- Draft Background Paper 4C -

Gender-based violence in Viet Nam: Strengthening the response by measuring and acting on the social determinants of health

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This document was prepared by Jennifer J. K. Rasanathan (consultant and principal writer), under the guidance of Anjana Bhushan (Technical Officer, Health in Development), WHO Regional Office for the Western Pacific, with extensive technical inputs from the WHO Viet Nam office. It forms part of a sub-series of three papers on the theme of gender-based violence as a social determinant of health in the Western Pacific Region.

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Executive Summary

Gender inequality impacts health in myriad ways, including "discriminatory feeding patterns, lack of decision-making power, and unfair divisions of work, leisure, and possibilities of improving one's life,"[1] in addition to limited access to health care services. One of the most significant consequences of gender inequality, however, is gender-based violence (GBV), including sexual violence, coercion, emotional and/or physical violence perpetrated by intimate partners and non-partners alike. GBV "reflects and reinforces inequality between men and women…[compromising] the health, dignity, security and autonomy" of its survivors.

The Government of Viet Nam demonstrated its commitment to acting on GBV through policy with the 2006 Law Gender Equality (GE Law) and the 2007 Law on Domestic Violence Prevention and Control (DV Law). The DV Law, developed in collaboration with the Ministry of Health and with support from WHO, recognizes the key role of the health sector in preventing GBV and supporting survivors. Still, some level of gender inequality and violence persists in Viet Nam, normalized and maintained by traditional family gender roles, and exacerbated by economic insecurity. Public knowledge of the DV Law is also limited, suggesting a gap between policy existence and implementation.

Prior to 2010, the national prevalence of GBV was unknown to health officials and policymakers. Health officials recognized that national data was imperative for monitoring progress, reflexively updating the National Strategy for Gender Equality and informing economic plans as well as work with UN and other partners. Drawing on the WHO Multi-country Study on Women's Health and Domestic Violence methodology, the Viet Nam General Statistics Office conducted the National Study on Domestic Violence in Viet Nam (NSDVVN) from late 2009 to mid-2010, in collaboration with other ministries and the United Nations–Government Joint Programme on Gender Equality (UN JP). The NSDVVN revealed a relatively high national prevalence of GBV: 32% of ever-married women aged 15-49 had experienced physical violence by a partner and 10% had experienced sexual violence. The lifetime prevalence of physical and/or sexual partner violence was 34%, and 54% of women had experienced emotional abuse in their lives. Women of Kinh, Muong and Hoa ethnicity faced the highest rates of GBV.

Too little time has elapsed since the completion of the NSDVVN to assess its full impact on public health programming and policymaking, but the research team considers it the "most important priority [that] the results described in [the study report] will be used widely to…guide and inform targeted polices, strategies and programs in support of the overall objective: to protect women from

domestic violence." The NSDVVN represents a key step in strengthening the existing Domestic Violence law, aspects of which can now be re-emphasized, re-directed and/or re-prioritized according to the results of the NSDVVN and the forthcoming National Strategy to Promote Gender Equality 2011-2020 (NSGE), developed in collaboration with UN-WOMEN. The UN JP plays a crucial, complementary and facilitative role with respect to the NSGE, especially for gender mainstreaming "by bringing together organizations that work on advocacy at a national level with those engaged in local programming and research…[providing] an opportunity to see research results and pilot programming contribute more directly to national policy development and planning."

The successful completion of the NSDVVN with subsequent dissemination of results and feedback into policymaking demonstrates several key lessons for addressing health inequities by acting on the social determinants of health. First, data collection is time-consuming and costly, but necessary. Selection of research methodology and indicators must be considered and goal-oriented, as the indicators measured (or not) will significantly impact the potential uses of data. Finally, including men in research provides an entry point for men and boys to become agents of social change with respect to policy implementation. Of note, the NSDVVN provided some measure of gender inequality, but root causes are frequently more challenging to quantify than health disparities themselves. The 2011-2020 NSGE has potential to prevent GBV by acting on its key determinant, gender inequality. Viet Nam can now draw upon this research and its increased capacity to more directly assess gender inequality – a baseline for evaluating the effects of the NSGE and its Plans of Action on gender equality and GBV.

Problem

Viet Nam has a demonstrated commitment to promoting gender equality and eliminating gender-based violence, but persistent violence against women – especially for those women with less education or belonging to certain ethnic groups, would need to be measured so as to reinforce existing policies.[2]

Gender-based violence (GBV) is defined as actions that result in "physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life."[3,4] Violence against women is globally recognized as "a manifestation of the historically unequal power relations between men and women,"[4] inherently related to gender-based inequalities that both lead to and result in violence against women, in a vicious cycle.[4,5] Additionally, children who see or suffer violence are more likely to be violent as adults, having been 'taught' violence as an acceptable option for conflict resolution.[6] In

Viet Nam, gender inequality and traditional gender roles foster GBV normalization and acceptance, exacerbated by economic insecurity.

