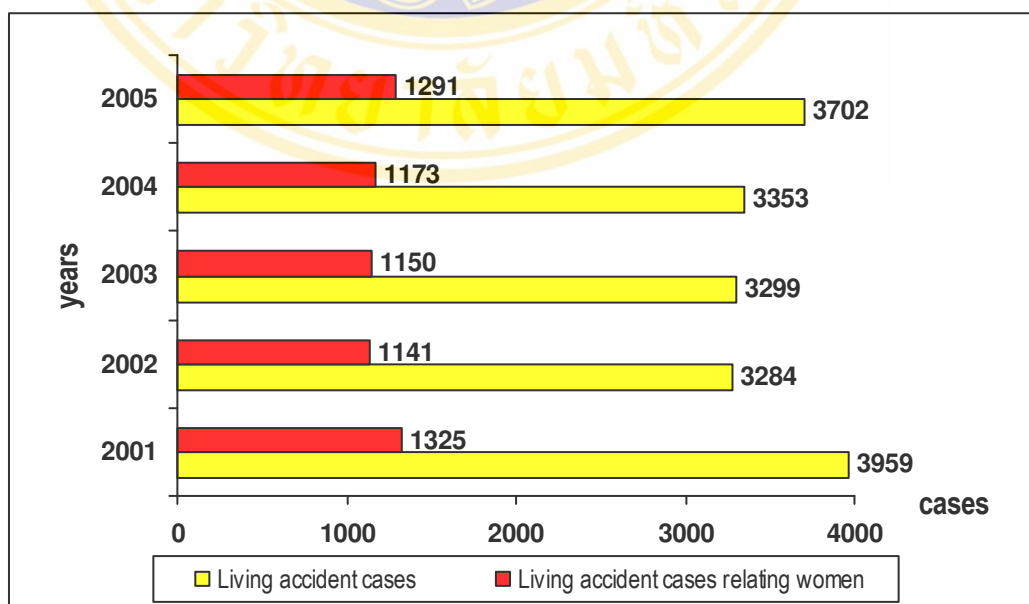


Figure 1 Living accident cases in Thanh Nhan hospital in 5 years

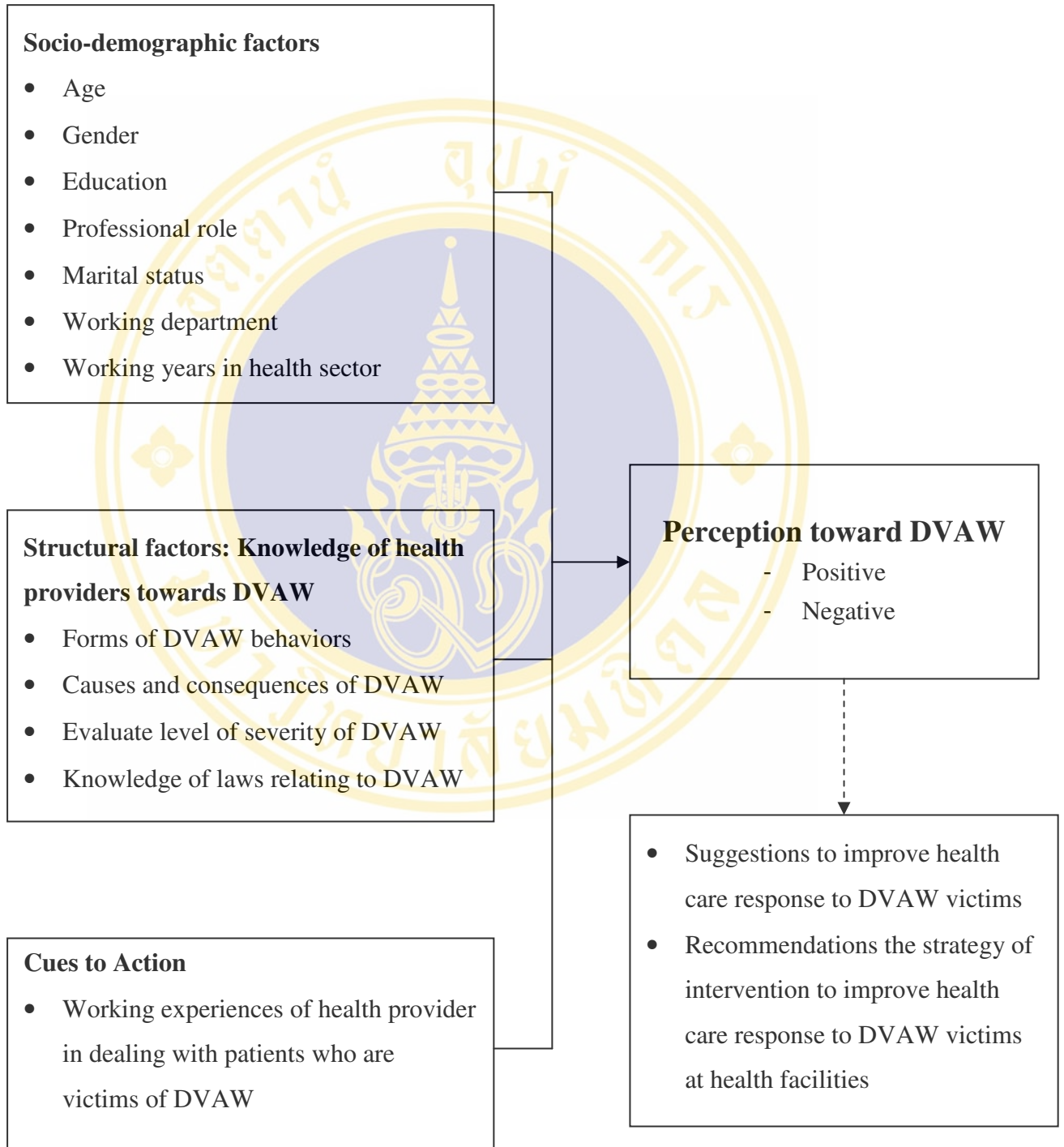
1.2 Research questions

1. What is the perception of health providers toward DVAW ?
2. What is health providers' experience in dealing with patients who are victims of DVAW ?
3. What are suggestions of health providers to improve the health care response to DVAW ?

1.3 Research objectives

1. General objective: To detect the perception of health providers toward DVAW victims.
2. Specific objectives:
 - To examine the knowledge of health providers toward DVAW.
 - To determine the experience of health provider toward DVAW.
 - To find the perception of health providers toward DVAW.
 - To identify the factors related to health providers' perception on DVAW.
 - To collect the health provider's suggestions to improve health care response to victims of DVAW.

1.4 Conceptual framework



1.5 Research hypothesis

1. Socio-demographic factors (age, gender, education, occupation, working department, working years in health sector, and married status) are associated with perception of health provider toward DVAW.
2. Knowledge of health provider toward DVAW is associated with their perception toward DVAW.
3. Working experiences in dealing with DVAW victims is associated with perception on DVAW of health providers.

1.6 Operational definition of studied variables

1.6.1 Domestic violence against women (DVAW)

The United Nations Declaration on the Elimination of Violence against Women (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Domestic violence against women, as defined for this study, includes violence perpetrated by intimate partners and other family members, and manifested through (2):

Physical abuse: such as slapping, beating, arm twisting, stabbing, strangling, burning, choking, kicking, threats with an object or weapon, and murder.

Sexual abuse: such as coerced sex through threats, female genital mutilation, intimidation or physical force, forcing unwanted sexual acts or forcing sex with others. It also includes traditional practices harmful to women such as wife inheritance (the practice of passing a widow, and her property, to her dead husband's brother).

Psychological abuse which includes behavior that is intended to intimidate and persecute, and takes the form of threats of abandonment or abuse, confinement to the home, surveillance, threats to take away custody of the children, destruction of objects, isolation, verbal aggression and constant humiliation.

Economic abuse: includes acts such as the denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment, etc (2)

1.6.2 Socio-demographic characteristics

Socio-demographic characteristics refer to age, gender, education, occupation, marital status who are respondents of this study.

Age: refers to real age of health providers at time of the interview. There are 4 groups:

Group 1: Under 30 years old

Group 2: 30 – 39 years old

Group 3: 40 – 49 years old

Group 4: Over 49 years old

Gender: Male and Female.

Education: refer to the level of health provider's formal education and categorized as: Elementary degree (Midwife); Secondary degree; Graduate profession, or Bachelor, or Post-graduate (Master, Doctor, Professor).

Professional role: refers to present occupation or the job of the respondents, which is categorized into Doctor, Assistant doctor, Nurse, Midwife.

Marital status: is the marriage situation of health providers is categorized as single, married, divorce, widowed.

Working department: working department of health provider in the hospital.

Working years in health sector: number of years of health provider worked in this hospital or health sectors before. There are 4 groups:

Group 1: Under 5 years.

Group 2: 6 – 15 years

Group 3: 16 – 25 years

Group 4: Over 25 years

1.6.3 Structural factors

Knowledge toward DVAW:

- The state or fact of knowing about domestic violence against women (Domestic violence against women behavior, Causes and Consequences of DVAW, etc.)

- Knowledge of Vietnam laws relating to DVAW

There are 9 main questions include 35 statements to measure the knowledge of the respondents toward DVAW consist of questions about the DVAW behaviors, causes, and consequences, law of DVAW. Each correct answer will be given a score of '1' and '0' for incorrect answer. The level of knowledge classified in to three groups as good knowledge, fair knowledge, and poor knowledge by using Mean \pm SD as the cut point:

1. Good knowledge : the total score $>$ Mean + 1SD
2. Fair knowledge : the total score from Mean - 1SD to Mean + 1SD
3. Poor knowledge : the total score $<$ Mean - 1SD

1.6.4 Cues to Action

Experiences in dealing with victims of DVAW:

- Seen/heard/know victims of any type of DVAW
- Screening victims of DVAW
- Helping, counseling to the victims beyond medical treatment

The experiences of health providers in dealing with victims of DVAW measure by 9 main questions will be asked. Total score will be classified in to two groups:

1. More experience: the total score \geq Mean
2. Less experience: the total score $<$ Mean

1.6.5 Perception toward DVAW

Perception of the health provider referred to the health provider's assessment about DVAW behaviors, capable and responsible of health provider as well as health facilities to help victims of DVAW.

Various factors influence what and how the health provider perceives: Receptors (sensory system such as vision, hearing, or touch); The brain (determine some aspects of perception); Learning, emotion, and motivation (important in defining what and how they perceive). This part has been accumulated from experiments that compare how people in different cultures perceive things. The perception of DVAW may differ from culture to culture, depending on habits and customs, and training of children.

To measure the perception of the respondents 14 main questions will be asked with 3 levels for choosing of responses that were Agree, Uncertain, and Disagree. Each correct answer will be given a score of '2', '1' for incorrect answer and '0' for 'Uncertain' answer. Total score will be classified in to two groups:

1. Positive perception : the total score \geq Mean
2. Negative perception: the total score $<$ Mean

1.7 Limitations of the study

Sensitivity of the Topic

DVAW is a sensitivity issue in Vietnam, health providers may be difficult to answer. They might be answer following the standard but contrary to their real perception. However, self-administration can reduce this limitation compare with interview directly, in-depth interview, and discussion.

Recall bias

It can be assumed that recall bias to memory of the health provider's experiences because they might see victims of DVAW long time ago.

Missing data

Data collecting tools is questionnaire and data collecting technique is self-administered. The questionnaires will be distributed to health providers. Therefore, the missing data might be anticipated more than usual.

Scope of study

This study conducted in the Thanh Nhan hospital in Hanoi, Vietnam, the knowledge and working condition are probably different from other hospitals; so the perception of health providers are probably different from other hospitals. Therefore, it may not be generalized to the health providers of whole health branch.

CHAPTER 2

LITERATURE REVIEW

The purpose of this study is to try to understand the perception and experience of health providers on working with DVAW victims (mainly focusing on domestic violence against women), which can recommend the strategy of intervention to improve health care response to DVAW victims at health facilities. The researcher has set the scope of the literature review and the research according to following topics:

1. Situation of DVAW.
2. Theories Model.
3. Concepts and forms of domestic violence.
4. Source of domestic violence against women.
5. Consequence of domestic violence against women.
6. Knowledge, attitude and practice of community on DVAW.
7. Role of the health care provider.

2.1 Situation of DVAW

2.1.1 Situation concerned in the world

Each year, more than a million people lose their lives, and many more suffer non-fatal injuries, as a result of self-inflicted, interpersonal or collective violence. Overall, violence is among the leading causes of death worldwide for people aged 14-44 years. Although precise estimates are difficult to obtain, the cost of violence translates into billions of US dollars in annual health care expenditures worldwide, and billions more for national economics in terms of day lost from work, law enforcement and lost investment (9). Along with increasing awareness of inter-nations, DVAW attracts attention of crowded social organizations. Up to now, there are many different researches on this situation. Informations provided concerning scale and

serious level of DVAW types happened to different groups of women in society are insufficient, but they still outlined the general picture of DVAW.

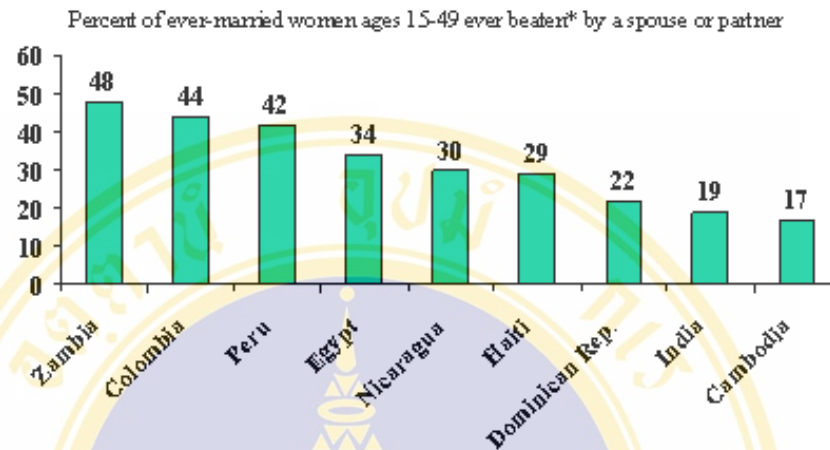
DVAW is the violation of women basic rights, true value and individual freedom. The level of this situation is the surveying ruler of inequality in the society, one of important indexes about status of women.

Violence against women continues to be a global epidemic that kills, tortures, and maims physically, psychologically, sexually and economically. It is one of the most pervasive of human rights violations, denying women equality, security, dignity, self-worth, and their right to enjoy fundamental freedoms. Violence against women is present in every country, cutting across boundaries of culture, class, education, income, ethnicity and age. Even though most societies proscribe violence against women, the reality is that violations against women's human rights are often sanctioned under the garb of cultural practices and norms, or through misinterpretation of religious tenets. Moreover, when the violation takes place within the home, as is very often the case, the abuse is effectively condoned by the tacit silence and the passivity displayed by the state and the law-enforcing machinery. The global dimensions of this violence are alarming, as highlighted by studies on its incidence and prevalence (10).

According to State of World Population Report, 2005 of UNFPA, studies on violence against women indicate that (11):

- The perpetrators of violence against women are almost exclusively men.
- Physical abuse in intimate relationships is almost always accompanied by severe psychological and verbal abuse. In 1 of 4 cases of domestic violence, women will also experience sexual abuse.
- Women are at greatest risk of violence from men they know. In Australia, Canada, Israel, South Africa and the United States, 40-70 per cent of female murder victims were killed by their partners.

Prevalence of Domestic Violence



*In most surveys includes having been hit, slapped, kicked, or physically hurt

Figure 2 Prevalence of domestic violence in the world

Many men and women believe wife-beating is justified. The shame associated with domestic violence, rape and other forms of abuse may contribute to the fact that women often suffer it in silence, afraid of repercussions and stigma, and never tell anyone.

Proportion of physically abused women who sought help from different sources, selected population-based studies					
Country or area	Sample (N)	Proportion of physically abused women who:			
		Never told anyone (%)	Contacted police (%)	Told friends (%)	Told family (%)
Australia ^a	6 300	18	19	58	53
Bangladesh	10 368	68	—	—	30
Canada	12 300	22	26	45	44
Cambodia	1 374	34	1	33	22
Chile	1 000	30	16	14	32 ^b /21 ^c
Egypt	7 121	47	—	3	44
Ireland	679	—	20	50	37
Nicaragua	8 507	37	17	28	34
Republic of Moldova	4 790	—	6	30	31
United Kingdom	430	38	22	46	31

Source: reproduced from reference 25 with the permission of the publisher.

^a Women who were physically assaulted in the past 12 months.

^b Refers to the proportion of women who told their family.

^c Refers to the proportion of women who told their partners' family.

WHO. 2002 *World Report on Violence and Health*. Geneva: WHO.

In the U.S., every 7.4 seconds a woman is beaten by her husband. However, it is generally believed that domestic violence is seriously underreported and undiagnosed. The paucity of accurate incident information underscores the problem. The U.S. Department of Justice estimates that 95% of assaults on spouses or exspouses are committed by men against women. Domestic violence is repetitive in nature: about 1 in 5 women victimized by their spouse or exspouse reported that they had been a victim of a series of at least 3 assaults in 6 months. A 1993 national poll found that more people (34% of men and women) have directly witnessed an incidence of domestic violence, than muggings and robberies combined (19%). And 14% of American women acknowledge having been violently abused by a husband or boyfriend (5).

Close to half of all incidents of domestic violence against women discovered in the National Crime Survey (48%) were not reported to police. 92% of women who were physically abused by their partners did not discuss these incidents with their physicians; 57% did not discuss the incidents with anyone. In 40% of cases in one study in which physicians treated battered women in an emergency department setting, staff did not discuss the abuse with the patients. A recent national study of the 143 accredited U.S. and Canadian medical schools revealed that 53% of the schools do not require medical students to receive instruction about domestic violence (5).

Physical injuries due to battering can range from relatively minor bruising and abrasions to injuries requiring hospitalization, major surgical intervention, or death. Emergency departments are not the only health care setting in which victims of DVAW seek care. Twenty-eight percent of women surveyed in three university-affiliated ambulatory care internal medicine clinics had experienced DVAW at some time in their lives; 14% were currently experiencing abuse. Obstetrical health providers have an especially important role in identifying battered women. Studies indicate that between 10 - 32% of women seeking care from prenatal health care providers has a past history of domestic abuse and 4 - 8% of women are battered while pregnant. Mental health care providers see battered women for suicide attempts, anxiety and depression. In one study, 64% of female psychiatric inpatients

experienced physical assaults and 38% experienced sexual assaults as adults; these were largely due to abusive relationships. Orthopedists, orthopedic nurse practitioners and physician assistants see battered women with fractures and other musculoskeletal complaints caused by domestic violence. These women seek care from specialists in “head and neck” medicine for perforated eardrums, nasal fractures, dislocated mandibles, and septal hematomata. Dentists see battered women with fractured teeth, “bad bites,” and broken jaws. Ophthalmologists and other eye care professionals see battered women with subconjunctival hematomata, retinal detachments, orbital blow-out fractures and lid lacerations. Practitioners who specialize in chronic pain syndromes, such as headache, chronic pelvic pain or functional gastrointestinal disorders, also see battered women (3).

According to a survey on contraceptive method in a district of Kenya showed that 42% women reported they were beaten regularly by their husbands. In the area of slums in Thailand, 50% women reported that the matter of being beaten by husbands happened frequently (3). In which few people being beaten used force of arms to defend themselves or looked for the help of law.

DVAW happens in different forms, in which violence on sexual intercourse is the phenomenon happening quite often. In connubial life, women can't control sexual life according to the meaning that they have no right to refuse sexual intercourse as they do not want it. They are often in passive position and have to pamper their husbands' ideas (13). A research in America showed that about 10-14% wives were forced to have sexual intercourse with their husbands as they did not want it. And among women beaten by husband, at least 40% were forced in sexual intercourse (14). Qualitative research on decision to abort of married women in two villages of Uttar Pradesh State (India) showed that 68% of people being interviewed said that they were forced to have sexual intercourse by their husbands as they didn't want it. If they rejected, they would have been victims of maltreatment (15). In many societies, the husbands often plays an important role in applying contraceptive method of the wife, especially in the societies where traditional value permits men forbidding their wives from using contraceptive method (16). In Kenya, people working on family planning

reported that there were cases of women being beaten by husbands after being found out using contraceptive method (14). The above data showed that this maltreatment action happens quite popularly. However, this is considered as a private problem, the actual data is not statistic accurately, fully.

However the data on DVAW taken from official sources such as at police stations, hospitals is often lower than the fact. The phenomenon of beating wife is still hidden and is not always condemned as in many places, men are still considered as the bread-winners, the hosts in the families and having right to control their wives.

2.1.2 Situation concerned in Vietnam

Vietnam with ethical behavior "three subjection, four virtues" of a woman still has strong effect upon the life of women. On traditional term, the husbands are still considered as the bread - winners and the wives have to obey the husbands absolutely. The husbands have right to teach to wife and the wife is considered as the husband's property. Therefore, DVAW still often happens in every social class, both in urban and countryside.

According to reported data of People's Procuracy and People's Committee of 18/53 provinces, cities in the whole country from 1990 to 1998, there were 11,630 cases of DVAW requiring intervention by the authorities were recorded. Over the same 8 year period, 515 reported cases occurred in Ba Ria-Vung Tau; 819 in Khanh Hoa; 1,123 in Thai Binh; 1,484 in Ha Tay; 967 in Ninh Thuan; and 2,002 in Kien Giang (The Law, 1997). The real number of cases of DVAW is undoubtedly much higher than these figures would suggest as they are derived only from cases that have proceeded to the hearing stage. Other surveys have demonstrated that victims frequently do not report acts of domestic violence and even where the violence is reported; women are often discouraged both by their families and by authorities from following through with complaints (8). If compared to the data in America, each 7.4 seconds, there is a women being maltreatment by husbands, or in India, over 5000 women are killed every year because they are assumed by the husband's family that they do not have enough marriage property, the date of 11,630 cases in 18 provinces

in 8 years in our country is no great. In average there are more than 50 cases/year in a province or city, in which including crowded city such as Ho Chi Minh city. But it is needed to state more that the data is not statistic fully. There are mainly symbolic cases needing to be intervened by law. One of popular maltreatment actions is body maltreatment without using "tool".

A study conducted in Northern Vietnam in 1998 by Dr. Le Thi Quy noted that “underlying domestic violence, as well as other forms of inequality between men and women in Vietnam is a more than 1000 year history of patriarchy that privileges men over women.” (17).

Research result of family sociology department in 3 provinces in 3 regions of North, Centre, and South in 1999 showed that 15% of wives were beaten by husbands, 50% were abused by husbands, more than 70% were left alone by husbands, nearly 10% had no sexual intercourse with husbands (18).

According to research result of the Women’s Union of Vietnam, the actions such as: punching, kicking, slapping in the face accounted for over 60% if calculating the most series cases of husbands beating wife only. The action of using tool such as stick or throwing objects was fewer than 10% (7). In study of Vu Manh Loi and colleagues when interview the Women’s Union representative in the urban quarter of Hue, she believed that couples with high status and education tackle issues of conflict through discussion, in contrast to families in which the husband has less education, and uses force to solve problems. A woman in a focus group discussion in an urban commune told that:

“My son-in-law gave his wife a few slaps in front of other family members. It happens frequently, even though it is the family of a medical doctor. My son-in-law is a doctor, his father is an assistant doctor, and they think that giving the wife slaps is normal” (18)

According to the research of the Population Council in 5 communes of Binh Duong province, the result of the interview showed that body maltreatment which was

dealt with much was punching and kicking (14%) (19), in which beating pregnant women is 2.0%. It means as the women need to be protected their health most to assure the development of both mother and baby, they can't avoid maltreatment action of their husbands. In 1998, the Population Council reported that domestic violence in Vietnam occurs “in families from all education and socio-economic levels” and that numerous factors including; poverty, alcohol and drug abuse, gambling, mental illness, stress and/or frustration and son preference may contribute to domestic violence (20). The action of DVAW happens many times. The other research result of the Population Council showed that 22% of reported women had ever been victims of one or many forms of maltreatment and 13% of that said they stood these maltreatment forms within a year (19).

Not only being beaten, but also women are maltreatment on spiritual life which were expressed through actions such as: abusing a scold, controlling, managing money in the family, even when the wife is sick, she is not given money for buying medicine, being forbidden in ever outside social relationship..., not letting women to enjoy minimum rights which are the rights of being a daughter, dutiful and loyal to parents, the rights to work and study. A 27 year olds woman in Phu Sang confided that she was not allowed to decide a work in the family, from small work to big one in the family, her husbands decided all. She wanted to go to school, go to the meeting of the Women Association but he didn't allow (19).

Also according to the research result of the Population Council in 5 communes of Binh Duong province showing that popular mental maltreatment action was abusing a scold that made women ashamed (17.1%). The husband leaving alone, not taking care accounted for 6.8%, 6.3% of cases were released out of house by husband (19). Compared to qualitative research data through interviewing in Ninh Nhat showed that husband abusing a scold wife accounted for 94.4%, the rate of husband leaving wife alone accounted for 15.6% and 87% of stated people said that in their villages, hamlets, there was phenomenon of DVAW (21). This is still conceal problem, the data still carries surface form, is not statistic accurately, fully.

Although maltreatment on spirit does not cause injure directly on body of women, it is a dangerous maltreatment form because it made the women suffer from pain, debility, having no chance to express to other people and it is very difficult for other people to recognize. This form is having a tendency to increase as the law has not had strict punishment frame.

Women rarely sustain a form of maltreatment action, they often sustain many different forms. Maltreatment on sexual intercourse often accompanies maltreatment on body, spirit. The research result of the Population Council showed that rate of women maltreatment on sexual intercourse in which force to have sexual intercourse when the wife does not want accounted for 2.4%, the husband not having sexual intercourse accounted for 2.9% (19). The above data is not big but it can be said that this maltreatment action happened. Besides, there is concept that sexual life is a private, tactful matter. The concept of "husband rapes wife" does not exist in the thoughts of many people including victims, therefore the data was calculated fully.

According to Nguyen Kim Ha, sexual compulsory towards wife is presented through the action of wanting to have sexual intercourse, but the wife due to a reason did not meet the demand, the husbands suspects his wife of adultery so that she is frigid with her husband and then he looks for a new relation outside marriage then he neglects, treats badly with his wife (22). In case the husband has a concubine, the husband's family can neglect but in case the wife commits adultery, it can't be acceptable. She will be condemned, beaten or dismissed to her parents' home. The women without children are forced to agree their husbands to have concubine. If the reason of having no children is due to the husbands, the women have to sustain that life the whole life (23).

2.2 Theory and Model

2.2.1 Subculture of Violence

This theory is based on Wolfgang and Ferracuti ideology (Gelles and Strauss, 1979). This theory mentioned about the response to the violence of individual by

learning from the expected outcome. The subculture of violence is the learning of the association between individual and the socio-culture. The subculture of violence is the compilation of social norms, social values of violence and violence behaviors. Then, everyone accepts the subculture of violence and socializes this subculture among the society members. This theory proposes that the society does not have a single culture, but there are many subcultures among the group of people. The subculture may adopt the main culture or totally refuse the main culture (Caroll, 1980). The deviant behavior in the main culture may be accepted by the specific group in the society. For example, homosexual is a deviant behavior in the main steam of heterosexual culture but it is accepted by the homosexual group.

This theory explain that persons learn how to use violence and aggressiveness from the others members in the society and when they move to the other group they have to adjust themselves to the others subculture which belong to the group (Wolfgang and Ferracuti, 1967 and Gelles and Strauss, 1979). Person who use violence against their partners have to absorb the culture of violence from the values and norms of the subgroup in the society. The subculture of violence prefers to use violence within the partners; the other members in the society will not blame the people who use violence in their family.

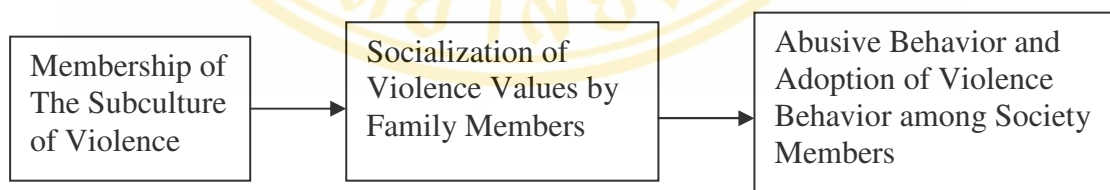


Figure 3 The subculture of violence framework

From the subculture of violence, the positive attitude towards violence is developed to be a legitimate behavior and be socialized from generation to generation by family. (Wolfgang and Ferracuti, 1967, Carral, 1980). The social learning process is involved in this theory by:

1. Different learning. Persons can learn from the other persons or any organization by either observation or participation. Persons can perceive different meaning even they are in the same context.

2. Association. The relation and interaction within individual can be motivated to response each other with in the social group.

3. Identification. Persons can conduct their identity from other persons or any objects.

In the subculture of violence, persons will have their own identity but they imitate from their parents. Therefore, culture violence will be existing in the community; through the value of violence is not an acceptable value in the community.

2.2.2 Health Belief Model

During 1950s, researchers began to learn about how individuals make decisions concerning health and what determines health behavior. Rosenstock and Hockbaum explained in the health belief model that for a person to display a certain health behavior in order to avoid disease.

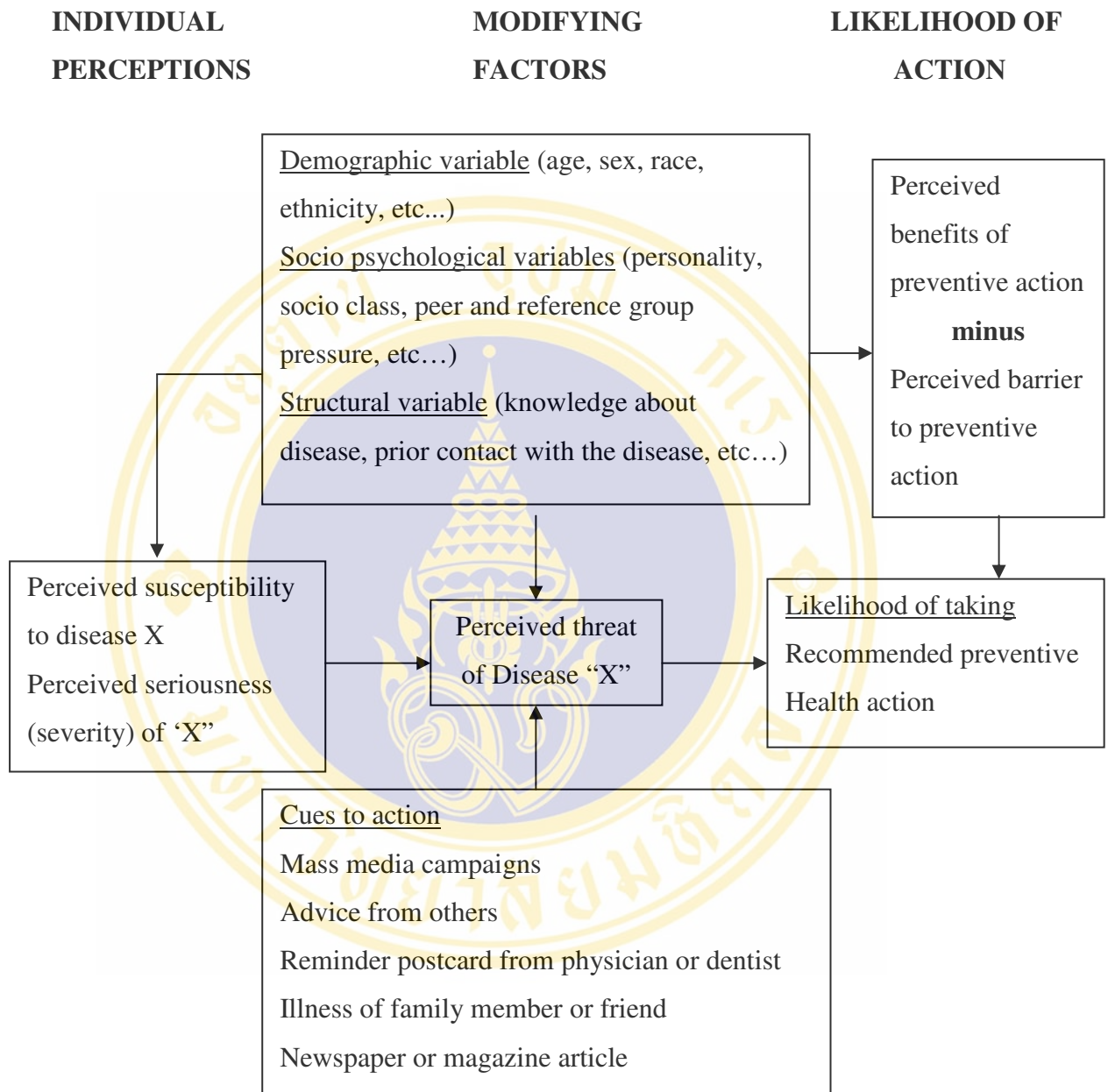


Figure 4 Health Belief Model

Components of the health belief model (Figure 4):

Socio-demographic factors: Socio-demographic factors of health provider include: age, gender, education, occupation, marital status, working department and working years in health sector of health providers

Structural factors: knowledge of health providers toward DVAV

Perceived Seriousness - refers to the beliefs a person holds concerning the effects a given disease (consequences of DVAW behaviors) or condition would have on one's state of affairs. These effects can be considered from the point of view of the difficulties that a disease would create. For instance, pain and discomfort, financial burdens, difficulties with family, relationships, and susceptibility to future conditions. It is important to include these emotional and financial burdens when considering the seriousness of a disease or condition.

Perceived Benefits of Taking Action - taking action toward the prevention of DVAW or toward dealing with victims of DVAW (physical and emotion injuries) is the next step to expect after an individual has recognized it is serious. They perceive benefits from improving the health care response to DVAW, improving health care quality and the patient-provider relationship and behavior. The direction of action that a person chooses will be influenced by the beliefs regarding the action.

Barriers to Taking Action - However, action may not take place, even though an individual may believe that the benefits to taking action are effective. This may be due to barriers. Barriers relate to the characteristics of a treatment or preventive measure may be inconvenient, lost time, unpleasant. These characteristics may lead a person away from taking the desired action.

Cues to Action - an individual's perception of the levels of seriousness provide the force to act. Benefits (minus barriers) provide the path of action. However, it may require a 'cue to action' for the desired behavior to occur. These cues may be internal or external.

Application of health models to the present study.

The health belief model was applied and used by the researcher to explain the behavior of individuals in improving the health care response to DVAW and preventing DVAW. The health providers need knowledge of the risk of DVAW and intensity; this knowledge will contribute to enhance their perception toward DVAW

to improve the health care response to DVAW and avoid DVAW. The researcher thus used the health belief model to explain behavior change in future.

2.3 Concepts and forms of domestic violence.

2.3.1 Concepts

Domestic Violence (DV)

Domestic violence is a pattern of assertive and coercive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners.

“All acts of gender-based physical. Psychological and sexual abuse by a family member against women in the family, ranging from simple assaults to aggravated physical battery, kidnapping, threats, intimidation, coercion, stalking, humiliating verbal abuse, forcible or unlawful entry, arson, destruction of property, sexual violence, marital rape, dowry or bride-price related violence, female genital mutilation, violence related to exploitation through prostitution, violence against household workers and attempt to commit such acts shall be termed “domestic violence”. (Coomaraswamy, 1993) (2)

Violence against women (VAW)

VAW with different forms has been occurred in all communities, countries in the world, no racial religious discrimination.

In the world, there are different concepts on VAW, these concepts previously was narrowed through actions that bring capture character, making the hurt to other and punished by law. Nowadays, this concept is enlarged more, including both action making hurt on body, spirit, happened in family scale and society. In this study, we use the definition on VAW noted in "Declaration on eliminating VAW" has been approved by the general assembly of United Nations in 1993:

"Any violent action is based on any sex that lead to or able to lead to hurt on body spirit, sex or psychology of woman, including action of threat, force or secure for oneself the freedom although in community or private lives. They are considered violence against women "(3).

At the article 2 of the Declaration, it defined also this definition should be understood largely more, including any action that causes the hurt on body, spirit, sex, psychology happened in family and society. Thus, VAW includes many different forms.

The Declaration on the Elimination of Violence against Women passed by the United Nations General Assembly (Vienna Declaration 1993) states that: "Violence against women is a manifestation of historically unequal power relations between men and women...and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position to men"

The United Nations Declaration on the Elimination of violence against women: "Any act of gender-based violence that result in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations, 1995) (2)

Domestic violence against women (DVAW)

The United Nations Declaration on the Elimination of Violence against Women (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty". Domestic violence against women, as defined for this study, includes violence perpetrated by intimate partners and other family members, and manifested through (2)

2.3.2 Forms of domestic violence against women.

Physical abuse

Physical abuse is defined as the use of physical force with the intent to harm or frighten and includes the use of weapons. Physical violence also includes actions like restraining someone.

Neglect could be seen as a form of physical abuse. Neglect can amount to a criminal offence under the Criminal Code if a person responsible for the care of another fails to provide the necessities of life.

Sexual abuse

Sexual violence is forced sexual activity including rape. Unwanted kissing or touching, or forcing someone to do something they don't want to do (e.g. looking at pornography) is also sexual abuse.

Psychological/ Emotional abuse

Emotional abuse is the systematic use of fear. This is where the perpetrator does or says things that make their partner feel scared or intimidated. For example, threatening to harm or kill, threats to abduct or harm children, hurting or killing pets, threatening with guns or other weapons. Prolonged silence, doing things to confuse the person, withholding important information or exclusion from decision making, are all forms of psychological abuse.

Social abuse

Family and domestic violence is about power and control. Perpetrators aim to control all aspects of their partner's life. Social abuse involves manipulation, isolation and/ or intimidation. A woman, for instance, may be prevented from making contact with family and friends. Restricting use of the telephone or the family car or insults aimed at shaming, belittling and publicly humiliating are all social abuse. Social and emotional abuse can be easily overlooked, yet its impact on psychological well being is enormous.

Economic abuse

Controlling money by denying access to bank accounts, forcing the surrender of bank cards to gain control of someone's income or social security payments, preventing them to seek or maintain employment, and denying input into important financial decisions are all financial abuse.

2.4 Sources of domestic violence against women

2.4.1 Cultural history

In the society, male is often encouraged to express oneself the muscular force, being taught the way of fight, struggle. Previously, the knocking wife was accepted in many places in the world, the British law allowed men to punish their wife, by any suitable tool, and after that to be amended those tools were no thicker more than the thumb (24). The acceptance of women maltreatment; action of society makes the men firmly believe in the maltreatment of women, that be a normal matter and they have this right.

In Thailand, the men have the right in religious society, this is a society that men have respect for and his position is also higher than woman. From Rattanakosin period, the wife and girl children are considered as property thing of husband, he has the right to sell, exchange goods, blame or punish. The women start only to have right to body of themselves from the Rama King IV (25). Up to now, although the law has defined the impartially between male and female, but the social structure is not yet changed, the confidence of women is a property thing of men is still engraved profoundly, that was explained why women have always the threat being a victim of domestic violence.

Source from social institution, Vietnam is a country to be come through thousands years under the feudal regime, near 100 years under the semi-feudal colonialist yoke. In that historical period, orthodox idea and ancient concept on role, position of man and woman in the society "Respect men and despise women" "Ten females are not equal one male" has defined. The absolute position of men in the

society, the husband, the father in family and the woman was an object of domestic violence (26). By the beginning years of 20th Century, the men were considered to have a position higher than their wife and women were considered as dependent. The husband claims the compliance of his wife, if not she may be beaten (27). This still influencing up to now, some surveys shown that women in family, especially women in rural and remote areas are still put up with losses from the inequality that bearing the stamp from the far remote times, no body examines women opinions, although that is related to them (28).

With the conversion in the economy, it led significant change in relationship, especially is the relation of sex, the role of women are raised. However the perception on sex is still limited (29). In some measure the deep cause of DVAW sources from the inequality on allotment of sex role, an allotment that not goes out the influence of family head idea system brought to male rights more than female (30).

2.4.2 The execution of authority and law on DVAW

Although there were law policy on protection of equal right and body freedom of citizen like Vietnamese constitution defined at the article 52 and the article 63 "Every people has the equal right before the law" "Forbid strictly forbid all action of treat discrimination to women, to hurt human right of women" (31). But the DVAW situation is still considered a personal matter, wife and husband can self-arrange. The local authority conciliates only and law intervenes only in case that provokes serious hurt to women. The lukewarm attitude of community, the settlement is not timely, not severe of law is also the cause, so the domestic violence still exists and develops (32).

2.4.3 Situation of economy

Difficult in economy is also an element to increase DVAW situation. Reduced to destitution, unemployed often lead to reduce to utmost poverty, many couples must take pains to look for a living, contradictions on economy made them fully stretched, inhibited nerves, leading to the debate and finally, male uses own right, force to call bad names and beat his wife and children.

The study of The Women's Unions of Vietnam in 3 provinces: Thai Binh, Lang Son and Tien Giang showed that the number of DVAW at families which have different economic condition, among them, accounting for a high rate is at families with lower economic situation, case of being lashed out at family accounting for 30.2%, being beaten is by 7.7%, in families which have rather economy, case being lashed out accounting for 11.1%, beaten is by 1% (7).

According to the study result of Instate of Sociology, the rate of maltreated women under income level shown also actions of maltreatment happened commonly at both families which have an average and rather income levels. However there is a higher rate in poor families: 86% (18). Thus, matters on economy, especially difficult economy is an important element that causes situation of DVAW.

2.4.4 Social evil

Some studies on DVAW shown the social evil like to be addicted to drinks, to drugs adultery are common dangers of that situation. In many cases, due to lazy, not take pains to labor, they led to the path of gambling, drinking heavily, even use of drugs which made family economy to be by nature a scanty circumstances, becoming difficult more. However, when the man is drunk, he beat his wife but being upheld because the woman doesn't know to stand, she speak much since the leading to maltreated action (17).

The report of the People's Committee of Ba Ria, Vung Tau shown that, among 515 cases of husband maltreated, beat his wife and children the main cause is by gambling, drinking heavily, and opium addiction from husband (33).

The study result of the Women's Union of Vietnam shown that the reason of lashing out at beating wife due to drunk with alcohol, accounting for a higher rate 24,3% of causes being beaten by drunk with alcohol from husband (7).

2.4.5 Children easily being contracted violence from parents

Many children must witness their father lashed out, beat his mother before them, since then to form them to have a habit to recognize DVAW to be come friendly with their life. The parents debate, lash out at and intimidate children will make them to have a think: all complicated matters in the life need to have maltreated action for solving. Hence, this action is fostered and maintained through many generations. Studies in Brazil, Cambodia, Canada, Chile, Colombia, Costa Rica, El Salvador, Indonesia, Nicaragua, Spain, the United States and Venezuela all found that rates of abuse were higher among women whose husbands had either themselves been beaten as children or had witnessed their mothers being beaten. Although men who physically abuse their wives frequently have violence in their background, not all boys who witness or suffer abuse grow up to become abusive themselves (9).

2.5 Consequences of domestic violence against women

The researches on DVAW have analyzed the woman has the danger to be maltreated throughout the life of herself. A girl child before being born may be a victim of violence by action of sex selection of adult. When growing, she will have a threat to have to live in violence because of being treated discrimination on take care of education between girl children and boy children or may be victim of sexual coercion. When having grown up, he (she) may be victim due to be sexual disturbed, coerced to sexual relation without safety or traded... and when getting married aged, may be also abused and scolded, beaten by husband, domestic relative...

DVAW has brought serious consequences not only at present but also affect for a long time, dignity of women is trampled on, the health, body, spirit, sex are hunt, family is in pieces, affected social progress. There is researches warned DVAW "not only make felling a lasting string the conscience of every one but also being becoming an interest of the while society" (17).

According to the World Health Organization, violence against girls and women throughout the world causes more death and disability among women in the 15 - 44 age groups than cancer, malaria, traffic accidents and even war (35).

The study of the Women's Union of Vietnam shown the consequence of most severe beats from husband to wife, 51% of case the soft tissue is violet swarm, 16,2% have to buy drugs for treatment, 6,2% have to hospitalize (7).

Thus, the common consequence is hurt soft tissue, almost these victims can stand, no need to the intervention of other. This is a cause - studying on anthropology in developing countries provided also proofs on serious damages to health of women, even it can lead to the death. In 1994 in Shanghai, China of the mortality of women due to DVAW was by 6% (14). There are women who are maltreated to the most and they must seek a negative solution that is suicide. In Vietnam, the report of the People's Procuracy of Hai Hung province shown in 8 years (1987 - 1994) there were 33 cases of wife and children must suicide due to maltreated, although this figure is not large but it needs to warm, especially there were heart - Rending cases of Mrs. Nguyen Thi N, born in 1966 at Dien Nam commune, Dien Ban, Quang Nam, due to husband was a heavy drinker, he has called bad names, beaten his wife, children, so she with four children drank insecticide for suicide (33).

Violence can lead directly to unwanted pregnancy or sexually transmitted infections, including HIV infection, through coerced sex, or else indirectly by interfering with a woman's ability to use contraceptives, including condoms. Violence also occurs during pregnancy, with consequences not only for the woman but also for the developing fetus. Population-based studies from Canada, Chile, Egypt and Nicaragua have found that 6 - 15% of ever-partnered women have been physically or sexually abused during pregnancy, usually by their partners. A recent study among 400 villages and seven hospitals in Pune, India, found that 16% of all deaths during pregnancy were the result of partner violence. In rural Uganda, a recent study of HIV transmission between heterosexuals women who reported being forced to have sex

against their will in the previous year had an eightfold increased risk of becoming infected with HIV (9).

Women interviewed in a study on agricultural workers in Mexico shown that, they felt impotent in the decision whether having sexual intercourse or not, and when they are beaten and considered as not faithful (38).

The study of Norton and colleagues showed that, a number of women with positive HIV, having sexual coerced history in beaten situation (40).

DVAW is a main cause of breaking through family life. According to the statistic in 1995, the court of the whole country has handled 33,562 cases of divorce, among than 18,927 cases (accounting for 56.4%) by domestic contradiction and maltreated women both body and spirit. Not only in remote area but right also in big city like Ho Chi Minh City, this situation should be warned. In 2000, this municipal court has handled 9,050 cases, among the 8,597 case (95%) women were beaten by their husband, in which including maltreated both body and spirit (42). The study of the People's Supreme Court of Hanoi in 3 years 1998 - 2000 shown the DVAW is an important cause, leading to divorce (52.62%) (43), although data may be different, but it could say that, divorce is a consequence of maltreated and just these actions is reason to oblige the wife must take the initiative to write an application for divorce.