The Government of Viet Nam has demonstrated its commitment to acting on gender inequality and GBV through policy with the 2006 Law Gender Equality (GE Law) and the 2007 Law on Domestic Violence Prevention and Control (DV Law). The DV Law, developed in collaboration with the Ministry of Health and with support from WHO, recognizes the key role of the health sector in preventing GBV and supporting survivors. Still, cultural acceptance of violence persists, and public knowledge of the DV Law is limited, suggesting a gap between policy existence and implementation.[7,8,9,10] GBV had been explored through small qualitative and quantitative studies[9] and some national studies that included GBV modules,[11] but no nationally representative study dedicated to GBV with internationally validated methodology had been done before 2010. Earlier studies found GBV rates as high as 21-37%,[11,12,13] but even those values were likely under-estimates[10] because publicly speaking about GBV is avoided out of fear and shame.[7,9,14] As a result, the national prevalence of GBV was unknown to health officials and policymakers, even as they were preparing economic plans, updating the National Strategy for Gender Equality and planning streamlined collaboration with the UN and other partners.[7] National data had become imperative to monitor progress and improve the impact of both existing and future action.[8]

From late 2009 to mid-2010, the Viet Nam General Statistics Office (GSO) conducted the National Study on Domestic Violence in Viet Nam (NSDVVN), in collaboration with the Ministry of Labour, Invalids and Social Affairs (MOLISA); the Ministry of Culture, Sports and Tourism (MOCST); and 12 UN agencies comprising the United Nations (UN)–Government Joint Programme (JP) on Gender Equality (funded by the Millennium Development Goals Fund).[2] Drawing upon WHO Multi-country Study on Women's Health and Domestic Violence methodology, the NSDVVN aimed to (1) estimate

the national prevalence, incidence and types of GBV experienced by women and children, (2) assess the links between GBV and health outcomes, (3) identify risk and protective factors and (4) note coping strategies and services used by survivors, perceptions about GBV and women's knowledge of their legal rights.[2,15] Indirect objectives were to (a) increase national capacity among those working on domestic violence, (b) raise awareness and sensitivity to GBV among researchers, policymakers and health care workers and (c) establish a network of people committed to work on GBV.[2]

The NSDVVN revealed relatively high national prevalence of GBV: 32% of ever-married women aged 15-49 had experienced physical violence by a partner and 10% had experienced sexual violence. The lifetime prevalence of physical and/or sexual partner violence was 34%, and 54% of women had

experienced emotional abuse in their lives. Women of Kinh, Muong and Hoa ethnicity faced the highest GBV rates (Figures 1 and 2). In sum, 58% of women had experienced at least one form of abuse in their lifetimes (Figure 3), and violence had occurred in the past year for half of those women. 10% of women survived non-partner violence, and 3% of women had been sexually abused before the age of 15. GBV survivors were more likely to report poorer health outcomes and were three times more likely to have attempted suicide.[2] The NSDVVN was implemented with high adherence to WHO methodology[2] and, as such, shares its limitations: primarily that, as a cross-sectional study, it cannot prove causality.[2,15] These results called for the reinforcement of existing policies and programs to prevent GBV and aid survivors.

Figure 1. Prevalence of ever-physical or sexual violence by husband, among ever-married women, by region, Viet Nam 2010 (N=4561) *National Study on Domestic Violence in Viet Nam*

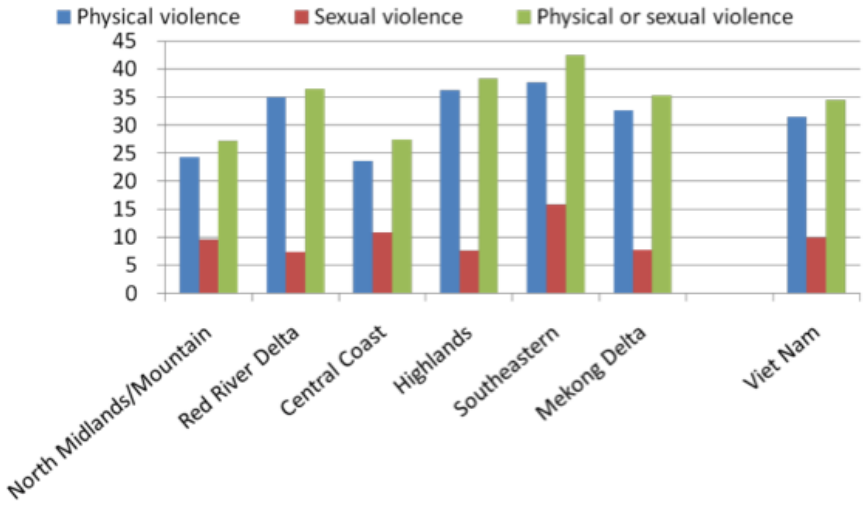
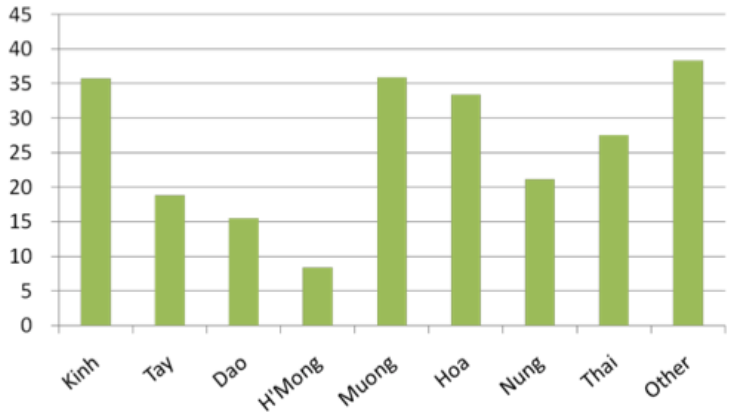