Children were born in family with maltreated will be also victim of this situation, the health, body, spirit of children are severe influenced, they often felt lack of self-confidence, be timid, complex, even must leave from house and easily become victim of social evil. These children may have psychological disorders like unstably, increasing mutual state, depression biased action, deteriorated learning (45). Many children were chafed or disabling injury when they deliberated to protect their beaten mother. They may be mental disease or broke the law due to have maltreated history (15). DVAW, through its compact to activity ability of women in the world has obstructed the social-economic development. The maltreatment causes the increased social evil, lost beautiful traits of fine custom, caused lost unity in community, and

influenced the order and social security. Moreover, this is a great obstacle to the implementation of equality, development and peace goals.

A matter should be interested being cost for the treatment and solving consequence of DVAW. According to the study of rush medical center in Chicago shown, the cost on medical service for maltreated victims with an average of 1,633 dollars/person/year, equivalent to total cost of nation is 857.3 million dollars/year. In addition, there was also expense for social organizations, the law will resolve and reeducate to violent person. Expanses for procurement of beaten damaged furniture is uncountable.

2.6 Knowledge, perception and practice on DVAW.

2.6.1 Situation concerned in the world

Over the last decade, concern and outrage over the prevalence, magnitude and impact of violence against women (VAW) has grown to the point that VAW is now recognized as a global human rights problem that requires a comprehensive and coordinated response from civil society, the State and the international community. This growing concern and attention to VAW has led to the formulation of international, inter-American, national, and institutional commitments to eliminating it. The 1990s saw the development of at least 5 major international declarations and platforms for action that specifically addressed the issue of VAW. Two of these, the Declaration on the Elimination of Violence against Women (1993), and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (or the Convention of Belem do Pará, 1994) were developed to explicitly guarantee women's right to live violence-free lives. All 5 international instruments are approaching their 10-year anniversaries, providing the international community, national governments and civil society a crucial opportunity to assess the progress that has (or has not) been made in complying with these commitments (5).

Through different international forums, DVAW was more and more recognized as "An obstruction of equality, the unacceptable violation towards human

dignity". This is a global phenomenon, affecting 20 - 50% of all women in the World (18). Knowledge on reasons, researchers argued that: the deep reason of DVAW is the attitude deeply rooting into subconscious of inhabitants on role, responsibility. Which are regulated on cultural, social aspects but sometimes it is taken for starting from biological difference between male and female. Therefore, action program of the Women Conference in Beijing emphasized "Women maltreatment is an expression of unequal power relation on sex that leads to the domination and discriminatory treatment of male towards female, preventing from making progress in every field of women" (7).

Together more and more all-sided knowledge, attention level of the community on the situation of DVAW more and more increase. In the world, many governments and international organizations are having activities to protect women from maltreatment. Many international organizations are proposing United Nations to take the 25 of November annually as the International Day for Prevention of Violence against Women with the symbol of a white cloth band. At International Conference on Population and Development in Cairo in 1994, representatives of countries, governmental officers and policy maker, undertaken to develop an action plan to protect reproduction health, sexual health and women right. The conference also drafted activities on politics, law, social service, information construction and people education in order to reduce and abolish every form of VAW (14). Action program of Women Conference in Beijing also emphasized the importance and essential of methods and the construction of policy on some action models participating in this match: national law on treating maltreaters, establishing the Family Violence Prevention Fund, Counseling centers in which the model of temporality shunning house is being built in some places such as Tallahassee (America), Shakti Shalini temporality shunning house in India, especially this model existed in New Zealand from 1973 (47). This is not only the place for women temporality shunning in a given time but also the place to provide information to help them enhance knowledge and promote personal strength in order to solve their problem by themselves. One of joining activities of social organization with hospital is 'One-Stop Crisis Center' (OSCC). This centre was established at emergency department, as maltreated female

patient screened from consulting room and emergency room will be moved here to fulfill record and provide consultancy, they are still treated at specialized departments.

In 1993, organized medicine officially joined the effort to strengthen the health care response to domestic violence when the American Medical Association (AMA) launched its landmark "Campaign Against Family Violence." The Campaign included the formation of a "National Coalition of Physicians Against Family Violence" as well as a national domestic violence council comprised of 35 national medical specialty organizations. Successful advocacy by the Philadelphia Coalition Against Domestic Violence and others led to a mandate by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) that hospitals develop protocols for the identification and the treatment of abused women. In 1990, JCAHO issued domestic violence standards for the nation's emergency departments. In 1992, the standards were applied hospital-wide, and in 1997 they were further updated. These domestic violence standards require all hospital departments to have the following in place:

- **Written domestic violence protocols** specifying the scope and conduct of patient care (including objective criteria for identifying and assessing possible victims of abuse, and policies and procedures that define the hospital's responsibility for collecting, retaining, and safeguarding information and evidentiary material);
- **A plan for educating staff** about domestic violence identification, treatment, and documentation;
- **A list of private and public community agencies** that provide help for abuse victims.

The Joint Commission standards represented an important first step in defining a role for responding to domestic violence in hospital and ambulatory care settings. In 1990, New York became the first state to require that all licensed hospitals establish protocols to identify and treat domestic violence victims and utilize community referral lists. California followed suit in 1995 with the passage of Assembly Bill 890, the first state law mandating development and implementation of protocols for all hospitals and licensed clinics to detect the presence of violence in the lives of patients.

In addition, this legislation made domestic violence coursework or training a part of the licensing and re-certification process for health care providers. Florida and New York also require domestic violence training for re-licensure of physicians. Florida's law requires all physicians to have two hours of training in domestic violence as a condition for re-licensure (48).

2.6.2 Situation concerned in Vietnam.

In Vietnam, although DVAW attracted attention of people in recent time, it is not, admitted as an important obstruction on women's progress by policy makers. It is still considered as a private matter in each family. Many actions are considered as necessary to maintain the development of family. One thing recognized through researches is that the action of DVAW can be accepted, especially for inhabitants in countryside. The research of the Women's Union of Vietnam showed that 22.8% of participating men agreed that the action of beating wife is a normal matter and 10% considered as necessary work as the wife is wrong, while over 50% women gave this reason. Besides, the concept on maltreatment action is sometimes not understood fully. Some people think that only actions causing serious consequences are considered as maltreatment. Even judicial cadre, the person understanding law also thinks that as husband and wife quarrel, slap on the face twice or three times, it is a normal matter not maltreatment (7). It can be said that domestic disagreement is a normal matter which happened because "Even bowls and chopsticks rush" but beating wife is an action violating law.

Up to now, there has not have a sufficient research studying on knowledge, attitude and practice of medical providers on DVAW. Qualitative research of Nguyen T. Hoai Duc on this matter showed that medical staff both in urban and countryside still have sympathy attitude with action of beating wife and almost of them do not participate in preventing this situation.

In Vietnam, essential centre of importance in policy of government is to enhance women's status. President Ho Chi Minh-the founder of modern State of Vietnam appealed his compatriots to abolish every fixed idea and injustice that had

historic nature towards women. In 1946, the first Constitution of the country acknowledges sex equality with the largest mean. Since then political leaders constantly assured sex equality as an essential development aim, including recent decision of Prime Minister approving the National strategy for women's progress up to 2010 (49). According to convention on expelling evidence against women raised: "Women have right to live without accepting any form of discriminatory treatment basing on sex, race" (50). The Vietnam government has guideline policy to protect women's right but all are at exterior form. But protection methods are not effective; they do not really protect women from the situation of DVAW. Up to now, there are only some organizations such as: Women's Union, authorities, law taking part in solving this situation. Vietnam's law also regulated clearly on human right, the right to be protected on life, health, honor and human dignity of citizens, as article 63 regulates: "To forbid strictly every action of discriminatory treatment towards women, hurting human dignity of women". At the same time establishing criminal and civil treatment methods towards DVAW action such as: punishing from 200,000 to 500,000 VND for maltreated action against grandparent, parents, wife and children (51). Because common knowledge of the society still considers DVAW as private matters of families, few cases were applied treatment method towards people having DVAW action by the authorities. Therefore law is not really a reliable support for victims. The research of the Women's Union of Vietnam on DVAW showed that intervention, helping rate of authorities towards cases of DVAW was very low. While intervention rate of relatives was 62.7% and that of the Women's Union of Vietnam was 36.3% that of authorities was 2.9% that of policemen was 4% (51).

For medical branch, DVAW is considered as health matter in general and reproductive health in particular, it was dealt with in aims and strategy activities to take care national reproductive health, Vietnam population strategy in the period 2001-2010. However, up to now there is no medical regulation on DVAW.

2.7 Roles of the health provider

DVAW is a sensitive matter relating to secret pangs in private life of women, therefore this situation seems to be hidden and has been only dealt with recently publicly through means of mass media and only few organizations took part in the fight to solve this situation, especially the role of health organization. Many maltreated victims had to bear the consequences on health because medical staff did not recognize or treat sufficiently. Further more, the researcher showed that fee for intervening; solving maltreatment was much smaller than that for curing pain caused by DVAW (5).

Despite the fact that health practitioners see many victims of DVAW in their clinical practices and despite the fact that the impact on the health care system is enormous, many health professionals fail to recognize the problem because they don't routinely inquire about or document abuse as the cause of their patient's symptoms. This failure occurs even though many physicians believe questions about physical and sexual assault should be asked routinely. Furthermore, studies document that most patients want health care providers to ask about abuse and would answer truthfully if asked. The reasons why health professionals have failed to appropriately respond to victims of domestic violence are myriad and complex, but crucial to understand if we are going to improve the response of the health care system to DVAW. They include a lack of training about DVAW; providers' misconceptions about who is affected by domestic violence, biases and/or prejudices; and current or prior experiences with DVAW outside of the health care setting. Health professionals may not want to inquire about DVAW because of the fear of opening a "Pandora's box" and/or because of concerns about time constraints. Some may not inquire because of concerns about privacy and/or confidentiality-especially in states where mandatory reporting laws exist. Others may feel that inquiry and intervention are not appropriate roles for them and should be the responsibility of social workers and mental health professionals. Still others may become frustrated with battered individuals who are "difficult" or intoxicated or have vague but recurring and seemingly undiagnosable symptoms that lead the professional to apply labels such as "crock," "hysterical,"

“somatization disorder,” or “self-defeating personality disorder” to the patient. It is also crucial that health care providers work with local domestic (8).

Most women who are injured by violence ask for help from health personnel rather than legal officials. A WHO report on violence and health emphasizes that health personnel are key to help women who are victims of violence. Unfortunately, in practice women fail to receive support or appropriate health services, partly due to the lack of hospitals' policy, procedures or reporting formats for women who have been assaulted. Identification of VAW depends on the woman's voluntarily voicing the problem and on the commitment and sensitization of health care staff to this problem. Studies by Warshaw and Heise demonstrate that health personnel often lack the relevant knowledge, tools, and skills to deal with this group of women. Health personnel tend to be afraid or uncomfortable in their interaction with these women. According to Abdullah the services provided to these women in the general hospital in Kuala Lumpur had the following failures: lack of referrals, insufficient emergency accommodation and inadequate hospital management (52).

The research of Nguyen Thi Hoai Duc showed that health providers can help battered women in many ways: by screening for domestic violence; by documenting abuse in the medical record; by safeguarding evidence; by providing medical advice, referrals, and safety planning; and by showing empathy and compassion for a woman's situation and the abuse she is experiencing. Knowledge of medical staff on this matter is still restrictive, is affected by culture, society where they live. They believe that DVAW often happens in poor, not educated families, or beaten wives are those who are not good, do not know how to behave in husband's family; do not know how to meet the sex demand of the husbands. Some staff believes that there are reasons that men can beat wives such as not listening to the advice, answering back, not respecting the husbands... Therefore although beating wives is wrong, most of beaten wives have fault. This perception of health providers towards DVAW will affect the sympathy, sharing and way of solving towards victims of this situation. In addition, some health providers refused to take part in the research and in general they assumed that: *"They had no responsibility or did not relate to DVAW, they only*

treated to relieve pain and be haemostatic"(53). Together treatment, health providers sometimes brought out mobilizing advisory words to patients about place possible to help, or helped them with safety residing place. But normally, health providers were not drilled, trained on advisory skills so that it sometimes affected patient's psychology. Therefore it is very necessary to have many researches studying on knowledge, practice of health providers about the situation DVAW, the role of medical establishment in intervention, solving, contributing to the improvement of health and role of women in the society.

Although many people have been existing the shy psychology, not wanting to "*Wash one's dirty line in public*", and the concept that medical establishment is the place to treat pains, victims do not often go to medical establishment or they only go there when having serious wound such as: breaking bone, bleeding, injuring internal organs, etc. But it can be said that medical staff play an important role in approaching this matter. Physicians are often first people and they are sometimes sole specialists that maltreated women look for to have their help. Therefore they have chance to help victims. As a victim go to a medical establishment for emergency or clinical examination, doctors, nurses and other medical experts are the most important people to define victim and intervene for solving this situation. In the study of Le T. Phuong Mai, health providers told that:

"GBV can be seen clearly among patients at the surgical department but at my internal department patients often suffer from mental abuse." (Female health provider, aged 45).

"There were some very serious cases of injuries that needed surgery, some husbands trampled their wives causing ruptured spleens and intestinal damage." (Female health provider, aged 44). (6)

They can also help by recording information in case history, providing safe place, giving advice or expressing sympathy for their situation. Some American researches showed that maltreated victims looked for medical establishment for treating wound on body as well as spiritual disorder. They themselves did not reveal on maltreatment but as they were asked, they had confidence to tell about DVAW in

their lives (54). Furthermore, studies document that most patients want health care providers to ask about abuse and would answer truthfully if asked (Friedman et al. 1972; Rounsaville & Weisimann, 1978) (2).

According to American Medicine Association, one of important contributions of physicians in stopping maltreatment, protecting health of victims is to define and identify these cases. But this work was not carried sufficiently. A research in Ireland showed that of the 1692 women who had ever had a sexual relationship, 651 (39%, 95% confidence interval 36% to 41%) had experienced violent behavior by a partner. 78/651 (12%) women reported that their doctor had asked about domestic violence. 298/651 (46%, 42% to 50%) women had been injured, 60 (20%) of whom reported that their doctor had asked about domestic violence. 1304/1692 (77%, 77% to 80%) were in favour of routine inquiry about domestic violence by their usual general practitioner. 1170 women (69%) reported controlling behavior by their partner and 475 (28%) reported feeling afraid of their previous or current partner (55).

In one study of 394 women seen consecutively by a family practice clinic in the Midwest, 89 (22.6%) of these patients had been physically assaulted by their partners within a past year, and 153 (38.8%) had been abused during their lifetime. However, only 6 women (1.5%) said they had ever been asked about domestic violence by their physicians. In a study of a major metropolitan emergency department that had a protocol for domestic violence, the emergency department physician failed to obtain a psychosocial history, ask about abuse, or address the woman's safety in 92% of the domestic violence cases (48).

K Cann and colleagues conducted a survey of detection, knowledge and attitudes in healthcare workers showed that most healthcare workers are detecting less than one case of domestic violence a month. Many healthcare workers (44%) feel uncomfortable talking about DV with their patients. Moreover, although attitudes were generally sympathetic and supportive, a lack of basic knowledge, particularly in doctors, has been demonstrated. Nurses have significant more positive attitudes and better knowledge on DV than doctors. Females have significant more positive

attitudes and better knowledge on DV than male health workers. No significant differences were found between age groups, although younger health workers tended to have better attitudes (56).

A research in Chicago showed that health providers only selected 10% among female patients and only 10% of medical staff selected victims of DVAW, in which 6% selected all female patients. Selection rate was higher at obstetrics. At emergency room, it was lower (57). Also in a research comparing numbers of maltreated women reported in asking board with numbers of women noted down in case history, 17% of cases (15/90) were noted down in case history (58).

Asking, selecting victims of DVAW at medical establishments can be good solution to bring out statistic data about this situation and through knowledge, attitude of the society. Their experiences and suggestion will represent for a social organization which plays an important role in defining, looking for victims of DVAW. However asking and screening victims are not carried out regularly at health facilities. The reason why physicians rarely screen victims of this situation may be because health providers only attach special importance to treat wounds. At present, health providers are not drilled to ask, define, help victims, asking about maltreatment is not in regulation of public health on diagnosing and healing sickness (59).

Furthermore it is due to the limitation in knowledge of health providers on the matter such as they think that victims often tell lie about the reason of the wounds on their bodies, and as they tell truth, medical staff suspect and do not believe what they say.

"We treated patients equally but after listening to their stories, I thought she ought to have fault so that she was beaten many times" (53).

This is the reason that makes health providers not really take part in the fight against this situation.

CHAPTER 3

METHODOLOGY

3.1 Research design

Descriptive cross-sectional study is used in this study.

3.2 Study population

All health providers will participate study including doctors, assistant doctors, nurse, and midwives of clinical departments: Examination Rooms (include special clinics), Obstetrics and Gynecology, General Internal (include Internal, Cardiology, Mental, Gastro Intestinal, Genito Urinary), General Surgery (include Traumatology Orthopedics - Brain trauma), Traditional medicine, and Physical therapy – Rehabilitation, of the Thanh Nhan general hospital, Hai Ba Trung district, Hanoi City, Vietnam.

3.3 Sample size and sampling technique

Number of health providers should be included in the sample with the prevalence may be estimated to within 5% with 95% confidence.

The standard score (Z) at alpha level ($\alpha = 0.05$) $\rightarrow Z_{\alpha/2} = 1.96$

$$n = \frac{Z_{1-\alpha/2}^2 P(1-P)}{d^2} = \frac{1.96^2 0.5(1-0.5)}{0.06^2} = \mathbf{266.8}$$

While :

n: The desirable calculated sample size

Z: The standard score at α level ($\alpha = 0.05$)

P: The expected value. (P = 0.5)

d: Degree of accuracy desired setting at 0.06

The required sample size is not less than **267** (health providers)

This study will be conducted to select census sampling about 380 health providers from clinical departments of total 413 health providers in the Thanh Nhan general hospital (See Figure 5).

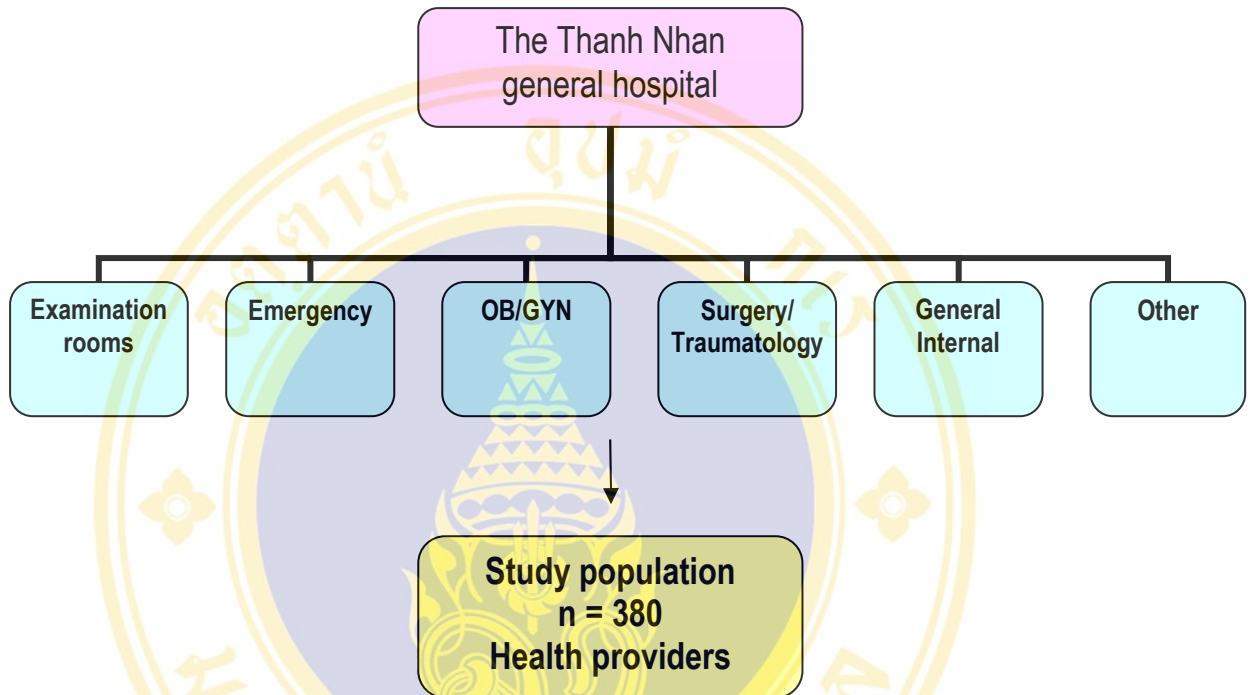


Figure 5 Sampling Frame

3.4 Data collecting tools

Data collecting tool is structured questionnaire.

Questionnaire consists of 4 parts:

- Part 1 is about Socio-demographic factors (age, gender, education, occupation, working department, working years in health sector, and married status) composed 7 questions.
- Part 2 is Structural factors (knowledge toward DVAW of health provider) composed 9 questions.
- Part 3 is Cues to action (working experiences in dealing with DVAW victims of health providers) composed 9 questions.
- Part 4 is the perception toward DVAW of health providers composed 14 questions..

- Part 5 is the suggestion and recommendation of health providers on improving health care for DVAW victims) composed 4 questions and 1 open question.

Data collecting technique is self-administered.

The questionnaires will be distributed to health providers.

3.5 Data collecting methods

- Prepare sets of questionnaires
- Consult advisors and experts for validity of the questionnaires.
- Pre-test of questionnaire: The questionnaires were pre-tested for the reliability test for 30 cases and identify whether some modifications on the questionnaire need to be made or not after a feedback. According to the reliability test of questionnaire used α -coefficient method. It revealed that the α -coefficient of perception part was 0.6037 and knowledge part was 0.8398. After improving and changing the meaning into easier questions to make sure that respondents could understand and also the number of questions. This question was valued feedback from study in those parts. Then we test again with α -coefficient of perception part increased to 0.7518 and knowledge part increased to 0.8522.
- Census sampling will be obtained by taking samples from the Thanh Nhan hospital.
- Submit the official document for permission of data collection in the Thanh Nhan general hospital. The objective of this study will be interpreted and approval of conducting the survey is needed.
- Conduct the official investigation based on the study plan. In order to maximize response rate, all the questionnaires will be delivered and collected face-to-face by investigators (See Figure 6).

3.6 Data analysis

Data was coded analyzed by using a computer with Minitab program.

The data is analyzed according to each objective of research. To describe each variable included into the study by percentages, mean and standard deviation are

applied based upon type of variables. The evaluation of the association between independent and dependent variable was significant or not was analyzed by Cross-Tabulation, Chi-square test, and Multiple Logistic Regression.