Figure 2. Prevalence of ever-physical or sexual violence by husband, among ever-married women, by ethnic group, Viet Nam 2010 (N=4561) *National Study on Domestic Violence in Viet Nam*



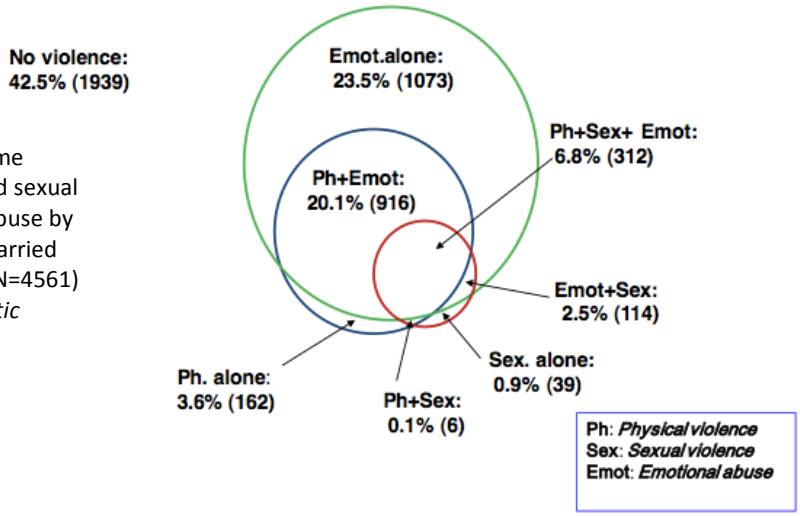


Figure 3. Overlap of lifetime prevalence of physical and sexual violence and emotional abuse by husbands, among ever-married women, Viet Nam 2010 (N=4561) *National Study on Domestic Violence in Viet Nam*

Context

Recognition of GBV as a human rights violation with real consequences for health increased during the 1990s, as worldwide advocacy spurred international declarations and agreements regarding gender equality and human rights[4,16,17] The Beijing Platform for Action in particular identifies the need for adequate data on the prevalence, causes and consequences of violence and calls upon governments to increase international knowledge on GBV (120 and 129a).[4]

The causes of GBV are multiple, but "it is clear that traditional gender values, roles, and responsibilities underlay many of all the factors that lead to domestic violence."[9] Despite significant governmental promotion of gender equality, the highest rate of female political participation in the Region (27% since 2002)[18] and better status for women than in countries with similar income levels,[7] gender equality has been advanced within the context of traditional gender roles, norms and cultural values. For example, in a "happy family," women must act to maintain harmony regardless of men's actions,[7,9,14] which can be "hot-tempered,"[9] uncontrollable and 'caused' by alcohol consumption, a common scapegoat.[7] GBV is an accepted form of discipline or 'teaching' for women who do not fill prescribed gender roles,[7,9] justifiable in some circumstances, according to 53% of women aged 15-19.[19] GBV is normalized to the extent that acts of violence such as coerced sexual activity in marriage[7,8, 20] may not be considered violent at all, but as accepted aspects of masculinity.[9,10]