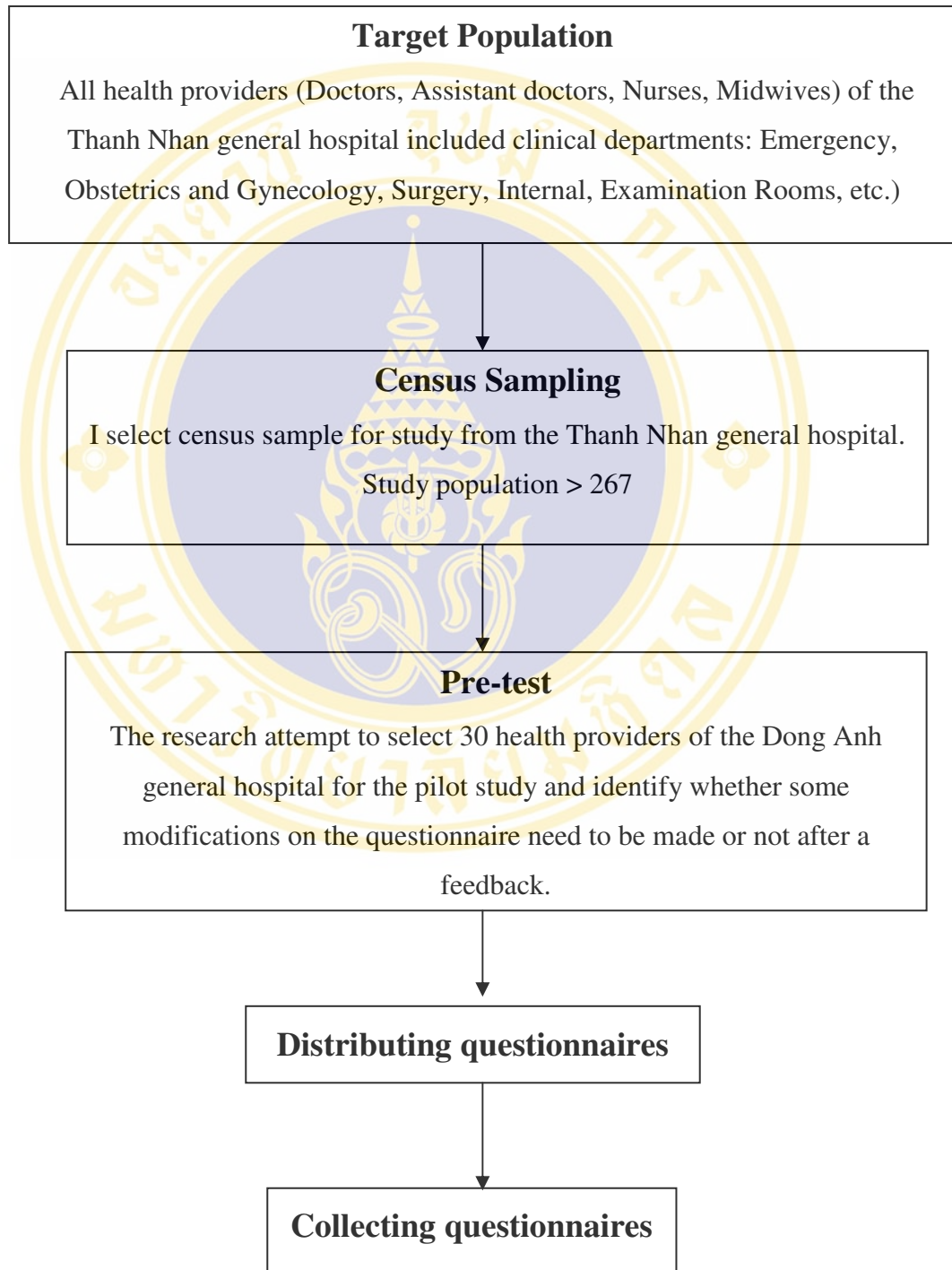


Figure 6 FLOW CHART OF DATA COLLECTION

CHAPTER 4

RESULTS

The results were described into 2 parts: descriptive and analytic part. 1) The descriptive part presented in 5 sections. There were socio-demographic factors; structural factors (knowledge of health providers toward DVAW); cues to action (working experiences of health providers in dealing with patients who are victims of DVAW); perception of health provider toward DVAW; and suggestions of health providers to improve health care response to victims of DVAW. 2) The analytic part presented the associations between perception of health providers toward DVAW and socio-demographics characteristics, knowledge of health providers toward DVAW, working experiences of health providers in dealing with patients who are victims of DVAW. It used Chi-square and p-value of < 0.05 to show the association between the independent variables and dependent variables. Multiple logistic regressions examine the potential strength of the selected factors when the influence of other factors is controlled.

Part 1 Descriptive of all independent and dependent variables

4.1 Socio-demographic characteristic of the respondents

The age range of health providers was 18 to 58 years old. The mean \pm SD was 39.02 ± 9.07 years. The median was 41. The highest proportion of age group was in 40 - 49 years old group (49.2%). The majority of health providers are female, 77.6%. The main education level of health providers was secondary degree (60.3%). 57.6% of health providers were nurse, 34.5% were doctor, 3.7% were assistant doctor, and 4.2% were midwife. Most of them, 81.6% were married (Table 1).

Table 1 Number and percentage of health providers by Socio-demographic factors

No	Socio-demographic factors	Number (n = 380)	Percent (%)
1	Age: (age group)		
	Under 30 years old	80	21.1
	30 - 39 years old	72	18.9
	40 - 49 years old	187	49.2
	Over 49 years old	41	10.8
	(mean = 39.02; median = 41; SD = 9.07; min = 18; max = 58)		
2	Gender		
	Male	85	22.4
	Female	295	77.6
3	Education level		
	Elementary degree	19	5.0
	Secondary degree	229	60.3
	Graduate profession/ Post-graduate	132	34.7
4	Professional role		
	Doctor	131	34.5
	Assistant Doctor	14	3.7
	Nurse	219	57.6
	Midwife	16	4.2
5	Married status		
	Single	59	15.5
	Married	310	81.6
	Legal separation	3	0.8
	Divorced	5	1.3
	Widowed	3	0.8

The respondents of this study were composed of all health providers from clinical departments related to DVAW directly. The highest number of health providers was from General Internal department, 26.3%; Examination Rooms, 18.9%; Emergency department, 16.8%; General Surgery department, 15.5%; and Obstetrics and Gynecology department, 7.4%. The remaining was from other departments (Table 2).

Table 2 Number and percentage of health providers by working departments

No	Working department of health providers	Number (n = 380)	Percent (%)
1	Examination rooms: include internal, surgery, and special clinics	72	18.9
2	Emergency	64	16.8
3	Obstetrics and Gynecology	28	7.4
4	General Surgery: include Traumatology Orthopedics-Brain trauma.	59	15.5
5	General Internal: include Internal, Cardiology, Mental, Gastro Entorology, Genito Urinary.	100	26.3
6	Other: Physical therapy-Rehabilitation; Traditional medicine; Specialties (Ophthalmology, Odonto-Maxillo-Facial, Oto-Rhino Laryngology).	57	15.0

The result of Table 3 showed that the largest proportion of health providers worked for 16 - 25 years in health sector was 50%; under 6 years, 23.2%; and 6 - 15 years, 15.5%. Over 25 years, 11.3%. The mean working years was 15.7 and the median was 19.5, with the minimum and maximum working years were one to 30 years respectively (Table 3).

Table 3 Number and percentage of health providers by working years in health sector

No	Working years in health sector	Number (n = 380)	Percent (%)
1	≤ 5 years	88	23.2
2	6 - 15 years	59	15.5
3	16 - 25 years	190	50.0
4	> 25 years	43	11.3

(mean = 15.7; median = 19.5; SD = 8.866; min = 1; max = 30)

4.2 The knowledge of health providers toward DVAW

4.2.1 Understanding of health providers about domestic violence against women

As this was the first study about knowledge on DVAW of health providers in Thanh Nhan general hospital, it was more appropriate to ask questions about specific behaviors rather than give definitions of violence against women. Over 96% of health providers thought acts causing physical injuries are acts of violence against women, which include beating, assault a woman (hit, choke, slap, push, kick, etc.). Near 95% thought that women's mental health is affected by behaviors of violence such as scolding, insults, humiliate a woman in front of other people, and use a knife, weapon, economic, her children, or a divorce to threaten a women. More than 93% believe that being forced her to have sex against her willing is also abuse of women. The percentage favoring these views among females is always higher than that of males (Table 4).

Table 4 Number and percentage of health providers by considering these behaviors as DVAW and by gender

DVAW acts	Female		Male		Total	
	(n=295)	(%)	(n=85)	(%)	(n=380)	(%)
Physical abuse						
a) Assault a woman (hit, choke, slap, push, kick, etc.)	290	98.3	78	91.8	368	96.8
Emotional abuse						
b) Insult /humiliate a woman in front of other people	281	95.3	79	92.9	360	94.7
c) Threaten (with a knife, weapon, economic, children, or a divorce)	282	95.6	79	92.9	361	95.0
Sexual abuse						
d) Force her to have sex against her willing	276	93.6	78	91.8	354	93.2

4.2.2 Assessment of severity

Identifying the seriousness of each act of DVAW varies greatly. Act of physical violence, by its name, is very serious, such as assault a woman (hit, choke, slap, push, kick, etc.). These are considered serious by 97.1% of health providers. In contrast, 89.2% of female versus 92.9% of male of health providers assess insulting, humiliate a woman in front of other people women is serious. And 76.9% of female versus 83.5% of male of health providers consider force her to have sex against her willing is a serious act. It is very surprise that acts of DVAW is considered to be less serious by females than by males (Table 5).

Table 5 Number and percentage of health providers by assessing these acts as serious and by gender of DVAW

DVAW acts	Female		Male		Total	
	(n=295)	(%)	(n=85)	(%)	(n=380)	(%)
Physical abuse						
a) Assault a woman (hit, choke, slap, push, kick, etc.)	285	96.6	84	98.8	369	97.1
Emotional abuse						
b) Insult /humiliate a woman in front of other people	263	89.2	79	92.9	342	90.0
c) Threaten (with a knife, weapon, economic, children, or a divorce)	284	96.3	83	97.7	367	96.6
Sexual abuse						
d) Force her to have sex against her willing	227	76.9	71	83.5	298	78.4

4.2.3 The reasons for DVAW

The most commonly-mentioned reasons include alcohol, gambling, drug addiction by one spouse (social evils) (98.7%); wife's/husband's extra marital relations (95%); effect of the traditional ideology of gender inequality (94.7%); family

economic difficulties (87.1%). Other conflicts such as conflict between husband and wife, conflict between daughter-in-law and husband's family, conflict in children education were mentioned (83.1%). The percentage favoring these views among males is always higher than that of females (Table 6).

Table 6 Number and percentage of health providers by reasons of DVAW

Reason of DVAW	Female		Male		Total	
	(n=295)	(%)	(n=85)	(%)	(n=380)	(%)
a) Effect of the traditional ideology of gender inequality	280	94.9	80	94.1	360	94.7
b) Family economic difficulties	254	86.1	77	90.6	331	87.1
c) Alcohol, gambling, drug addiction by one spouse (social evils)	291	98.6	84	98.8	375	98.7
d) Adultery	277	93.9	84	98.8	361	95.0
e) Other conflicts (conflict between husband and wife, conflicts between daughter-in-law and husband family, conflict in children education, etc.)	245	83.1	74	87.1	319	83.9

4.2.4 The consequences of DVAW on a woman

As service providers, the participants know very well the consequences of violence to women's health. The mentioned consequences are physical health (97.9%), mental health (98.9%); children's development (98.2%), and family welfare (98.9%) (Table 7).

Table 7 Number and percentage of health providers by consequences of DVAW on a woman

Consequences of DVAW on a woman	Number (n = 380)	Percent (%)
a) Physical health consequences (trauma, disable, death)	372	97.9
b) Mental health consequences (nervous strain, stress, depression, psychology trauma, hysterical, mental sickness, etc.)	376	98.9
c) Consequences on child's development (unlettered, social evils, psychology disorder, nervous disorder, etc.)	373	98.2
d) Family welfare, broken family	376	98.9

4.2.5 How to contact with victims of DVAW ?

The result shows that most of health providers though that directly ask patients (91.1%), 90% patient's family member (s) speak out, 83.4% patients speak out, and 68.4% by the nature of the injuries (Table 8).

Table 8 Number and percentage of contact way with victims of DVAW

Contact way with victims of DVAW	Number (n = 380)	Percent (%)
a) The nature of injuries	260	68.4
b) Ask patients	346	91.1
c) Patients speak out	317	83.4
d) Patient's family member (s) speak out	342	90.0

4.2.6 The knowledge of organizations, associations to support victims

The result in Table 9 shows that, most of health providers knew the organizations, associations that support female victims of DVAW. Organizations

mostly mentioned are the Women's Union (97.6%), Local authorities (94.7%), Police (93.2%), and Conciliation groups (91.8%), Court or Justice (88.7%), Youth's Union (83.4%) (Table 9).

Table 9 Number and percentage of health providers knew organizations, associations to support victims of DVAW

Organizations to support victims of DVAW	Number (n = 380)	Percent (%)
a) Women's Union	371	97.6
b) Local authorities	360	94.7
c) Police	354	93.2
d) Court / Justice	337	88.7
e) Conciliation groups	349	91.8
f) Youth's Union	317	83.4

4.2.7 The knowledge of laws relating to DVAW

The result shows that majority of health providers reported they knew legal regulations relating to DVAW, such as the punishment for intentionally inflicting injury or causing harm to the health of other people. 96.1% of participants knew that physical abuse was illegal; emotional abuse, 94.7%; and bigamy, 92% (Table 10).

Regarding the trend of DVAW, 61.8% of health provider thought that DVAW acts have increased as compare to 5 years ago (Table 10).

Table 10 Number and percentage of health providers knew Government's laws/regulations against DVAW and thought DVAW acts increase as compared to 5 years ago.

Statements	Number (n = 380)	Percent (%)
Government's laws/regulations against DVAW		
a) Physical abuse (murders, intentionally inflicting injury or cause harm to other person, ill-treating other persons.)	365	96.1
b) Emotional abuse (forcing suicide, threaten to murder, humiliating other persons, slander)	360	94.7
c) Violate the principle of monogamy of the Family and Marriage Law	350	92.1
DVAW acts increase as compared to 5 years ago	235	61.8

4.2.8 The role of health providers to help victims of DVAW

Most of health providers know their roles to help victims of DVAW. Besides medical care, the most common support mentioned is to encourage a patients' emotional well-being (94.7%), provide information about community support resources (91.1%), and refer patients to counseling (90.5%) (Table 11).

Table 11 Number and percentage of health providers aware the roles of health providers to help victims of DVAW

The roles of health providers to help victims of DVAW	Number (n = 380)	Percent (%)
a) Examine and treat medical problems	370	97.4
b) Emotion/Mental encouragement	360	94.7
c) Provide information about community support resources (Women's Union, Authority, Police, etc.)	346	91.1
d) Refer patients to counseling	344	90.5

4.2.9 Evaluation of overall knowledge level of health providers toward DVAW

There are 9 main questions include 35 statements to measure the knowledge of the respondents toward DVAW, consisted of questions about the DVAW behaviors, causes, and consequences, law of DVAW. Each correct answer will be given a score of '1' and '0' for incorrect answer. Overall knowledge score is 35. The average knowledge score is 31.26 (SD = 3.72), the minimum score is 11, the maximum score is 35, and mean \pm SD = 31.26 \pm 3.72. The level of knowledge classified into three groups as good knowledge, fair knowledge, and poor knowledge by using mean \pm SD as the cut point. The score of respondent had good knowledge is 21.1% (≥ 35 score), fair knowledge is 64.7% (29 – 34 score), and poor knowledge is 14.2% (≤ 28 score) toward DVAW (Table 12).

Table 12 Number and percentage of knowledge toward DVAW of health providers

Level of knowledge	Number (n = 380)	Percent (%)
Good knowledge (≥ 35 score)	80	21.1
Fair knowledge (29 – 34 score)	246	64.7
Poor knowledge (≤ 28 score)	54	14.2
(mean = 31.26; median = 33.0, SD = 3.72; min = 11; max = 35)		

4.3 The work experiences of health providers in dealing with patients who are victims of DVAW

4.3.1 Screening patients

This study show that there are 67.9% of health providers had contacted directly with victims of DVAW. Among them, there is much difference number of patient who health providers have ever seen. 72.5% of health providers reported of having directly examination the patient and 80.2% were asked patients of DVAW directly (Table 13).

Table 13 Number and percentage of health provider worked by work experiences with victims of DVAW

No	Work experiences on DVAW victims	Number (n)	Percent (%)
1	Health providers have ever seen female patients who are victims of DVAW.	258	67.9
	Total	380	100.0
	(mean = 15.1, median = 10; SD = 18.96, min = 1, max = 100)		
2	Health providers examined victims of DVAW directly.	187	72.5
	Total	258	100.0
3	Health providers ask directly about DVAW patients related to DVAW.	150	80.2
	Total	187	100.0

The study showed that health providers asked about violence only in cases of emergency or initial visit (86.7%), patients presents with physical injuries (67.3%), only 33.3% were asked in routine exams/regular check-ups (Table 14).

Table 14 Number and percentage of health providers asked questions to identify victims of DVAW by type of situation of visit

Situation of visit *	Number (n = 150)	Percent (%)
Initial visit/ Emergency	130	86.7
Routine exams/ Regular check ups	50	33.3
Patients presents with physical injury	101	67.3

* *Multiple answers*

4.3.2 The forms of abuse met to health providers

The most common injuries are soft tissue injuries (bruising, swelling, torn skin - 98.4%), broken bones (arm, legs, ribs, etc.- 70.6%), and injuries in vulnerable areas (head, neck, abdomen - 60.4%). Very low percentage of health providers knew about patients had mental injuries like nervousness, psychological disorders - only 57.2%) (Table 15)

Table 15 Number and percentage of health providers recognizing DV victims by type of injury

Type of injury *	Number (n = 187)	Percent (%)
Soft tissue injuries (bruise, swollen, torn skin)	184	98.4
Broken bones (arm, legs, rib, etc.)	132	70.6
Injuries at vulnerable areas (head, neck, abdomen)	113	60.4
Mental trauma (nervous strain, stress, depression, psychology trauma, hysterical, mental sickness, etc.)	107	57.2

* Multiple answers

4.3.3 Barriers to an effective response to victims of DVAW

Approximately 20% (37/187) of the health providers in all relevant departments revealed that they never ask patients when they worked with patients of DVAW. Majority of reasons were time constraints (67.6%), not being trained in how to identify DVAW injuries (67.6%); 64.9% focusing on health problems that are of higher priority. Half of health providers (51.4%) thought that they could not help patients who are DVAW victims (Table 16).

Table 16 The reasons for the failure of health providers to ask patients of DVAW directly

The reasons	Number (n = 37)	Percent (%)
a) Time constraints	25	67.6
b) Think I could not help patients	19	51.4
c) My attention must be focused on other health problems that are of higher priority	24	64.9
d) Not being trained in how to ask to identify reasons of DVAW injuries	25	67.6

4.3.4 Treatment for patients who are victims of DVAW

The result shows that 100% of health providers gave medical treatment to the victim of DVAW, and 86.7% of health providers support patients' spirit. Only 49.5% of health providers gave counseling for patients and 39.4% of them provide information about community support resources to patients (Women's Union, authority, police, counseling center, etc.) (Table 17)

Table 17 Number and percentages of health providers who were capable and responsible to support victims of DVAW

No	Supports for victims of DVAW	Number (n = 188)	Percent (%)
1	Medical treatment only	188	100
2	Spiritual encouragement	163	86.7
3	Counseling for patient	93	49.5
4	Provide patients with information about community support resources (Women's Union, Authority, Police, Counseling centers, etc.)	74	39.4

4.3.5 The total experiences in dealing with DVAW victims of health provider

There are 22 questions about experiences in dealing with DVAW victims of health providers. Total experience score is 22. The average experience score is 7.395

(SD = 6.569), the minimum score is 0, the maximum score is 18. The level of experience classified into two groups as more experience and less experience by using mean as a cut point. The score of respondents with more experience in dealing with DVAW victims is 47.4% (≥ 7.395 score), and less experience is 52.6% (< 7.395 score) toward DVAW (Table 18).

Table 18 Number and percentage of experiences in dealing with DVAW victims of health provider

Level of experiences	Number (n = 380)	Percent (%)
More experiences (≥ 7.395 score)	180	47.4
Less experiences (< 7.395 score)	200	52.6

(mean = 7.395; median = 5.0; SD = 6.569; min = 0; max = 18)

4.4 The perception of health providers toward DVAW

4.4.1 The perception of health providers regarding acceptable behaviors between spouses

Only 46.8% of health providers disagreed that a man should show himself to his wife that he is boss of the family. In contrast, 82.6% of health providers disagree that a good wife should obey her husband even if she did not agree with him and 85% disagree that a wife is obligated to satisfy her husband's sexual desire if she does not want to. The study result shows that health provider's responses following the positive trend but a general still support for the traditional view of the man's role as family leader (Table 19).

Table 19 Number and percentage of health providers regarding acceptable behaviors between spouses within a family

No	Behaviors between spouses within a family	Level of agreement (n = 380)					
		Agree		Uncertain		Disagree	
		(n)	(%)	(n)	(%)	(n)	(%)
1	A man should show himself to his wife that he is boss of the family	139	36.6	63	16.6	178	46.8
2	A good wife should obey her husband even if she disagrees with his thoughts and actions	24	6.3	42	11.1	314	82.6
3	It's is a wife's obligation to have sex with her husband even if she does not like it	17	4.5	37	9.7	326	85.8

It is surprise that 62.1% of health providers thought that a husband can beat his wife when she impertinent/scolds/insults her husband; when she has extramarital relations (52.4%); when she does not complete her household duties (38.4%); when she does not satisfy his sexual demands (18.4%); when she contraries with her husband (17.9%) (Table 20)

Table 20 Number and percentage of health providers regarding acceptable behavior of beating wife

No	A man has a good reason to hit for beating his wife if:	Level of agreement (n = 380)					
		Agree		Uncertain		Disagree	
		(n)	(%)	(n)	(%)	(n)	(%)
1	She does not fulfill her household-work at his expectation (lazy, not take care of children, spend a lot money, etc.)	146	38.4	77	20.1	157	41.3
2	Contrary with her husband	68	17.9	105	27.6	207	54.5
3	Impertinent/ scolds/ insults her husband	236	62.1	35	9.2	109	28.7
4	She refuses to have sex with him	70	18.4	96	25.3	214	56.3
5	Adultery/ extramarital relations	199	52.4	45	11.8	136	35.8

The majority of healthcare providers agreed that a woman has the right to refuse sexual relations with her husband if she is sick (83.4%), the husband gets drunk (83.4%), or treats his wife badly (85.8%). However, only 58.2% of health providers agreed that a wife can refuse simply because she does not want to. (Table 21)

Table 21 Number and percentage of health providers regarding acceptable reasons of refuse sex of a married woman.

No	A married woman can refuse sex with her husband in case that:	Level of agreement (n = 380)					
		Agree		Uncertain		Disagree	
		(n)	(%)	(n)	(%)	(n)	(%)
1	She doesn't want (no reason)	221	58.2	91	23.9	68	17.9

Table 21 Number and percentage of health providers regarding acceptable reasons of refuse sex of a married woman (cont.)

No	A married woman can refuse sex with her husband in case that:	Level of agreement (n = 380)					
		Agree		Uncertain		Disagree	
		(n)	(%)	(n)	(%)	(n)	(%)
2	She is sick	317	83.4	28	7.4	35	9.2
3	He is drunk	317	83.4	22	5.8	41	10.8
4	She is mistreated	326	85.8	10	2.6	44	11.6

4.4.2 The perception of health providers regarding to support victims of DVAW

The study result shows a positive perception of health providers on the important issue of DVAW in public health. Most of health provider (94.5%) thought so. Over 82% of health providers disagree that DVAW is a private matter between partners only. 93.2% of health providers thought that can help victims of DVAW both in medical treatment and counseling. Although medical practices always busy but 76.8% of health providers thought that should spent time to ask women about DVAW within their initial assessment interview/ normal contact times; their profession should be more involved in identifying cases of DVAW (80%). Only 47% of health providers disagree that ask every women (who is relevant to your practice and has been DVAW) they will offend a lot of your patients. It shows that they were not confident to ask their patients directly about DV (Table 22).

Table 22 Number and percentage of health providers considered being responsible to help victims of DVAW.

No	Health providers have responsible to help victims of DVAW.	Level of agreement (n = 380)					
		Agree		Uncertain		Disagree	
		(n)	(%)	(n)	(%)	(n)	(%)
1	DVAW is an important health care issue in public health?	359	94.5	13	3.4	8	2.1
2	DVAW is a private matter between partners only	38	10.0	29	7.6	313	82.4
3	Health providers can help victims of DVAW both in medical treatment and counseling	354	93.2	21	5.5	5	1.3
4	Health providers should spent time to ask women about DVAW within their initial assessment interview/ normal contact times	292	76.8	52	13.7	36	9.5
5	If ask patients related to DVAW health provider will offend a lot of their patients	73	19.2	127	33.4	180	47.4
6	Profession should be more involved in identifying cases of DVAW	304	80.0	49	12.9	27	7.1

The majority of the health providers respond that should have guidelines for working with DVAW victims (92.9%); should display poster or leaflets about DVAW in health care establishments (83.9%); and it is necessary to have a specific protocol for health providers working with victims of DVAW (75%). The percentage of health providers thought that recognizing DVAW will make any difference to the long term

health of a victim is 73.2% and over 96% health providers agreed that the training on DVAW will help improve awareness and knowledge of them toward DVAW (Table 23).

Table 23 Number and percentage of health providers considered with bellowing statements

No	Statements	Level of agreement (n = 380)					
		Agree		Uncertain		Disagree	
		(n)	(%)	(n)	(%)	(n)	(%)
1	Should have guidelines for working with DVAW victims	353	92.9	14	3.7	13	3.4
2	Health care establishments should display poster or leaflets about DVAW	319	83.9	45	11.8	16	4.2
3	It is necessary to have a specific protocol for health providers working with victims of DVAW	285	75.0	57	15.0	38	10.0
4	Recognizing DVAW will make any difference to the long term health of a victim	73	19.2	29	7.6	278	73.2
5	Health providers would improve awareness and knowledge by training on DVAW	365	96.1	10	2.6	5	1.3

4.4.3 Evaluation of perception toward DVAW of health providers

As explained in chapter 3, methodology chapter, a perception is now comprise of positive and negative. There are 14 main questions include 23 statements to measure the perception of respondents with 3 level for choosing of responses that were agree, uncertain, and disagree. There are two kinds of statements, positive and negative statements. The question 3, 4, 6, 7, 9, 10, 11, 12, and 14 are positive statements and the rest are negative statements. The score of the positive answer can be scored as '2' for agree, '1' for disagree, and '0' for uncertain. For the negative answer can be score as '2' for agree, '1' for disagree, and '0' for uncertain, which is the opposite way with the positive answer. Overall perception score is 46. The average perception score is 36.5 (SD = 5.9), the minimum score is 11, the maximum score is 46. The level of perception divided into 2 groups as positive perception and negative perception by using mean as the cut point. The score of respondent had positive perception 55.5% (≥ 36.5 score) and negative perception 44.5% (< 36.5 score) toward DVAW (Table 24).

Table 24 Number and percentage of perception level of health providers toward DVAW

Level of perception	Number (n = 380)	Percent (%)
Positive perception (≥ 36.5 score)	211	55.5
Negative perception (< 36.5 score)	169	44.5
(mean = 36.5 ; median = 37.0; SD = 5.9 ; min = 11; max = 46)		

Part 2 Factors associating with perception of health providers toward DVAW

4.5 Association of socio-demographic characteristic factors with perception of health providers toward DVAW

Table 25 shows the association between socio-demographic characteristic factors with perception of health providers toward DVAW. There is no significant

association between some socio-demographic characteristic factors (age, education level, married status, and working years) ($p > 0.05$).

Table 25 Association of socio-demographic characteristic factors with perception of health providers toward DVAW

Socio-demographic factors	Total n=380	Positive perception n=211 (%)	Negative perception n=169 (%)	χ^2	df	p-value
Age group				0.40	3	> 0.05
Under 30 years old	80	45 (56.3)	35 (43.7)			
30 - 39 years old	72	41 (56.9)	31 (43.1)			
40 - 49 years old	187	101 (54.0)	86 (46.0)			
Over 49 years old	41	24 (58.5)	17 (41.5)			
(mean = 39.024; median = 41; SD = 9.077; min = 18; max = 58)						
Education level				5.08	2	> 0.05
Elementary degree	19	12 (63.2)	7 (36.8)			
Secondary degree	229	136 (59.4)	93 (40.6)			
Graduate profession/ post-graduate	132	63 (47.7)	69 (52.3)			
Married status				3.21	2	> 0.05
Single	59	33 (55.9)	26 (44.1)			
Married	310	169 (54.5)	141 (45.5)			
Separation	11	9 (81.8)	2 (18.2)			
Working years				1.04	3	> 0.05
≤ 5 years	88	48 (54.6)	40 (45.4)			
6 - 15 years	59	32 (54.2)	27 (45.8)			
16 - 25 years	190	104 (54.7)	86 (45.3)			
> 25 years	43	27 (62.8)	16 (37.2)			
(mean = 15.697; median = 19.5; SD = 8.866; min = 1; max = 30)						

4.5.1 Association of gender and perception of health providers toward DVAW

Table 26 shows association between gender and perception of health providers toward DVAW. This association is significantly found at p -value = 0.042. The percentage of positive perception of female health providers (58.3%) is higher than male health providers (45.9%).

Table 26 Association of gender and perception of health providers toward DVAW

Gender	Total n=380	Positive perception n=211 (%)	Negative perception n=169 (%)	χ^2	df	p-value
Male	85 (22.4)	39 (45.9)	46 (54.1)	4.12	1	0.042*
Female	295 (77.6)	172 (58.3)	123 (41.7)			

Note: * Significant at p -value < 0.05

4.5.2 Association of professional role and perception of health providers toward DVAW

The groups that have high percentages of positive perception are midwife (62.5%) and nurse groups (61.6%). The group that has lowest percentage of positive perception is doctor group who is high professional level. This association is significantly found at p -value < 0.05 (Table 27).

Table 27 Association of professional role and perception of health providers toward DVAW

No	Professional role	Total n=380	Positive perception n=211 (%)	Negative perception n=169 (%)	χ^2	p- value
1	Doctor	131	60 (45.8)	71 (54.2)	9.56	0.023*
2	Assistant doctor	14	6 (42.9)	8 (57.1)		
3	Nurse	219	135 (61.6)	84 (38.4)		
4	Midwife	16	10 (62.5)	6 (37.5)		

Note: * Significant at p -value < 0.05

Base on the result by using Multiple Logistic Regression model, after adjusting other factors, nurse tends to has positive perception toward DVAW higher than doctor 12.14 times. This association is significantly found at p-value < 0.05 (Table 34).

4.5.3 Association of working department and perception of health providers toward DVAW

Table 28 shows the association between working department and perception of health providers toward DVAW. It found that working department factor is significantly associated with perception of health providers toward DVAW (p-value < 0.001). The highest percentage of positive perception of health providers have worked at general surgery (81.4%) and the lowest percentage of health providers have worked at examination rooms (37.5%).

Table 28 Association of working department and perception of health providers toward DVAW

No	Working department	Total n=380	Positive perception n=211 (%)	Negative perception n=169 (%)	χ^2	p-value
1	Examination rooms	72	27 (37.5)	45 (62.5)	29.63	<0.001*
2	Emergency	64	39 (60.9)	25 (39.1)		
3	OB/GYN	28	13 (46.4)	15 (53.6)		
4	General surgery	59	48 (81.4)	11 (18.6)		
5	General internal	100	49 (49.0)	51 (51.0)		
6	Other	57	35 (61.4)	22 (38.6)		

Note: * Significant at p-value < 0.05

4.5.4 Association of knowledge and perception of health providers toward DVAW

It is clearly when we see the bellowing study results. There is relationship between knowledge factor and perception of health providers toward DVAW. This

association is strong significantly found at $p < 0.001$. In other word, the percentage of health providers with good knowledge and those with positive perception toward DVAW (68.8%) higher than health providers with poor or fair knowledge (Table 29).

Base on the result by using multiple logistic regressions, after adjusting other factors, health providers with good knowledge and those tends to positive perception toward DVAW higher than health providers with poor knowledge 4.5 times. This association is significantly found at $p = 0.001$. (Table 34).

Table 29 Association of knowledge and perception of health providers toward DVAW

No	Knowledge level	Total n=380	Positive perception n=211 (%)	Negative perception n=169 (%)	χ^2	p-value
1	Good knowledge* (≥ 35 score)	80	55 (68.8)	25 (31.2)	20.52	< 0.001*
2	Fair knowledge (29 – 34 score)	246	140 (56.9)	106 (43.1)		
3	Poor knowledge (≤ 28 score)	54	16 (29.6)	38 (70.4)		

Note: * Significant at p -value < 0.05

4.5.5 Association of experiences in dealing with DVAW victims and perception of health providers toward DVAW.

Table 30 shows the association between experiences in dealing with DVAW victims and perception toward DVAW of health providers. It found that experiences dealing with DVAW victims factor of health providers is significantly associated with perception of health providers toward DVAW ($p = 0.038 < 0.05$). In other word, the percentage of health providers with good experience (61.1%) and those with positive perception toward DVAW higher than health providers with poor experience (50.5%).

Table 30 Association of experiences in dealing with victims and perception of health providers toward DVAW.

Experience level	People n=380 (%)	Positive perception n=211 (%)	Negative perception n=169 (%)	χ^2	df	p- value
More experiences (≥ 7.395 score)	180 (47.4)	110 (61.1)	70 (38.9)	4.32	1	0.038*
Less experiences (< 7.395 score)	200 (52.6)	101 (50.5)	99 (49.5)			

Note: * Significant at p -value < 0.05

4.6 Suggestion and recommendation of health providers on improving health care for victims of DVAW

4.6.1 Sufficient of healthcare facilities to dealing with victims of DVAW

The percentage of health providers thought that healthcare facilities have not sufficient to assist victims of DVAW is 45%. Among them, the reasons provided were lack of collaboration between health facilities with relevant local agencies to help victims of DVAW (92.4%); lack of specific medical protocol on examination of victims of DVAW in health facilities (83.6%); limited awareness and knowledge on DVAW among health managers and health providers (70.8%), inadequate finances (78.95%), and lack of skills to approach and counsel victims among health providers (70.8%) (Table 31).

Table 31 Reasons of health provides did not think that there are sufficient resources in health care facilities to assist patients who are victims of DVAW

No	Statements	Number (n)	Percent (%)
1	There are sufficient resources in healthcare facilities to assist victims of DVAW	380	

Table 31 Reasons of health provides did not think that there are sufficient resources in health care facilities to assist patients who are victims of DVAW (cont.)

No	Statements	Number (n)	Percent (%)
	a) Sufficient resources	209	55.0
	b) Insufficient resources	171	45.0
2	Reasons for insufficient resources *	171	
	a) Lack of awareness and knowledge on DVAW among health managers and health providers	138	80.7
	b) Lack of skills to approach and counsel victims among health providers	121	70.8
	c) Lack of specific medical protocol on examination of victims of DVAW in health facilities	143	83.6
	d) Lack of collaboration between health facilities with relevant local agencies to help victims of DVAW	158	92.4
	e) Lack of budget	135	79.0

4.6.2 Training on DVAW

Over 80% of health providers want more training on this matter. Their greatest concern is the lack of counseling skills (91.6%), and issues relating to laws and information on DVAW (90.3%) (Table 32).

Table 32 Topics which health providers wanted to be trained about DVAW

Topic wanted to be trained about DVAW *	Number (n = 380)	Percent (%)
a) Screening/ identify DVAW female victims?	307	80.8
b) How to help DVAW victims (validating, providing information, safety planning, etc.)	316	83.2
c) Health consequences (physical, spirit, reproductive, etc.)	308	81.1

Table 32 Topics which health providers wanted to be trained about DVAW (cont.)

Topic wanted to be trained about DVAW *	Number (n = 380)	Percent (%)
d) Counseling skills to patients	348	91.6
e) Law relating to DVAW	343	90.3

* *Multiple answers*

4.6.3 Suggestions of health providers to improve the health care response to DVAW

Most responses of health providers included there is a specific medical protocol on examination of victims of DVAW in health facilities (93.4%), a plan for educating staff about DVAW identification, treatment, and documentation (90%), a list of private and public community agencies that provide help for abuse victims (87.9%), counseling room for DVAW victims in hospital (82.9%) (Table 33).

Table 33 The suggestion of health providers to improve the health care response to DVAW

Statements *	Number (n = 380)	Percent (%)
a) There is a specific medical protocol on examination of victims of DVAW in health facilities.	355	93.4
b) A plan for educating staff about DVAW identification, treatment, and documentation.	342	90.0
c) A list of private and public community agencies that provide help for abuse victims.	334	87.9
d) There is counseling room for DVAW victims in hospital	315	82.9

* *Multiple answers*

4.6.4 Other suggestions of health providers.

Medical branch

The great suggestions concern of most health providers are the need training course on DVAW, the specific medical protocol, the assistant fund for DVAW victims, and the counseling room in health facilities.

“Health manager need to organize training courses for health providers how to identify DVAW female victims, counseling skills to patients, law relating to DVAW, real situation of DVAW in our city, our country. There are reference document about DVAW.” (Female nurse, 42 years of age, OB/GYN department).

“The hospital should have an assistant fund for DVAW victims; especially female victims are very poor. Many cases can not pay hospital fees because they did not be paid by health insurance company, by their husband, difficult economy, undermine the morale” (Female nurse, 47 years of age, Emergency department).

“The health facilities should has a specific medical protocol on treatment of DVAW victims” (Female doctor, 51 years of age, Gastro Entorology department)

“It is best if the hospital has a counseling room and consultants with good knowledge on DVAW. Because of the pressures and medical profession treatment time consuming the health providers have no time to confide or consult for DVAW victims. We only can introduce that patient to counseling room. There are other patients waiting for us”. (Male doctor, 49 years of age, Emergency department)

Promoting IEC work among all people in order to raise awareness on DVAW

The majority of health providers mentioned that awareness and an understanding of DVAW by IEC in community.

“IEC work should be strengthened by all branches and organizations including medical branch. Secondly, there should be not only meetings and

seminars on specific topics, but also DVAW topics more. This will provide health providers with the knowledge of DVAW so that they can increase awareness and share experience on working with DVAW victims". (Male doctor, Internal department).

IEC activities can be integrated into commune's meetings and discussions, which involve not only women's participation, but men's participation too.

"The dissemination of DVAW information, DVAW consequences, legal information amongst all population groups should be promoted, particularly among young couples, in order to provide them with more knowledge on family and society. It is necessary for people to know that domestic violence should be prevented within the family to avoid disintegration" (Female doctor, Surgery department).

"Men should be involved in IEC work so that they can respect women, love their wives and children, and protect family happiness" (Male doctor, Traditional department).

IEC on laws is also emphasized to improve the knowledge of laws relating to the protection of the rights of women and children.

"Disseminating of the government's legal documents relating DVAW, especially the protection of the rights of women and children" (a female nurse, Examination rooms).

Collaboration among local organizations and branches

The great suggestions concern of most health providers is the need for effective community collaboration to help female victims to trust in the system. Close collaboration among local organizations and branches is necessary in the prevention of violence against women.

"The medical establishment mainly disease treatment, resolve the consequence. The thorough settlement needs to close collaboration among local organizations and branches. Depending on the case, we ask the Youth or Women's Unions to get involved. Some cases are referred to the police and justice. The commune justice has its preventative officers in many

organizations and authorities. This is stipulated by law” (Female doctor, 52 years of age, Internal department).

“Good conciliation needs to have the positive participation of many organizations such as Youth or Women’s Unions, and Conciliation groups. The leader has policies, strategies aim to improve strengthen on IEC in community about DVAW” (Female nurse, 34 years of age, Physical therapy-Rehabilitation department).

“ Before wedding, couple must take part in short training course about family knowledge, responsibilities of the husband, the wife, treatment in together with the of families, relatives, surround neighbors, and community” (Female doctor, 49 years of age, OB/GYN department).

Other recommendations

Other recommendations include strengthening counseling services at a local level; IEC activities on laws; strengthening the efficacy of laws by the strict punishment of violations; and more specific degrees and forms of punishment.

“Legal regulations on punishment of violence against women and children should be created immediately. Until now, have been no guidelines for implementation” (Female doctor, 46 years of age, Genito Urinary department)

CHAPTER 5

DISCUSSION

The purpose of this study was to detect the perception of health providers toward domestic violence against women according to the study at the Thanh Nhan general hospital, Hai Ba Trung district, Hanoi city, Vietnam.

The discussion of this study is presented into 5 parts as follows:

Part 1 Discussion on the perception of health providers toward DVAW

Part 2 Discussion on the association between socio-demographic characteristics and perception of health providers toward DVAW

Part 3 Discussion on the association between knowledge and perception of health providers toward DVAW

Part 4 Discussion on the association between experiences in dealing with patients of DVAW and perception of health providers toward DVAW

Part 5 Suggestions and recommendation of health providers

5.1 Discussion on the perception of health providers toward DVAW

5.1.1 Spousal relationships

Since domestic violence against women is a very sensitive topic in spousal relationships, several examples on spousal relations should be referred to before discussing behaviors relating to abuse of women. The finding of this study that health providers had positive trend in general but some of them still support the traditional view of the man's role as family leader. Only 46.8% of health providers disagreed that a man should show himself to his wife that he is boss of the family. In contrast, 82.6% of health providers disagreed that a good wife should obey her husband even if she did not agree with him and 85.8% disagree that a wife is obligated to satisfy her husband's sexual desire if she does not want to (Table 19). In the study of Le T. Phuong Mai, a male health provider mentioned the effects of traditional gender s

tereotypes that “respect men and despise women”, and consider male patriarchy and arbitrariness to be the root of DV.

“In rural areas, the concept of respecting men and despising women still exists. Most of the men with violent behaviors are often the family’s bread-winner and control the family in all aspects.” (Male health provider aged 52) (6).

Can a man beat his wife?

It is surprised that 62.1% of health providers thought that a husband can beat his wife when she impertinent, scolds, insults her husband: Over half of health providers thought that a husband can beat his wife when she has extramarital relations (52.4%); when she does not complete her household duties (38.4%); when she does not satisfy his sexual demands (18.4%); when her contraries with her husband (17.9%) (Table 20). Every people should fully understand a woman’s right to be free of any kind of abuse. All actions of women maltreatment in any cases are considered as violating human being, but some people still have been accepted in current society. The study result of Nguyen T. Hoai Duc realized there is an acceptance of beating the wife of health providers in both urban and rural areas. A male health provider in rural area said:

“I think the man has no mistake when he beats his wife. Certainly they aren’t also glad when doing that matter. The wife can’t walk by beaten. They must do everything instead of the wife must do that one” (53)

Beating wife is a way to teach them in order to keep family order and discipline.

“Right, many wives are much behaved. Say to them that means not is useless. Beating is an effective way”. (53)

Can a married woman refuse sex with her husband?

In this study, the result shows that the majority of health providers agreed that a woman has the right to refuse sexual relations with her husband if she is sick, the husband gets drunk, or treats his wife badly. However, only 58.2% of health providers

agreed that a wife can refuse simply because she does not want to. So, the main role of the man is always accepted and this traditional concept often exists in consciousness of the people. It might be said that the limits in knowledge on sex of the health provider. The study of Nguyen T. Hoai Duc also realized health providers in Hanoi and HoChiMinh cities and rural areas, they have the same concept.

A female health provider said: *“There was a woman who told with me that her husband had sexual demand too much but she didn’t respond him. This is a reason that she was beaten. I think her husband was right. I don’t know what matters were occurred in foreign countries, but in Vietnam, the women must be accepting if they want to protect their families”* (53).

This shows that perception of some health providers also agree and support to concept that a man is the head of the family.

The perception of health providers regarding to support victims of DVAW

Most of health providers agreed that DVAW was an important issue of in public health (94.5%). This 93.2% of health providers thought that can help victims of DVAW both in medical treatment and counseling. Although medical practices always busy but 76.8% of health providers thought that should spend time to ask women about DVAW within their initial assessment interview, normal contact times; their profession should be more involved in identifying cases of DVAW (80%). But only 47.4% of health providers disagree that ask female patients related to DVAW they will offend a lot of their patients (Table 22). This might be feeling uncomfortable or they were not confident to ask their patients directly about DV.

The majority of the health providers agreed that it is useful and necessary of guidelines for working with DVAW victims, posters or leaflets about DVAW; a specific protocol in health care establishments; and training course on DVAW for health staff.

As result showed and explained in chapter 4, the level of perception divided into 2 groups as positive perception and negative perception toward DVAW. Health providers had positive perception toward DVAW were 55.5% and negative perception were 44.5% (Table 24).

5.2 Discussion on the association between socio-demographic characteristics and perception of health providers toward DVAW

5.2.1 Age

The study conscripts were in the age range of health providers was 18 to 58 years old, mean age was 39 years. The result showed that there was not much variation in perception among age groups regarding these issues. No significant differences of perception were found between age groups ($p > 0.05$), but older health providers tended to have positive perception and better knowledge: 58.5% of health providers of the oldest group (over 49 years old) had positive perception (Table 25) and 36.6% of them had good knowledge on DVAW (Table 35). Furthermore, the oldest group tended to have more experience (65.9%) than other respondent groups, although there is no significant ($p > 0.05$) (Table 37). DVAW may be regarded as a social problem in which the older health providers might be having more experience. The findings from this study are the need for health providers of this hospital to improve knowledge and perception on DVAW, especially younger people who have less experience in their life.

5.2.2 Gender

There is significant association between gender and perception of health providers toward DVAW ($p < 0.05$). It is surprise that male health providers had significantly less positive perception (Table 26) although more knowledge toward DVAW than female health providers (Table 35). The above result shows that although male health providers had knowledge on DVAW but they still support for the traditional view of the man's role as family leader, "value men above women" "male superiority".

5.2.3 Professional role

This study found that professional role was independently associated with perception score ($p < 0.05$). Nurses had more positive perception than other respondents, even doctors. This result similar finding has been reported in previous study of Oxford, UK (56). Based on the result by using multiple logistic regressions, after adjusting other factors, nurses tend to have positive perception toward DVAW higher than doctors around 12 times. This association is significantly found at p -value < 0.05 (Appendix 1). This might be that doctors who have higher specialist knowledge level than nurses, but DVAW is regarded as a social problem in which the doctor may be powerless to intervene or may be very time limited. The doctor has higher responsibility, pressures and time constraints of medical practices than the nurse. Moreover, the nurse and midwife have more time to contact with people than the doctor.

5.2.4 Working department

There is significant association between working department with perception of health providers toward DVAW (p -value < 0.001). It is similar with study result of Oxford, UK. But the proportions of positive perception between working departments of this study were different with the study of Oxford, UK (56). Health providers of surgery and emergency departments had significantly better knowledge (p -value < 0.001) and more positive perception toward DVAW than other departments (Table 28). Because surgery and emergency departments usually have been received patients with serious health problems and health providers of there more experience in dealing with DVAW than other departments (Table 36). The lowest percentage of positive perception of health providers have worked at examination rooms (37.5%). A reason for health providers had worked at examination rooms included specialist rooms might be their heavy workload with crowded patients every day, the spent time for each patient is limited.

There is no significant association between education levels, married status, working years with perception of health providers toward DVAW ($p > 0.05$).

5.3 Knowledge of health providers toward DVAW

5.3.1 Understanding of health providers about DVAW

Understanding DVAW behavior to women as well as the gender equality is very important especially to health providers, those who take care of people's health, and can see the important role and problems affected on health. Moreover, the health provider, are also the first people or sometimes are the unique specialists to have opportunities to communicate with patients of DVAW.

The result of the study found that almost health provider have knowledge of DVAW behavior, over 96% of health providers fully understand that physical abuse acts are DVAW behaviors. Lower rates were 95.0%; 94.7%; and 93.2% of health providers fully understand that spiritual, sexual abuse behaviors. The percentage favoring these views among females is always higher than that of males (Table 4). It shows that the physical abuse acts was identified more easily than others. The spiritual and sexual injuries or hurt caused by DVAW behaviors often have affects in a long term so some health providers considered them as not the DVAW behaviors.

In the study of Le T. Phuong Mai, these results indicate that health providers mention other forms of DV, not only physical but also mental and sexual violence, and its prevalence in examination and treatment of patients at the hospital:

“Scolding a wife is an abuse; patriarchal behavior is also an abuse; having three or four wives is an abuse too; having no respect for a wife is an abuse” (female healthcare provider, age 46).

“I often see patients suffering from mental abuse. There was a case of a woman who already had two daughters but was forced to have a son, she was not healthy and her family was poor so she did not want to have another child. Her husband could not persuade her then emotionally persecuted her.” (Female health provider aged 40) (6)

5.3.2 Assessment of severity

There problem were also revealed through the health provider's assessment on differently serious degrees of DVAW behaviors. For the physical abuse, 97.1% of health providers though that assault a woman was serious. But for the spiritual abuse 90 and 96.6% of health providers though that its were serious behaviors; especially for the sexual abuse such as forcing to have sex they might be though this subject may be private and delicate so near 22% of health providers didn't appraise it seriously (Table 5). The percentage favoring these views among males is always higher than that of females. The above results are similar with the study of Le T. Phuong Mai (Population Council, Vietnam) (6). We can say that the health provider's knowledge about DVAW is not fully. Because under the United Nations Declaration on the Elimination of Violence against Women (1993) (37) defines DVAW is all behaviors hurt women's body, their spirit and their sexual are DVAW behaviors although degree of injury are different and are difficult to identify. Some cases the spiritual injuries are more serious than physical injuries. Due to the daily life, many people often understand that the DVAW means behaviors related to the using the force to hurt or over permission, they don't think that these behaviors causing spiritual hurt are the violence. Moreover, the concept "violence" has been unknown by many people.

5.3.3 Reasons for DVAW

There are many factors leading to DVAW behaviors. This study found that most of health providers though that social evils, effect of the traditional ideology of gender inequality, adultery, contradiction in family are also these important factors leading to the DVAW. The higher reasons were social evils (98.7%), and adultery (95%) (Table 6). These social evils such as drinking, gambling are explained for the beating, the insult to the wife without a reason when the husband are drunk or are in deeply engrossed in gamble, he is easy to lose his control and dealt with the contradiction by violent behavior. It's a reason for why in fact many husbands beat their wives very seriously.

According to study result of Le T. Phuong Mai, 61.5% of health provider though that cause by social evils, 65.1% by adultery, and only 24.4% by effect of the

traditional ideology of gender inequality (6). But this study result shows that the most of health providers (94.7%) of the Thanh Nhan hospital understood feudal conception, sexual role is the origin of domestic violence against to the women. The nature of DVAW in which the conception “attaching much importance to the man, thinking little of the role of the women” or a unequally assignation role of the sex, the assignation is not out of patriarchal ideology bringing to the man much more power than the women, is the major cause. The health providers have understood of gender inequality and the impact of the traditional social standards that pressure women to sacrifice, submit and remain silent lead to GDVAW and its acceptance. These reasons put women at the risk of DV.

There are 87.1% of health providers though that cause of DVAW by family economic difficulties (Table 6). Because the business in market economy although has many occasions, but there are also changes, when having contradictions or not he convenient to do business, it may lead to contradict in the life, in bringing up their children, and reaction of man also leads to violent action. Besides the economic problems, social evils, there are many other factors such as low level of education, a lack of knowledge of law or deep discrimination between female sex and male sex and even the victims hasn't realized.

5.3.4 Consequences of DVAW on a woman

Knowledge about consequences of DVAW behaviors to be persons to care for people health, the health provider is person most fully understand on consequence of DVAW action to women's health (97.9%) (Table 7). This may be interpreted that health providers not only pay attention to health-related consequences but also other social effects. In group-interviews in the study of Le T. Phuong Mai, these points are mentioned in:

“The abuse of women firstly affects women's health physically and mentally. It also affects children and childbearing, economic conditions and leads to family disintegration” (Male healthcare provider, age 45).

“Children may be addicted or influenced by other social evils. If it were a good family, children would be well brought up. In generally, exist many problems” (Female healthcare provider, age 45) (6).

5.3.5 How to identify the victims of DVAW?

The result shows that most of health providers though that directly ask patients (91.1%), 90% patient's family member (s) speak out, 83.4% patients speak out, and only 68.4% by the nature of the injuries (Table 8). Similar findings have been reported in the study of Le T. Phuong Mai that it was better to in identify DVAW victims by ask patients more than by the nature of the injuries only (6). But the findings have been reported of Oxford, UK that most healthcare workers do not agree with ‘direct’ questioning of large, non-specie groups of patients (56). It might be the difference characteristic easier sharing with each other between Asian and European.

5.3.6 Knowledge of organizations, associations to support victims

The majority of health providers knew on the role of organizations, associations to support female victims are DVAW. Over 97% of health providers who knew the Women’s Union is an organization may help for DVAW victims (Table 9). This may be seen because the function and operation position of the association, being an organization of women, and near with the people, so the association has many conditions for help victims. However, in order to resolve this situation, it needs to have the collaboration of organizations, union and to be the responsibility of each people.

5.3.7 Knowledge of laws relating to DVAW

In order for healthcare providers to assist victims with more than basic medical care, they must have an understanding of the law. The study result show that 96.1% report they know legal regulations relating to DVAW, such as the punishment for intentionally inflicting injury or causing harm to the health of other people. 94.7% of participants know that emotional abuses are illegal. Almost 92% know bigamy is illegal (Table 10). It is clear that acts of physical violence are easily recognized and seen as unacceptable. This is well stated in legal documents, which are commonly

known, but in cases of mental abuse, it is more difficult to prove. Therefore, there was the gap between existing legislation and its implementation.

Regarding estimation of health providers on DVAW situation over the past 5 years, 61.8 % of them thought that number of DVAW cases increased (Table 10). It shows that the health provider had awarded DVAW occurs among current social, and their patients. There are an increase of the number of cases because nowadays, the changes in the living makes traditional values like conjugal affects of magazines, newspaper, books, films, social evils make the nature of people changed. This problem is a delicate issue, the women normally don't want to reveal so the estimation of DVAW number statistics on this situation is incorrect. This stems from participants' experience in dealing with DVAW, but also depends on their interest of gender-related perspectives, the development of mass media.

5.3.8 Role of health providers to help victims of DVAW

Most of health providers knew the role of health providers should help victims of DVAW in healthcare facilities (over 90%) (Table 11). Besides medical care, the most common support mentioned is to encourage a patients' spirit, provide information about community support resources, and refer patients to counseling. The above result shows that most of health providers have willingness to help victims of DVAW not only treatment physical injuries but also assisting on spirit for patients, in addition, the other support on economy or introduction to assistant address may help them, counseling, etc. It is useful for victims of DVAW. Beside, it is necessary there is an official support system exists in the community.

5.3.9 Association between knowledge and perception of health providers toward DVAW

The score of respondent had good knowledge toward DVAW only was 21.1%, fair knowledge was 64.7%, and poor knowledge was 14.2% (Table 12). There is association between knowledge factor and perception of health providers toward DVAW ($p < 0.001$). It shows that the percentage of health providers with good knowledge and those with positive perception toward DVAW higher than health

providers with poor or fair knowledge. It is clear that the health providers need to have a proper knowledge of DVAW in order to be able to understand how the abuser treats the abused woman and the consequences that violence has on women's life and health. Consequently, the provision of training about DVAW is a first step toward a change in health care practice and it might be contribute to change their perception on this issue.

5.4 Experiences of health provider in dealing with DVAW victims

5.4.1 Screening patients

One of “the most important contribution physicians can make to ending abuse and protecting the health of its victims is to identify and acknowledge the abuse” (8). Traditionally, healthcare providers are trained to obtain information from patients through asking their medical history, undertaking an examination and then giving a specific diagnosis. Although this familiar doctor-patient relationship can produce a quick diagnosis and an appropriate prescription, it may not allow for the detection and assessment of victims of abuse.

Health providers are in a unique position to identify, gauge and provide treatment for gender based violence. Health providers have opportunities to heal with comforting words and a friendly attitude. Research in other studies show that trauma injuries can partially be cured with health providers questioning and treatment of DVAW with careful attention and understanding. This study shows that 67.9% of health providers contacted with patients who are victims of DVAW (Table 13). So like some other social organizations, the health establishment is place, where the DVAW women need to find the assistance and health providers who are persons having many occasions to help DVAW victims.

And 80.2% report having asked patients directly if they have experienced some kind of violence. However, in fact, this way of asking is unusual, and often aims simply to identify the reasons for the violence. It is understandable that identifying patients as victims of violence is not a mandate of healthcare providers. Among them, health providers of surgery department (21.7%), internal department

(21.2%), examination rooms (20.2%), and emergency department (17.6%) often are the first place that maltreated victim comes to treat wound and almost health providers in that departments have more occasions to contact with DVAW victims. The OB/GYN is department with lowest ratio. It shows that health providers in the obstetric department, who either rarely or never ask questions relating to DVAW in routine visits or pregnancy examinations. So, many opportunities are missed for identifying DVAW victims (Table 36).

5.4.2 Forms of abuse that health providers faced

The most common injuries are soft tissue injuries, broken bones, and injuries in vulnerable areas. Very low percentage of health providers knew about patients had mental injuries like nervousness. This reveals that when a victim visits a hospital, discussions center almost on the physical injuries. When a health provider believes a patient is suffering from mental abuse, they have few tools available to them with which to help the patient, other than verbal discussion.

5.4.3 Barriers to an effective response to victims of DVAW

Approximately 20% (37/187) of the health providers in all relevant departments revealed that they never ask patients when they worked with patients of DVAW. Majority of reasons were time constraints (67.6%) (Table 16). While the pressures and time constraints of medical practice may pose serious conflicts in providing quality care (especially in emergency, surgery, and examination rooms), early intervention ultimately takes far less time than addressing the repeated and long-term consequences of unrecognized abuse. There is 67.6% of health providers responded that they did not know how to ask to identify reasons of DVAW injuries. And 64.9% of focusing on health problems that was higher priority. Half of health providers (51.4%) thought that they could not help patients who are DVAW victims (Table 16). They may be uncomfortable asking about DVAW because they view partner abuse as a private and sensitive matter. DVAW may be regarded as a social problem in which the health provider is powerless to intervene or which may be very time constraints. They might be fear of opening potentially troubling issues. The lack of basic knowledge about DVAW demonstrated here must also contribute to under-

detection. However, as mentioned above, 80.2% report having asked patients directly if they have experienced some kind of violence (Table 13). It suggests that screening questions might be acceptable to health providers in more defined circumstances.

Beside, there are also health providers who never meet DVAW victim. It might be due to victim only goes to hospital when they has serious injuries or they concept violence behaviors cause trauma which means DVAW, therefore, other injures on spirit, psychologies don't be interested. It is difficult to identify cases with injured on spirit as nervous strain, stress, depression, hysterical, mental sickness, etc. Furthermore, DVAW may be missed when a woman is reluctant to raise the issue if she is not asked. She may provide an alternate explanation for her injuries or symptoms because she fears retribution of she discusses the abuse. She may be embarrassed to talk about the violence. She may fear that the health provider is too busy to care about her situation.

5.4.4 Treatment for patients who are victims of DVAW

The result shows that 100% of health providers gave medical treatment to the victim of DVAW, and 86.7% of health providers support patients' spirit. Only 49.7% of health providers gave counseling for patients and 39.4% of them provide information about community support resources to patients (Women's Union, authority, police, counseling center, etc.) (Table 17). Therefore, other than medical treatment, many providers do not know of other possible interventions such as the understanding of patients' safety, encouragement of spiritual values and the provision of information on violence issues. Historically, documentation of cases of violence has not been required.

5.4.5 Association between experiences in dealing with DVAW victims and perception of health providers toward DVAW

The result of this study revealed that the score of respondents with more experience in dealing with DVAW victims is 47.4%, and less experience is 52.6% (Table 18). It found that factor of experiences dealing with DVAW victims of health providers is significantly associated with perception of health providers toward DVAW (p -value < 0.05). In other word, the percentage of health providers with good experience (61.1%) and those with positive perception toward DVAW higher than health providers with poor experience (50.5). One of main reasons for the failure of health providers to identify DVAW victims that is lack of knowledge on DVAW. 66.7% (36/54) of health providers with poor knowledge have less experience; 67.5% (54/80) of health providers with good knowledge have more experience (Table 38). The lack of knowledge and less experience in dealing with DVAW victims, health providers have tended to negative perception toward DVAW (68.4%) and health providers with good knowledge and more experience have tended to positive perception toward DVAW (74.6%) (Table 40). This shows that it is necessary to train on DVAW for health providers to provide knowledge, apply it in their practices and improve their perception toward DVAW too.

Overall, 80% of health providers would personally welcome training on this matter. Their greatest concern is the lack of counseling skills (91.6%), and issues relating to laws and information on DVAW (90.3%) (Table 32).

5.5 Suggestion and recommendation of health providers

Most of health providers suggested that there should be a specific medical protocol on examination of victims of DVAW in health facilities, a plan for educating staff about DVAW identification, treatment, and documentation, a list of private and public community agencies that provide help for abuse victims, and counseling room for DVAW victims in hospital.

The great suggestions concern of most health providers are the need training course on DVAW, the assistant fund for DVAW victims, and the counseling room in health facilities.

Some health providers mentioned that IEC activities can be integrated into commune's meetings and discussions, which involves not only women's participation, but men's participation too. And IEC on laws is also emphasized to improve the knowledge of laws relating to the protection of the rights of women and children.

The majority suggestions concern of most health providers is the need for effective community collaboration to help female victims to trust in the system. Close collaboration among local organizations and branches is necessary in the prevention of violence against women.

Other recommendations include strengthening counseling services at a local level; IEC activities on laws; strengthening the efficacy of laws by the strict punishment of violations; and more specific degrees and forms of punishment.

CHAPTER 6

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

This was a descriptive cross-sectional study aimed at detecting perception of health providers toward DVAW in the Thanh Nhan general hospital, Hai Ba Trung district, Hanoi city, Vietnam. The pre-test of the questionnaire was conducted with 30 health providers of the Dong Anh general hospital, Dong Anh district, Hanoi city, Vietnam. The data were collected among 380 health providers of clinical departments which are contact with patients of DVAW directly of Thanh Nhan general hospital: Examination Rooms (consist of internal, surgery, and special clinics); Emergency unit; Obstetrics and Gynecology unit (OB/GYN); General Internal unit (include Internal, Cardiology, Mental, Gastro Entorology, Genito Urinary); General Surgery unit (include Traumatology Orthopedics-Brain trauma); Physical therapy-Rehabilitation unit; Specialties unit (Ophthalmology, Odonto-Maxillo-Facial, Oto-Rhino Laryngology); and Traditional medicine unit. Self-administered questionnaires were sent to the hospital based health providers working in examination rooms, emergency, obstetrics and gynecology, general internal, general surgery, physical therapy-rehabilitation, traditional medicine, and specialties departments. These comprised all doctors, assistant doctors, nurses, and midwives of these departments.

From the result of this study is collected and analyzed in chapter 4. There are various possible factors could related to the perception of health providers toward DVAW. According to the conception framework, there are 3 factors comprised of predisposing factor (socio-demographic characteristics), structural factor (knowledge of health providers toward DVAW), and cues to action (working experiences of health providers in dealing with patients who are victims of DVAW). For 3 factors of independent variable that may be relevant to the perception of health providers toward DVAW. The major findings of this study are discussed in following section.

Base on the finding of this study and interpretation, the following conclusions are drawn as follows:

6.1.1 The perception of health providers toward DVAW

This study revealed that health providers of the Thanh Nhan general hospital had positive perception toward DVAW were 55.5% and negative perception was 44.5%.

1. The finding of this study that health providers had positive trend but a general still support for the traditional view of the man's role as family leader. Only 46.8% of health providers disagree that a man should show himself to his wife that he is boss of the family.

2. Over 62% of health providers thought that a husband can beat his wife when she impertinent, scolds, insults her husband; over half of health providers believe that a husband can beat his wife when she has extramarital relations (52.4%).

3. The majority of healthcare providers agreed that a woman has the right to refuse sexual relations with her husband if she is sick, the husband gets drunk, or treats his wife badly. However, only 58.2% of health providers agreed that a wife can refuse simply because she does not want to. It might be said that the limits in knowledge on sex of the health provider and perception of some health provider also have the agreeing and support to concept that a man is the head of the family.

4. Most of health providers agreed that DVAW was an important issue of in public health (94.5%). 93.2% of health providers thought that can help victims of DVAW both in medical treatment and counseling; should spent time to ask women about DVAW within their initial assessment interview, normal contact times (76.8%); and their profession should be more involved in identifying cases of DVAW (80%). But only 47% of health providers disagree that ask female patients of DVAW they will offend a lot of their patients. It shows that they were not confident to ask their patients directly about DV.

The majority of the health providers agreed that it is useful and necessary of guidelines for working with DVAW victims; poster or leaflets about DVAW; a specific protocol in health care establishments; and training course on DVAW for health staff.

6.1.2 Association between factors and perception of health providers toward DVAW

1. There is significant association between gender and perception of health providers toward DVAW ($p < 0.05$). Female health providers had significantly more positive perception but less knowledge toward DVAW than male health providers. The finding of this study shows that the percentage favoring identify DVAW behaviors among females is higher than that of males. But acts of DVAW are considered to be less serious by females than by males. But male health providers identify DVAW reasons better than female health providers. The above result shows that although male health providers had knowledge on DVAW but they still support for the traditional view of the man's role as family leader, "value men above women" "male superiority".

2. This study found that professional role was independently associated with perception score ($p < 0.05$). Nurses had more positive perception than other respondents, even doctors. Base on the result by using Multiple Logistic Regression model, after adjusting other factors, nurse tends to has positive perception toward DVAW higher than doctor around 12 times.

3. There is significant association between working department with perception of health providers toward DVAW ($p\text{-value} < 0.001$). Health providers of surgery and emergency departments had significantly more positive perception and better knowledge toward DVAW than other departments ($p\text{-value} < 0.001$). The lowest percentage of positive perception of health providers have worked at examination rooms (37.5%).

4. The respondents with good knowledge toward DVAW was 21.1%, fair knowledge were 64.7%, and poor knowledge were 14.2%. There is association between knowledge factor and perception of health providers toward DVAW ($p < 0.001$). The result shows that the percentage of health providers with good knowledge and those with positive perception toward DVAW higher than health providers with poor or fair knowledge. After adjusting other factors in a logistic regression model, health providers with good knowledge tends to positive perception toward DVAW higher than health providers with poor knowledge around 4 times. This association is significantly found at $p = 0.001$.

Almost health provider have knowledge by considering of DVAW behavior, over 96% of health providers fully understand that physical abuse acts are DVAW behaviors. Lower rates of health providers understand that spiritual, sexual abuse behaviors. The percentages favoring these views among females were higher than that of males. It shows that although the spiritual and sexual injuries caused by DVAW behaviors often have affects in a long term so some health providers considered them as not the DVAW behaviors.

The health provider's knowledge about DVAW is not fully about assessment on differently serious degrees of DVAW behaviors. For the physical abuse, 97.1 % of health providers though that assault a woman was serious. But for the spiritual abuse 90 and 96% of health providers though that its were serious behaviors; especially for the sexual abuse such as forcing to have sex they might be though this subject may be private and delicate so near 22% of health providers didn't appraise it seriously. The percentage favoring these views among females is always higher than that of males.

94.7% of health providers understood feudal conception; sexual role is the origin of domestic violence against to the women.

The health provider had most fully understood on consequence of DVAW action to women's health (97.9 - 98.9%).

The most of health providers thought that directly ask patients, or patient's family member(s) speak out, or patients speak out, and only 68.4% by the nature of the injuries in order to identify victims of DVAW.

The majority of health providers knew on the role of organizations, associations to support female victims are DVAW. 97.6% of health providers who knew the Women's Union is an organization may help for DVAW victims.

Over 90% of respondents knew the role of health providers should help victims of DVAW in healthcare facilities. The above result shows that most of health providers have willingness to help victims of DVAW not only treatment physical injuries but also assisting on spirit for patients, in addition, the other support on economy or introduction to assistant address may help them, counseling, etc.

5. The result of this study revealed that the score of respondents with more experience in dealing with DVAW victims is 47.4%, and less experience is 52.6. There is significantly association between experiences of health providers dealing with DVAW victims and perception of health providers toward DVAW (p -value < 0.05). This shows that health providers had more experience and those with positive perception toward DVAW higher than health providers with less experience.

There were 67.9% of health providers contacted with patients of DVAW. And 80.2% report having asked patients directly if they have experienced some kind of violence. Among them, health providers of surgery department (21.7%), internal department (22.1%), examination rooms (20.2%), and emergency department (17.4%) often are the first visit of DVAW victims to treat health problems and almost health providers in these departments have more occasions to contact with DVAW victims. The OB/GYN is department with lowest ratio.

The most common injuries of DVAW forms that health providers faced were soft tissue injuries, broken bones, and injuries in vulnerable areas (over 60 - 98%). Very low percentage of health providers knew about patients had mental injuries like nervousness (57.2%).

Approximately 20% (37/187) of the health providers in all relevant departments revealed that they never ask patients when they worked with patients of DVAW. Majority of reasons were time constraints (67.6%); they did know how to ask to identify reasons of DVAW injuries (67.6%); and 64.9% of focusing on health problems that was higher priority; thought that they could not help patients of DVAW (51.4%).

The result shows that 86.7% of health providers support DVAW patients' spirit beside medical treatment. Only 49.5% of health providers gave counseling for patients and 39.4% of them provide information about community support resources to patients (Women's Union, authority, police, counseling center, etc.).

6. Only 45% of health providers thought that healthcare facilities have not sufficient to assist victims of DVAW. Among them, the reasons provided were lack of collaboration between health facilities with relevant local agencies to help victims of DVAW; lack of specific medical protocol on examination of victims of DVAW in health facilities; limited awareness and knowledge on DVAW among health managers and health provider; inadequate finances; and lack of skills to approach and counsel victims among health providers.

Overall, 80% of health providers would personally welcome training on this matter. Their greatest concern is the lack of counseling skills (91.6%), and issues relating to laws and information on DVAW (90.3%)

Most of health providers (82.9 - 93.4%) responded that there should be have a specific protocol on examination and treatment for DVAW victims in health facilities; a plan for educating staff about DVAW identification, treatment, and documentation; a list of private and public community agencies that provide help for abuse victims; and counseling room for DVAW victims in the hospital.

7. More suggestions:

- Need training course on DVAW, guidelines on examination and treatment for DVAW victims
- There are assistant funds for DVAW victims, and the counseling room in health facilities.
- IEC activities can be integrated into commune's meetings and discussions, which involve not only women's participation, but men's participation too.
- IEC on laws relating to the protection of the rights of women and children.
- The need for effective collaboration among local organizations and branches to help female victims to trust in the system and prevention of DVAW in community.
- Other recommendations include strengthening counseling services at a local level; strengthening the efficacy of laws by the strict punishment of violations; and more specific degrees and forms of punishment.

6.2 Recommendation

6.2.1 Recommendation for Implementation

Violence against women is a serious problem that affects women's health and well-being. Health providers are in a unique position to address DVAW and though their attention, women's health, well-being and safety might improve. The findings of this study serve to highlight the need for in-service training for health providers in the field of DVAW in order to meet the needs of the victims. These findings also emphasize the health administrators' responsibility in evaluating and readdressing the implemented interventions.

1) *Health branch*

General administration

- Health leaders and managers improve awareness on DVAW. DVAW is an important health care issue in public health.

- Propose setting up a health program of improving health care for victims of DVAW
- Product a specific protocol on examination and treatment for DVAW victims in health facilities
- Make plan for training health staff and health volunteers about DVAW is one of activity of regular training programs.
- Establish a counseling room for DVAW victims in general hospitals of each districts. Consultants have knowledge on DVAW and professional advice.
- Set up assistant funds for DVAW victims (appealing and mobilizing from government, non government, and charitable organizations)
- Build a list, address of private and public community agencies that provide help for abuse victims of DVAW and inform health providers of health facilities.
- In order to manage information on female DVAW victims who come to health facilities, regular hospital examination forms and statistics system can have a section on DVAW. This will help to improve follow-up care to victims after discharge.

Training for health providers

This study shows that it is necessary to train on DVAW for health providers to provide knowledge, apply it in their practices and improve their perception toward DVAW. Victims of DVAW are mainly seeking help from health departments. The detected and improving health care response for victims of DVAW suffer from receiving a more-than-satisfactory level of health care services. The development of a training program for healthcare providers (including health staff and volunteers of communitie level) should focus on:

- Providing knowledge on DVAW as the nature of DVAW, reasons for and consequences of violence, explanations for on-going problems, relationship to health in general and particularly reproductive health.
- Vietnamese laws relating to solving DVAW.
- Healthcare in cases of DVAW as screening patients, communication skills, counseling skills, providing sensitive support during repeat cases, encouraging patient's spiritual values, providing information on violence to patients, respect of

patient's decisions, recording cases of violence, developing safety strategies for victims and their children, and the importance of referring victims to other support agencies.

- Exchange experiences in dealing with DVAW victims between health providers who have more experience and those have less experience, between older and younger health providers.

Retraining and advance training attach special importance to health providers of Surgery, Emergency departments and Examination rooms which are places have more opportunity to deal with DVAW victims. Doctors need to train on DVAW aim to improve their perception toward DVAW, and nurses, midwives need to be provided basic knowledge on DVAW.

Health IEC activities

In order to improve perception of health providers toward DVAW, beside training courses, regular IEC activities about DVAW are very important too. Health providers gradually winning recognition that their practice settings are responsive to victims of DVAW by participating in community wide efforts to end DVAW. They can play an important role in primary and secondary prevention as well. Health IEC activities include:

- Propose plan for IEC about DVAW is one of activity of health IEC programs every year.
- Develop the Guidelines for health providers dealing with patients of DVAW and leaflets, posters on DVAW in order to provide to health facilities from communities to high level.

2) Collaboration between organizations, branches in sociality

Dealing with violence cannot be done with the involvement of only one single branch. In establishing a support network to prevent violence and support victims, there should be strong commitment and direction of leaders at different levels. It is necessary to divide responsibilities among organizations and branches to avoid overlooking and shirking of responsibilities and duties, which limits the prevention of violence and support to victims.

Health IEC activities

- Ways to set up a social support network for victims of violence in the community. Expecially health staff and volunteers with Women's Union organizations, Conciliation groups in communities.
- Integrated IEC activities into commune's meetings, seminar or workshop (of Women's Union, Youth's Union, Conciliation groups, Clubs, etc.) which involve not only women's participation, but men's participation too. In order to encourage active participation of local officers in addressing DVAW, it is important to improve IEC activities not only for people but also for officers of branches.

6.2.2 Recommendation for further studies

1. This study was carried out in a general hospital, so that its results had limited for generalization. Therefore, it is suggested to study the same objectives with two general hospitals in rural and urban areas; or health providers of all health facilities of one or two districts; or health workers and volunteers from commune level.

2. Domestic violence is not only DVAW but also children abuse, rape, etc. Therefore, future studies respects that relate to domestic violence such as children abuse, rape, etc.

3. In this study, the current health statistic system of Hanoi had no management information on female DVAW victims who come to health facilities. It is better if the researcher would collect exactly statistic data of DVAW victims in study area and the hospital.

4. Dealing with violence needs involvement of other communitie branches (Women's Union, Youth's Union, Conciliation groups, Police, etc.). The future studies detect knowledge and perception toward DV not only health staff but also officers, leaders of these branches to buid a support network to prevent violence and support victims in community. The interventions are effective only when community

leaders understand that prevention of DVAW is useful, it results in safety for women, their children and families and we should mobilize all resources to this fight. Their work and their actions contribute to the improvement of the violent situation of the victims.



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APPENDIX A

QUESTIONNAIRES

The Hanoi Department of Health
No:.....

PERCEPTION OF HEALTH PROVIDERS TOWARD DOMESTIC VIOLENCE AGAINST WOMEN OF A GENERAL HOSPITAL IN HANOI, VIETNAM.

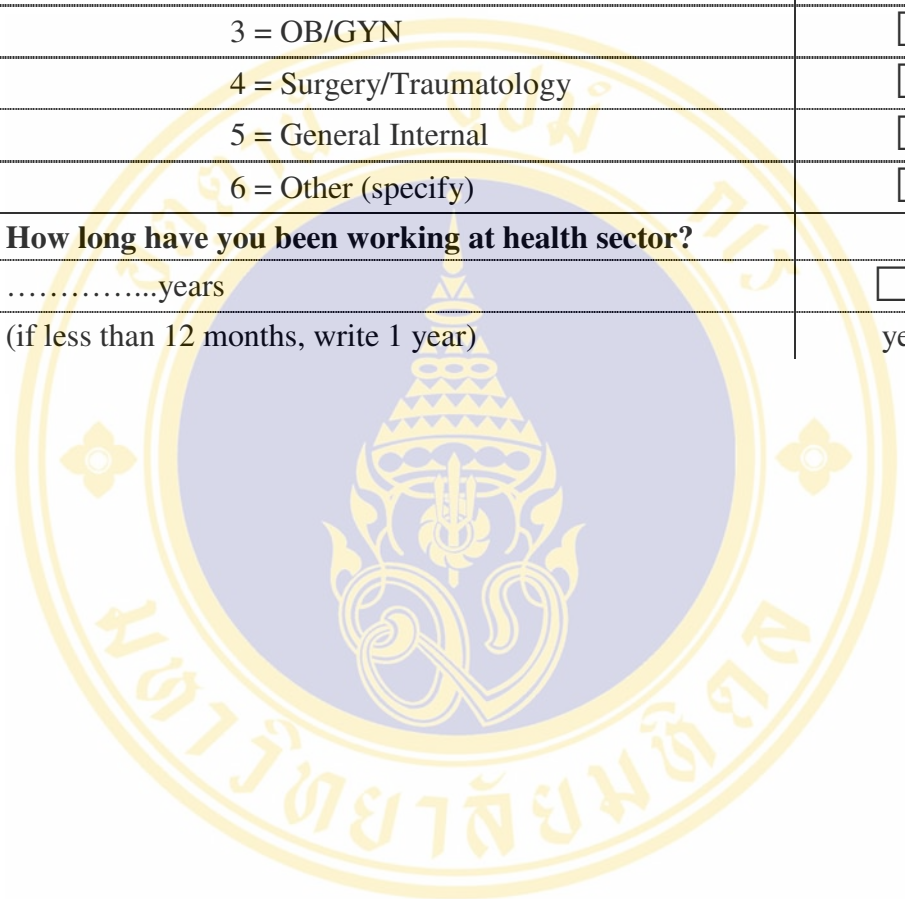
Aim to implementation a first step plan of improving knowledge and perception of health providers on DVAW and development of the “Guidelines for health staff on working with DVAW victims”, the Hanoi Department of Health conduct to study on knowledge and perception of health providers toward DVAW. Please, answer all bellowing questions by check in squares. We do hope you will close collaborate with us.

Thank you very much!

A. SOCIO-DEMOGRAPHIC FACTORS

	Questions	Answer (Check one)
A01	Age	<input type="checkbox"/> <input type="checkbox"/>
A02	Gender	
	1 = Male	<input type="checkbox"/>
	0 = Female	<input type="checkbox"/>
A03	Educational level	
	1= Elementary degree	<input type="checkbox"/>
	2= Secondary degree	<input type="checkbox"/>
	3 = Graduate profession/Post-graduate	<input type="checkbox"/>
A04	Health provider is:	
	1 = Physician	<input type="checkbox"/>
	2 = Assistant Physician	<input type="checkbox"/>
	3 = Nurse	<input type="checkbox"/>
	4 = Midwife	<input type="checkbox"/>
A05	Married status	
	1 = Single	<input type="checkbox"/>
	2 = Married	<input type="checkbox"/>
	3 = Separate	<input type="checkbox"/>

	4 =Divorced	<input type="checkbox"/>
	5 =Widowed	<input type="checkbox"/>
A06	Health provider is working at the department of:	
	1 = Examination rooms	<input type="checkbox"/>
	2 = Emergency	<input type="checkbox"/>
	3 = OB/GYN	<input type="checkbox"/>
	4 = Surgery/Traumatology	<input type="checkbox"/>
	5 = General Internal	<input type="checkbox"/>
	6 = Other (specify)	<input type="checkbox"/>
A07	How long have you been working at health sector?	
years	<input type="checkbox"/> <input type="checkbox"/>
	(if less than 12 months, write 1 year)	years



**B. KNOWLEDGE OF HEALTH PROVIDERS TO DOMESTIC VIOLENCE
AGAINST WOMEN**

	Questions (Please check all sub questions a,b,c,d,..)	Answer (Check one)	
		Yes	No
B01	What are the following acts are considered as DVAW	Yes	No
	a) Assault a woman (hit, choke, slap, push, kick, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Insult /humiliate a woman in front of other people	<input type="checkbox"/>	<input type="checkbox"/>
	c) Threaten (with a knife, weapon, economic, children, or a divorce)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Force her to have sex against her willing	<input type="checkbox"/>	<input type="checkbox"/>
B02	Which of the following types of DVAW is considered to be serious?	Yes	No
	a) Assault a woman (hit, choke, slap, push, kick, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Insult /humiliate a woman in front of other people	<input type="checkbox"/>	<input type="checkbox"/>
	c) Threaten (with a knife, weapon, economic, children or a divorce)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Force her to have sex against her willing	<input type="checkbox"/>	<input type="checkbox"/>
B03	What are the following reasons of DVAW?	Yes	No
	a) Effect of the traditional ideology of gender inequality	<input type="checkbox"/>	<input type="checkbox"/>
	b) Family economic difficulties	<input type="checkbox"/>	<input type="checkbox"/>
	c) Alcohol, gambling, drug addiction by one spouse (social evils)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Adultery	<input type="checkbox"/>	<input type="checkbox"/>
B04	What are the following consequences of DVAW on a woman?	Yes	No
	a) Physical health consequences (trauma, disable, death)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Mental health consequences (nervous strain, stress, depression, psychology trauma, hysterical, mental sickness, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Consequences on child's development (unlettered, social evils, psychology disorder, nervous disorder, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Broken family	<input type="checkbox"/>	<input type="checkbox"/>

B05	How do you know a patient is a victim of DVAW?	Yes	No
	a) The nature of injuries	<input type="checkbox"/>	<input type="checkbox"/>
	b) Ask patients	<input type="checkbox"/>	<input type="checkbox"/>
	c) Patients speak out	<input type="checkbox"/>	<input type="checkbox"/>
	d) Patient's family member (s) speak out	<input type="checkbox"/>	<input type="checkbox"/>
B06	What are the following agencies in social can help DVAW victims?	Yes	No
	a) Women's Union	<input type="checkbox"/>	<input type="checkbox"/>
	b) Local authorities	<input type="checkbox"/>	<input type="checkbox"/>
	c) Police	<input type="checkbox"/>	<input type="checkbox"/>
	d) Court / Justice	<input type="checkbox"/>	<input type="checkbox"/>
	e) Conciliation groups		<input type="checkbox"/>
	f) Youth's Union	<input type="checkbox"/>	<input type="checkbox"/>
B07	Is DV against any the following government's laws /regulations?	Yes	No
	a) Physical abuse (murders, intentionally inflicting injury or cause harm to other person, ill-treating other persons)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Emotional abuse (forcing suicide, threaten to murder, humiliating other persons, slander)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Violate the principle of monogamy of the Family and Marriage Law	<input type="checkbox"/>	<input type="checkbox"/>
B08	What are the roles of health providers to help victims of domestic violence against women?	Yes	No
	a) Examine and treat medical problems	<input type="checkbox"/>	<input type="checkbox"/>
	b) Emotion/Mental encouragement	<input type="checkbox"/>	<input type="checkbox"/>
	c) Counseling for victims	<input type="checkbox"/>	<input type="checkbox"/>
	d) Provide information about community support resources (Women's Union, Authority, Police, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
B09	Do you think, do DVAW acts increase as compared to 5 years ago?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

C. EXPERIENCES OF HEALTH PROVIDER IN DEALING WITH VICTIMS OF DVAW

	Questions (Please check all sub questions a,b,c,d,..)	Answer (Check one)	
C01	Since you started working at this facility, have you ever seen female patients who are victims of DVAW?	Yes	No
	If answer "No" ----> Skip to D01	<input type="checkbox"/>	<input type="checkbox"/>
C02	If C01 answer "Yes", How many patients who are victims of DVAW have you seen?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
C03	What types of DVAW were they suffering?	Yes	No
	a) Assault a woman (hit, choke, slap, push, kick,..)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Insult /humiliate a woman in front of other people	<input type="checkbox"/>	<input type="checkbox"/>
	c) Threaten (with a knife, weapon, economic, children, or a divorce)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Force her to have sex against her willing	<input type="checkbox"/>	<input type="checkbox"/>
C04	Do you exam that patients directly ?	Yes	No
	If answer "No" ----> Skip to D01	<input type="checkbox"/>	<input type="checkbox"/>
C05	How serious are patient's injuries that you have seen?	Yes	No
	a) Soft tissue injuries (bruise, swollen, torn skin)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Broken bones (arm, legs, rib, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Injuries at vulnerable areas (head, neck, abdomen)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Mental trauma (nervous strain, stress, depression, psychology trauma, hysterical, mental sickness, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
C06	During examination, do you ask patients directly about DVAW whether female patients have been abused or threatened by partner/family member?	Yes	No
	If answer "No" ----> Skip to C08	<input type="checkbox"/>	<input type="checkbox"/>

C07	If C06 answer "Yes", How frequently do you ask female patients who are DVAW victims directly about DVAW?	Yes	No
	a) Initial visit/ Emergency	<input type="checkbox"/>	<input type="checkbox"/>
	b) Routine exams/ Regular check ups	<input type="checkbox"/>	<input type="checkbox"/>
	c) Patients presents with physical injury	<input type="checkbox"/>	<input type="checkbox"/>
C08	If C06 answer "No", There are many barriers in asking female patients about DVAW. What are reasons that you do not ask about DVAW?	Yes	No
	a) Time constraints	<input type="checkbox"/>	<input type="checkbox"/>
	b) Think I could not help patients	<input type="checkbox"/>	<input type="checkbox"/>
	c) My attention must be focused on other health problems that are of higher priority	<input type="checkbox"/>	<input type="checkbox"/>
	d) Not being trained in how to ask to identify reasons of DVAW injuries	<input type="checkbox"/>	<input type="checkbox"/>
C09	When you know patients are victims of DVAW, what else do you do for them along with medical treatment?	Yes	No
	a) Medical treatment only	<input type="checkbox"/>	<input type="checkbox"/>
	b) Spiritual encouragement	<input type="checkbox"/>	<input type="checkbox"/>
	c) Counseling for patient	<input type="checkbox"/>	<input type="checkbox"/>
	d) Provide patients with information about community support resources (Women's Union, Authority, Police, Counseling centers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

**D. PERCEPTION OF HEALTH PROVIDERS TO DOMESTIC VIOLENCE
AGAINST WOMEN**

	Questions (Please check all sub questions a,b,c,d,..)	Answer (Check one)		
D01 *	Would you tell me whether you generally agree or disagree with the following statements?	Agree	Uncertain	Disagree
	a) A man should show himself to his wife that he is boss of the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) A good wife should obey her husband even if she disagrees with his thoughts and actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) It's is a wife's obligation to have sex with her husband even if she does not like it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D02 *	Would you tell me whether you generally agree or disagree with a man have a good reason to hit for beating his wife if:	Agree	Uncertain	Disagree
	a) She does not fulfill her household-work at his expectation (lazy, not take care of children, spend a lot money, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Contrary with her husband	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Impertinent/ scolds/ insults her husband	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) She refuses to have sex with him	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) Adultery/ extramarital relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D03	Do you think a married woman can refuse sex with her husband in case that:	Agree	Uncertain	Disagree
	a) She doesn't want (no reason)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) She is sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) He is drunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) She is mistreated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D04	DVAW is an important health care issue in public health?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D05 *	Do you think DVAW is a private matter between partners only?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D06	Do you think that health providers can help victims of DVAW both in medical treatment and counseling?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D07	Do you think health providers should spent time to ask women about DVAW within their initial assessment interview/ normal contact times?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D08 *	Do you think if you ask every women (who is relevant to your practice and she has been DVAW) you will offend a lot of your patients?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D09	Do you think your profession should be more involved in identifying cases of DVAW?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D10	Do you think should have guidelines for working with DVAW victims?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D11	Health care establishment/your department should display poster or leaflets about DVAW?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D12	Do you think that it is necessary to have a specific protocol for health providers working with victims of DVAW?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D13 *	Recognizing DVAW will make any difference to the long term health of a victim?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D14	Do you think health providers would improve awareness and knowledge by training on DVAW?	Agree	Uncertain	Disagree
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**E. SUGGESTIONS AND RECOMMENDATION OF HEALTH PROVIDERS
ON IMPROVING HEALTH CARE FOR VICTIMS OF DVAW**

	Questions (Please check all sub questions a,b,c,d,..)	Answer (Check one)	
E01	Do you think there are sufficient resources in healthcare facilities to assist victims of DVAW?	Yes	No
	If answer "Yes" ----> Skip to E03	<input type="checkbox"/>	<input type="checkbox"/>
E02	If answer "No", Why?	Yes	No
	a) Lack of awareness and knowledge on DVAW among health managers and health providers	<input type="checkbox"/>	<input type="checkbox"/>
	b) Lack of skills to approach and counsel victims among health providers	<input type="checkbox"/>	<input type="checkbox"/>
	c) Lack of specific medical protocol on examination of victims of DVAW in health facilities	<input type="checkbox"/>	<input type="checkbox"/>
	d) Lack of collaboration between health facilities with relevant local agencies to help victims of DVAW	<input type="checkbox"/>	<input type="checkbox"/>
	e) Lack of budget	<input type="checkbox"/>	<input type="checkbox"/>
	f) Others (Specify):		
E03	What area you want to be trained?	Yes	No
	a) Screening/ identify DVAW female victims?	<input type="checkbox"/>	<input type="checkbox"/>
	b) How to help DVAW victims (validating, providing information, safety planning, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Health consequences (physical, spirit, reproductive,etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Counseling skills to patients	<input type="checkbox"/>	<input type="checkbox"/>
	e) Law relating to DVAW	<input type="checkbox"/>	<input type="checkbox"/>
	f) Others (Specify):		
E04	Would you have any suggestion to improve the health care response to DVAW in your hospital?	Yes	No

Sở Y tế Hà Nội

Số phiếu:.....

**BẢNG HỎI CÁN BỘ Y TẾ VỀ NHẬN THỨC VÀ KINH NGHIỆM LÀM VIỆC
VỚI NẠN NHÂN CỦA BẠO HÀNH PHỤ NỮ TRONG GIA ĐÌNH**

Nhằm mục đích triển khai bước đầu kế hoạch nâng cao kiến thức và nhận thức cho cán bộ y tế về bạo hành giới và xây dựng tài liệu hướng dẫn cho cán bộ y tế làm việc với nạn nhân của bạo hành phụ nữ trong gia đình, Sở Y tế Hà Nội tiến hành điều tra tìm hiểu về nhận thức và kinh nghiệm làm việc với nạn nhân bạo hành giới của các cán bộ y tế. Đề nghị anh/chị trả lời đủ tất cả các câu trả lời nhỏ (a, b, c,...) trong mỗi câu hỏi bằng cách đánh dấu vào các ô vuông. Rất mong sự cộng tác nhiệt tình của các anh/chị.

Xin chân thành cảm ơn!

A. THÔNG TIN CÁ NHÂN CỦA CÁN BỘ Y TẾ

	Câu hỏi	Phần trả lời (Đánh dấu vào ô vuông)
A01	Tuổi:	<input type="text"/> <input type="text"/>
A02	Giới:	
	1 = Nam	<input type="checkbox"/>
	0 = Nữ	<input type="checkbox"/>
A03	Trình độ văn hoá:	
	1 = Sơ cấp	<input type="checkbox"/>
	2 = Trung cấp	<input type="checkbox"/>
	3 = Đại học / Sau đại học	<input type="checkbox"/>
A04	Cấp bậc chuyên môn:	
	1 = Bác sĩ	<input type="checkbox"/>
	2 = Y sĩ	<input type="checkbox"/>
	3 = Y tá	<input type="checkbox"/>
	4 = Hộ lý	<input type="checkbox"/>
A05	Tình trạng hôn nhân:	
	1 = Chưa có gia đình	<input type="checkbox"/>
	2 = Có gia đình	<input type="checkbox"/>
	3 = Ly thân	<input type="checkbox"/>
	4 = Đã ly dị	<input type="checkbox"/>
	5 = Goá	<input type="checkbox"/>
A06	Cán bộ y tế đang làm tại khoa:	
	1 = Phòng khám	<input type="checkbox"/>

	2 = Hồi sức cấp cứu	<input type="checkbox"/>
	3 = Khoa Sản	<input type="checkbox"/>
	4 = Khoa Ngoại/chấn thương	<input type="checkbox"/>
	5 = Khoa Nội	<input type="checkbox"/>
	6 = Khác (ghi rõ):	<input type="checkbox"/>
A07	Số năm công tác trong ngành y tếnăm (Nếu dưới 12 tháng, ghi tròn 1 năm)	<input type="text"/> <input type="text"/> năm



B. KIẾN THỨC CỦA CÁN BỘ Y TẾ VỀ BẠO HÀNH PHỤ NỮ TRONG GIA ĐÌNH

	Câu hỏi (Đề nghị đánh dấu tất cả các câu trả lời nhỏ c, b, c, d,...)	Trả lời (Đánh dấu vào ô vuông)	
		Có (1)	Không (0)
B01	Theo anh/chị hành vi nào dưới đây được coi là bạo hành phụ nữ trong gia đình?	Có (1)	Không (0)
	a) Hành hung làm người phụ nữ bị đau đớn (đánh, đấm, đá, tát, đẩy ngã,...)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Lãng mạ, chửi, hạ nhục, làm người phụ nữ phải xấu hổ trước mặt người khác.	<input type="checkbox"/>	<input type="checkbox"/>
	c) Đe dọa, khống chế (dùng dao, vũ khí, kinh tế hoặc con cái để khống chế hoặc đe dọa li dị)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Cưỡng ép quan hệ tình dục khi người vợ không muốn	<input type="checkbox"/>	<input type="checkbox"/>
B02	Theo anh/chị, những dạng bạo hành phụ nữ trong gia đình nào dưới đây coi là nghiêm trọng ?	Có nghiêm trọng (1)	Không nghiêm trọng (0)
	a) Hành hung làm người phụ nữ bị đau đớn (đánh, đấm, đá, tát, đẩy ngã,...)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Lãng mạ, chửi, hạ nhục, làm người phụ nữ phải xấu hổ trước mặt người khác.	<input type="checkbox"/>	<input type="checkbox"/>
	c) Đe dọa, khống chế (dùng dao, vũ khí, kinh tế hoặc con cái để khống chế hoặc đe dọa li dị,...)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Cưỡng ép quan hệ tình dục khi người vợ không muốn	<input type="checkbox"/>	<input type="checkbox"/>
B03	Theo anh/chị, những nguyên nhân nào gây nên tình trạng bạo hành phụ nữ trong gia đình ?	Có (1)	Không (0)
	a) Ảnh hưởng của tư tưởng phong kiến, trọng nam khinh nữ	<input type="checkbox"/>	<input type="checkbox"/>
	b) Khó khăn về kinh tế	<input type="checkbox"/>	<input type="checkbox"/>
	c) Rượu chè, cờ bạc, ma túy (các tệ nạn xã hội)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Ngoại tình	<input type="checkbox"/>	<input type="checkbox"/>
	e) Những mâu thuẫn khác	<input type="checkbox"/>	<input type="checkbox"/>
B04	Theo anh/chị, bạo hành với phụ nữ trong gia đình sẽ gây nên những hậu quả nào dưới đây ?	Có (1)	Không (0)
	a) Ảnh hưởng đến sức khỏe thể chất/tính mạng (chấn thương, tàn phế, chết)	<input type="checkbox"/>	<input type="checkbox"/>

	b) Ảnh hưởng đến sức khỏe tinh thần (căng thẳng thần kinh, stress, sang chấn tâm lý, hoảng loạn, thần kinh,..)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Ảnh hưởng đến sự phát triển của con cái (thất học, tệ nạn xã hội, rối loạn tâm lý, thần kinh)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Phá vỡ hạnh phúc gia đình	<input type="checkbox"/>	<input type="checkbox"/>
B05	Theo anh/chị, làm sao để nhận biết một bệnh nhân là nạn nhân của bạo hành phụ nữ trong gia đình ?	Có (1)	Không (0)
	a) Nhìn vết thương có thể đoán ra	<input type="checkbox"/>	<input type="checkbox"/>
	b) Hỏi bệnh nhân	<input type="checkbox"/>	<input type="checkbox"/>
	c) Bệnh nhân tự nói	<input type="checkbox"/>	<input type="checkbox"/>
	d) Người nhà bệnh nhân nói	<input type="checkbox"/>	<input type="checkbox"/>
B06	Anh/chị có biết những tổ chức, cơ quan nào dưới đây có thể giúp đỡ phụ nữ bị bạo hành trong gia đình không?	Có (1)	Không (0)
	a) Hội Phụ nữ	<input type="checkbox"/>	<input type="checkbox"/>
	b) Chính quyền	<input type="checkbox"/>	<input type="checkbox"/>
	c) Công an	<input type="checkbox"/>	<input type="checkbox"/>
	d) Tư pháp / Tòa án	<input type="checkbox"/>	<input type="checkbox"/>
	e) Tổ hòa giải	<input type="checkbox"/>	<input type="checkbox"/>
	f) Đoàn Thanh niên	<input type="checkbox"/>	<input type="checkbox"/>
B07	Anh/chị có biết qui định luật pháp của Nhà nước nào dưới đây liên quan đến những hành vi bạo hành phụ nữ trong gia đình không ?	Có (1)	Không (0)
	a) Đối với bạo hành thể xác (giết người, gây thương tích hoặc gây tổn hại cho sức khỏe người khác, tội hành hạ người khác)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Đối với bạo hành tinh thần (tội bức tử, đe dọa giết người, làm nhục người khác, vu khống,...)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Luật hôn nhân và gia đình (khi người chồng ngoại tình, vi phạm luật hôn nhân 1 vợ, 1 chồng)	<input type="checkbox"/>	<input type="checkbox"/>
B08	Theo anh/chị, các CBYT có vai trò gì trong việc giúp đỡ nạn nhân bị bạo hành trong gia đình tại các cơ sở y tế?	Có (1)	Không (0)
	a) Khám và điều trị các vết thương	<input type="checkbox"/>	<input type="checkbox"/>
	b) Động viên tinh thần	<input type="checkbox"/>	<input type="checkbox"/>

	c) Tư vấn cho bệnh nhân	<input type="checkbox"/>	<input type="checkbox"/>
	d) Cung cấp thông tin về địa chỉ các cơ quan, tổ chức, phòng tư vấn có thể giúp bệnh nhân nữ là nạn nhân bị bạo hành trong gia đình (Hội Phụ nữ, Chính quyền, Công an, Trung tâm tư vấn,..)	<input type="checkbox"/>	<input type="checkbox"/>
B09	Anh/chị có cho rằng tình trạng bạo hành phụ nữ trong gia đình tăng so với 5 năm trước đây không?	Có (1)	Không (0)
		<input type="checkbox"/>	<input type="checkbox"/>



C. KINH NGHIỆM CỦA CÁN BỘ Y TẾ TRONG KHÁM CHỮA BỆNH CHO BỆNH NHÂN LÀ NẠN NHÂN CỦA BẠO HÀNH TRONG GIA ĐÌNH

	Câu hỏi (Đề nghị đánh dấu tất cả các câu trả lời nhỏ c, b, c, d,...)	Trả lời (Đánh dấu vào ô vuông)	
		Có (1)	Không (0)
C01	Từ khi làm việc tại cơ sở y tế này, anh/chị đã từng biết, gặp, tiếp xúc trực tiếp với bệnh nhân nữ là nạn nhân bị bạo hành trong gia đình không?	Có (1)	Không (0)
	Nếu trả lời "Không" ---> Chuyển sang câu D01	<input type="checkbox"/>	<input type="checkbox"/>
C02	Nếu câu C01 trả lời "Có", khoảng bao nhiêu bệnh nhân là phụ nữ bị bạo hành trong gia đình mà anh/chị đã từng gặp ? _____		
C03	Anh/chị đã từng biết/gặp những bệnh nhân nữ bị bạo hành với những loại hình thức nào dưới đây ?	Có (1)	Không (0)
	a) Hành hung làm người phụ nữ bị đau đớn (Đánh, đấm, đá, tát, đẩy ngã,...)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Lãng mạ, chửi, hạ nhục, làm người phụ nữ phải xấu hổ trước mặt người khác.	<input type="checkbox"/>	<input type="checkbox"/>
	c) Đe dọa, khống chế (dùng dao, vũ khí, kinh tế hoặc con cái để khống chế hoặc đe dọa li dị)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Cường ép quan hệ tình dục khi người vợ không muốn	<input type="checkbox"/>	<input type="checkbox"/>
C04	Anh/chị có trực tiếp khám cho bệnh nhân không?	Có (1)	Không (0)
	Nếu trả lời "Không" ---> Chuyển sang câu D01	<input type="checkbox"/>	<input type="checkbox"/>
C05	Các dạng thương tích của bệnh nhân nữ bị bạo hành trong gia đình mà anh/chị đã gặp là:	Có (1)	Không (0)
	a) Tổn thương phần mềm (bầm tím, rách da thịt...)	<input type="checkbox"/>	<input type="checkbox"/>
	b) Gãy xương (chân tay, xương sườn...)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Tổn thương nội tạng	<input type="checkbox"/>	<input type="checkbox"/>
	d) Sang chấn mặt tinh thần (hoảng loạn, tâm thần....)	<input type="checkbox"/>	<input type="checkbox"/>

C06	Trong quá trình thăm khám anh/chị có trực tiếp hỏi bệnh nhân để xác định xem họ đã từng bị bạo hành bởi người chồng/thành viên khác trong gia đình không?	Có (1)	Không (0)
	Nếu trả lời "Không" ---> Chuyển sang câu C08	<input type="checkbox"/>	<input type="checkbox"/>
C07	Nếu câu C06 trả lời "Có", thì anh/chị hỏi bệnh nhân trong trường hợp nào?	Có (1)	Không (0)
	a) Khám cho bệnh nhân đến lần đầu/cấp cứu	<input type="checkbox"/>	<input type="checkbox"/>
	b) Khám thường kỳ	<input type="checkbox"/>	<input type="checkbox"/>
	c) Khám bệnh nhân bị thương	<input type="checkbox"/>	<input type="checkbox"/>
C08	Nếu câu C08 trả lời "Không", thì có trở ngại gì khiến anh/chị không hỏi bệnh nhân nữ về việc bị bạo hành của họ ?	Có (1)	Không (0)
	a) Không có thời gian	<input type="checkbox"/>	<input type="checkbox"/>
	b) Nghĩ rằng không thể giúp gì cho bệnh nhân	<input type="checkbox"/>	<input type="checkbox"/>
	c) Coi chữa bệnh là chính	<input type="checkbox"/>	<input type="checkbox"/>
	d) Chưa được tập huấn về cách hỏi để xác định nguyên nhân thương tích là do bị bạo hành.	<input type="checkbox"/>	<input type="checkbox"/>
C09	Khi biết hoặc đoán biết bệnh nhân nữ bị bạo hành trong gia đình thì anh/chị đã làm gì?	Có (1)	Không (0)
	a) Khám và điều trị các vết thương	<input type="checkbox"/>	<input type="checkbox"/>
	b) Động viên tinh thần cho bệnh nhân	<input type="checkbox"/>	<input type="checkbox"/>
	c) Tư vấn cho bệnh nhân	<input type="checkbox"/>	<input type="checkbox"/>
	d) Cung cấp thông tin về địa chỉ các cơ quan, tổ chức, phòng tư vấn có thể giúp nạn nhân của hành hạ phụ nữ trong gia đình (Hội Phụ nữ, Chính quyền, Công an, Tổ hòa giải, Trung tâm tư vấn,..)	<input type="checkbox"/>	<input type="checkbox"/>

D. NHẬN THỨC CỦA CÁN BỘ Y TẾ VỀ BẠO HÀNH PHỤ NỮ TRONG GIA ĐÌNH

	Câu hỏi (Đề nghị đánh dấu tất cả các câu trả lời nhỏ a, b, c,)	Trả lời (Đánh dấu vào ô vuông)		
		Đồng ý	Không chắc chắn	Không đồng ý
D01 *	Mỗi người có thể có những cách nhìn nhận khác nhau về mối quan hệ giữa vợ và chồng. Anh/chị có đồng ý hoặc không đồng ý với những ý kiến dưới đây ?	Đồng ý	Không chắc chắn	Không đồng ý
	a) Người đàn ông cần phải thể hiện là ông chủ trong gia đình	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Người vợ tốt cần phải nghe lời chồng cho dù không đồng ý với ý kiến và hành vi của chồng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Người vợ phải có nghĩa vụ đáp ứng nhu cầu tình dục của chồng kể cả khi chị ta không muốn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D02 *	Theo anh/chị, vì những nguyên nhân nào dưới đây người đàn ông có thể đánh vợ ?	Đồng ý	Không chắc chắn	Không đồng ý
	a) Người vợ không có trách nhiệm với gia đình (lời biếng, ăn tiêu phung phí, không chăm sóc con cái,..)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Làm trái ý chồng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Chửi, nhục mạ chồng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Không đáp ứng nhu cầu tình dục của chồng	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e) Ngoại tình	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D03	Theo ý kiến anh/chị, người vợ có quyền từ chối quan hệ tình dục với chồng khi:	Đồng ý	Không chắc chắn	Không đồng ý
	a) Không muốn (nhưng không có lý do cụ thể)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b) Bị mệt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c) Chồng say rượu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d) Chồng đối xử thô bạo với vợ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D04	Anh/chị có cho rằng bạo hành phụ nữ trong gia đình là một vấn đề nghiêm trọng của sức khỏe cộng đồng không ?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	
D05 *	Anh/chị có cho rằng bạo hành phụ nữ trong gia đình chỉ là vấn đề riêng tư trong phạm vi gia đình họ không?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D06	Theo anh/chị, cán bộ y tế có nên tư vấn kết hợp với điều trị y tế cho bệnh nhân nữ bị bạo hành trong gia đình không ?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D07	Theo anh/chị, cán bộ y tế (CBYT) có nên giành thời gian trong khi khám bệnh để hỏi bệnh nhân nữ về việc bị bạo hành trong gia đình không ?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D08 *	Anh/chị có cho rằng sẽ làm bệnh nhân khó chịu khi anh/chị hỏi trong khi khám bệnh về việc bị bạo hành của bệnh nhân nữ (mà anh/chị nghĩ là nạn nhân của bạo hành phụ nữ trong gia đình) không ?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D09	Anh/chị có cho rằng, trong công việc chuyên môn của anh/chị có nên lưu tâm thêm nhận dạng các trường hợp là nạn nhân của bạo hành trong gia đình không ?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D10	Anh/chị thấy có cần thiết phải có tài liệu hướng dẫn cho CBYT làm việc với nạn nhân bị bạo hành không ?	Đồng ý	Không chắc chắn	Không đồng ý
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D11	Anh/chị có cho rằng, tại các cơ sở y tế/khoa phòng của anh/chị nên có những tờ rơi, áp phích về phòng chống bạo hành đối với phụ nữ trong gia đình không ?	Đồng ý (2)	Không chắc chắn (0)	Không đồng ý (1)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D12	Theo anh/chị có cần thiết phải có một qui định chuyên môn cho CBYT khi làm việc với bệnh nhân nữ là nạn nhân bị bạo hành trong gia đình không ?	Đồng ý (2)	Không chắc chắn (0)	Không đồng ý (1)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D13 *	Anh/chị có cho rằng, nhận thức đúng của CBYT về bạo hành phụ nữ trong gia đình cũng không ảnh hưởng đến lợi ích sức khoẻ lâu dài của nạn nhân ?	Đồng ý (1)	Không chắc chắn (0)	Không đồng ý (2)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D14	Theo anh/chị, qua tập huấn về bạo hành giới CBYT có nâng cao nhận thức và kiến thức về bạo hành phụ nữ trong gia đình?	Đồng ý (2)	Không chắc chắn (0)	Không đồng ý (1)
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**E. CÁN BỘ Y TẾ GÓP Ý NHÀM CẢI THIỆN CHĂM SÓC Y TẾ CHO
NẠN NHÂN CỦA BẠO HÀNH PHỤ NỮ TRONG GIA ĐÌNH**

	Câu hỏi (Đề nghị đánh dấu tất cả các câu trả lời nhỏ c, b, c,...)	Trả lời (Đánh dấu vào ô vuông)	
		Có (1)	Không (0)
E01	Anh/chị có cho rằng hiện nay tại các cơ sở y tế có đủ điều kiện để giúp đỡ nạn nhân bị bạo hành trong gia đình không?	Có (1)	Không (0)
	Nếu trả lời "Có" ---> Chuyển sang câu E03	<input type="checkbox"/>	<input type="checkbox"/>
E02	Nếu câu E01 trả lời "Không", thì vì sao?	Có (1)	Không (0)
	a) Nhận thức và kiến thức về bạo hành phụ nữ trong gia đình của các cấp quản lý y tế và cán bộ y tế chưa đầy đủ	<input type="checkbox"/>	<input type="checkbox"/>
	b) Cán bộ y tế thiếu kỹ năng tiếp cận và tư vấn cho nạn nhân của bạo hành phụ nữ	<input type="checkbox"/>	<input type="checkbox"/>
	c) Các cơ sở y tế thiếu tài liệu hướng dẫn, qui định chuyên môn cho cán bộ y tế để giúp đỡ nạn nhân nữ bị bạo hành.	<input type="checkbox"/>	<input type="checkbox"/>
	d) Thiếu sự phối hợp giữa các cơ sở y tế và các ban ngành liên quan để giúp đỡ nạn nhân nữ bị bạo hành	<input type="checkbox"/>	<input type="checkbox"/>
	e) Thiếu kinh phí	<input type="checkbox"/>	<input type="checkbox"/>
	f) Khác (ghi rõ):		
E03	Nếu có khoá tập huấn về bạo hành giới được tổ chức, anh/chị muốn được tập huấn về lĩnh vực nào?	Có (1)	Không (0)
	a) Cách thức nhận dạng bệnh nhân nữ bị bạo hành?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Hướng can thiệp, giúp đỡ nạn nhân (xem xét sự an tâm, cung cấp thông tin, kế hoạch an toàn cho nạn nhân,...)	<input type="checkbox"/>	<input type="checkbox"/>
	c) Hậu quả đối với sức khoẻ (thể chất, tinh thần, sức khoẻ sinh sản,..)	<input type="checkbox"/>	<input type="checkbox"/>
	d) Kỹ năng tư vấn cho nạn nhân bị bạo hành	<input type="checkbox"/>	<input type="checkbox"/>
	e) Các vấn đề về luật pháp liên quan đến bạo hành phụ nữ	<input type="checkbox"/>	<input type="checkbox"/>
	f) Khác (ghi rõ):		

APPENDIX B

Table 34 Logistic Regression Table: Comparing association between doctor and perception with another professional roles and perception of health providers toward DVAW.

Predictor	Constant	Odds Ratio	p-value	95% CI	
				Lower	Upper
Age group					
Under 30 years old (Ref.)		1			
30 - 39 years old		1.20	0.735	0.42	3.40
40 - 49 years old		1.28	0.707	0.36	4.57
Over 49 years old		0.64	0.579	0.13	3.12
Gender					
Female (Ref.)		1			
Male		0.60	0.089	0.33	1.08
Education level					
Elementary degree (Ref.)		1			
Secondary degree		0.60	0.543	0.12	3.06
Graduate profession/ post-graduate		4.75	0.263	0.31	72.67
Professional role					
Doctor (Ref.)		1			
Assistant doctor		8.40	0.116	0.59	119.64
Nurse		12.14	0.039	1.14	129.28
Midwife		7.00	0.176	0.42	117.26
Knowledge level					
Good knowledge (Ref.)		1			
Fair knowledge		0.72	0.288	0.39	1.32
Poor knowledge		0.22	0.00	0.10	0.52

Note: * Significant at p -value < 0.05

Table 35 Association of socio-demographic characteristic factors with knowledge level of health providers toward DVAW

Socio-demographic factors	Knowledge level				χ^2	p-value
	People n=380	Good n=80 (%)	Fair n=254 (%)	Poor n=46 (%)		
Age group					18.1	0.006*
Under 30 years old	80	21 (26.3)	53 (66.3)	6 (7.4)		
30 - 39 years old	72	19 (26.4)	42(58.3)	11 (15.3)		
40 - 49 years old	187	25 (13.4)	130 (69.5)	32 (17.1)		
Over 49 years old	41	15 (36.6)	21 (51.2)	5 (12.2)		
Gender					6.24	0.044*
Male	85	26 (30.6)	47 (55.3)	12 (14.1)		
Female	295	54 (18.3)	199 (67.5)	42 (14.2)		
Education level					1.48	> 0.05
Graduate profession/ post-graduate	132	28 (21.2)	88 (66.7)	16 (12.1)		
Secondary degree	229	49 (21.4)	146 (63.8)	34 (14.8)		
Elementary degree	19	3 (15.8)	12 (63.2)	4 (21.0)		
Professional role					4.99	> 0.05
Doctor	131	28 (21.4)	87 (66.4)	16 (12.2)		
Assistant doctor	14	0	11 (78.6)	3 (21.4)		
Nurse	219	48 (21.9)	139 (63.5)	32 (14.6)		
Midwife	16	4 (25.0)	9 (56.2)	3 (18.8)		
Married status					4.79	> 0.05
Single	59	16 (27.1)	38 (64.4)	5 (8.5)		
Married	310	60 (19.3)	202 (65.2)	48 (15.5)		

Socio-demographic factors	Knowledge level				χ^2	p-value
	People n=380	Good n=80 (%)	Fair n=254 (%)	Poor n=46 (%)		
Separation group	11	4 (36.4)	6 (54.5)	1 (9.1)		
Working dept.					35.98	<0.001*
Examination rooms	72	11 (15.3)	50 (69.4)	11 (15.3)		
Emergency	64	15 (23.4)	43 (67.2)	6 (9.4)		
OB/GYN	28	7 (25.0)	13 (46.4)	8 (28.6)		
Surgery	59	26 (44.1)	29 (49.1)	4 (6.8)		
Internal	100	11 (11.0)	70 (70.0)	19 (19.0)		
Other	57	10 (17.6)	41 (71.9)	6 (10.5)		
Working years in health sector					9.22	> 0.05
≤ 5 years	88	25 (28.4)	56 (63.7)	7 (7.9)		
6 - 15 years	59	13 (22.0)	35 (59.3)	11 (18.7)		
16 - 25 years	190	31 (16.3)	130 (68.4)	29 (15.3)		
> 25 years	43	11(25.6)	25 (58.1)	7 (16.3)		

Note: * Significant at p-value < 0.05

** Chi-Square approximation probably invalid

(9 cells with expected counts less than 5.0)

Table 36 Comparing the percentage of health provider worked with DVAW victims in departments.

Department	Number (n = 255)	Percent (%)
Examination rooms	52	20.2
Emergency	45	17.7
OB/GYN	20	7.8
Surgery	56	21.7
Internal	54	21.2
Other	28	10.8

Table 37 Association of working department with experiences in dealing with DVAW victims of health providers.

Age group	Experience level			χ^2	p-value
	People n=380	More n=80 (%)	Less n=254 (%)		
Under 30 years old	80	38 (47.5)	42 (52.5)	7.24	> 0.05
30 - 39 years old	72	35 (48.6)	37 (51.4)		
40 - 49 years old	187	80 (42.8)	107 (57.2)		
Over 49 years old	41	27 (65.9)	14 (34.2)		

Table 38 Association of knowledge level with experiences in dealing with DVAW victims of health providers.

Experience	Knowledge level				χ^2	p-value
	People n=380	Good n=80 (%)	Fair n=254 (%)	Poor n=46 (%)		
More	180	54 (67.5)	108 (43.9)	18 (33.3)	18.5	<0.001*
Less	200	26 (32.5)	138 (56.1)	36 (66.7)		

Table 39 Association of gender with perception toward DVAW of doctor and nurse.

Role	Gender	Total n	Positive perception n (%)	Negative perception n (%)	χ^2	p- value
Doctor	Male	53	26 (49.06)	27 (50.94)	0.38	> 0.05
	Female	78	34 (43.59)	44 (56.41)		
Nurse	Male	29	13 (44.83)	16 (55.17)	3.99	0.046 *
	Female	190	122 (64.21)	68 (35.79)		

Table 40 Association of perception, knowledge and experience dealing with DVAW victims of health providers.

Perception	Knowledge	Total N = 380	Experience level		χ^2	p-value
			More n (%)	Less n (%)		
Positive	Good	55	41 (74.6)	14 (25.4)	15.29	< 0.001*
	Fair	140	63 (45.0)	77 (55.0)		
	Poor	16	6 (37.5)	10 (62.5)		
Negative	Good	25	13 (52.0)	12 (48.0)	2.71	> 0.05
	Fair	106	45 (42.5)	61 (57.5)		
	Poor	38	12 (31.6)	26 (68.4)		

Note: * Significant at p-value < 0.05

BIOGRAPHY

NAME	Pham Thi Kim Loan
DATE OF BIRTH	June 13, 1971
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