Other conditions and structures of daily life (shaped by gender inequality) contribute to GBV as well. Viet Nam has one of the highest economic participation rates for women,[18] and although primary education is well attended by girls and boys,[19] rural girls may have limited access to credit, education and training, rendering them less employable.[18,21] Unemployment can worsen GBV, but its more important effect is to constrain survivors who lack sufficient social protection to remain in abusive relationships.[2,9] In 1986, Viet Nam adopted "*doi moi*," a shift to a market economy with trade liberalization,[7] bringing positive economic change and new employment opportunities.[22] *Doi moi* and WTO accessation in 2007 had mixed effects for women: employment increased, but most positions open to women are unskilled manual labor with poor job security and lower earning potential, which may actually increase risk of harassment or abuse.[22] Additionally, open markets have increased trafficking of women and girls in light of demand from manufacturing and commercial sex industries.[23] In this context, gender inequality (exacerbated by GBV), poor economic status and the global political economy intersect to fuel the sex industry in Viet Nam, which has nearly 88,000 female sex workers (FSWs).[24] While full health services are available to FSWs in principle, sex work itself is criminalized[25] and regarded as a "social evil."[26] Consequently, FSWs experience high levels of stigma and discrimination that elevate their vulnerability to GBV[27] and HIV[28] and limit access to necessary health and social services including HIV care as well as violence support services.[29]

In the event of violence, most women are deterred from seeking judicial and medical services because of gender and family norms that prioritize family harmony and which permit 'routine' violence while stigmatizing the acts of reporting violence and relationship separation.[7,8] Without secure employment; access to credit; full social protection; or social freedom to access support services, GBV survivors may be constrained to stay in abusive relationships.[2,7,9,14]

Viet Nam adopted targeted legislation to reduce gender inequality and GBV in the mid 2000s, as a result of government commitment, advocacy by local and international NGOs, as well as support from donor and UN agencies:[7,10] the 2006 GE Law provides for universal gender equality; the 2007 DV Law protects citizens from GBV; decrees on aspects of implementing the DV Law were issued in 2008, 2009 and 2010; action plans for the advancement of Vietnamese Women were in place for the periods 2001-2005 and 2006-2010; and the 2004-2010 National Plan of Action against the Crime of Trafficking in Children and Women strengthens efforts to combat human trafficking prevention.[7] Also, Viet Nam ratified CEDAW in 1982[30] and has signed other international human rights treaties and conventions related to gender equality.[7]

Planning

Government commitment to gender equality and the elimination of GBV is evident in its policies and efforts to promote subsequent policy implementation, coordination and budgeting, such as decrees, circulars and supplementary national plans.[2,7,31] Despite those efforts, gender inequalities persist, and a variety of factors have limited successful implementation of gender equality legislature including: a relative paucity of multi-sectoral action; the lack of a clear monitoring and evaluation framework; insufficient institutional capacity for implementation, gender analysis, research and data collection pertinent to gender equality, monitoring and reporting; insufficient funding; traditional gender norms and roles perpetuating GBV acceptance as well as family reconciliation over violence reporting; stigmatization of both GBV and sex work; small-scaled interventions on GBV and low public knowledge of women's rights under the law.[2,7,18,31] Actions taken by the government, local and international NGOs, formal networks such as the Women's Union as well as UN agencies may have had positive impacts,[10] but this could not be demonstrated in the absence of reliable, sex-disaggregated data on GBV.[7,10]

The UN JP on Gender Equality for 2009-2011 in Viet Nam is an innovative collaboration of 12 UN agencies, three national ministerial implementing partners and civil society organizations working at local and national levels toward collective goals. The JP aims to "improve the capacity of national and provincial authorities, institutions and other duty bearers to effectively implement, monitor, evaluate and report on the Law on Gender Equality and Law on Domestic Violence Prevention and Control."[32] As such, the JP's third main outcome is to "[strengthen] evidence-based data and data systems for promoting gender equality." Output 3.1, that "Current gender equality and sex-disaggregated indicators are reviewed and new indicators identified through research," stipulated activity 3.1.2, the administration of a national survey on women's health and domestic violence,

including production of a report and dissemination of results.[31] The JP supported over $370,000 in funding and further agreed to help GSO secure an additional $89,000 for the completion of the NSDVVN, to be implemented through GSO and the Ministry of Health (MINISTRY OF HEALTH) with lead technical support from WHO. UNDP would additionally support GSO to store and disseminate gender related and sex-disaggregated data with periodical publications.[31]

In early 2009, planning for the NSDVVN began. The "National Survey on Women's Health and Life Experiences" is the alias 'safe name' that was given to the NSDVVN so as to encourage participation while protecting survey respondents and interviewers alike. The objectives of the NSDVVN were to:

1. Estimate the national prevalence, frequency of three types of violence experienced by women and children:
   a. Physical and sexual violence, emotional and economic abuse and controlling behaviors by men against their wives,
   b. Physical and sexual violence against women by any perpetrator beyond the age of 15 and sexual abuse by any perpetrator before the age of 15 and
   c. Violence against male and female children younger than 15 such as emotional abuse and physical and sexual violence perpetrated by their fathers, as reported by their mothers;
2. Assess the extent to which GBV is associated with a range of health outcomes;
3. Identify factors that may protect women from or increase their risk to GBV; and
4. Document and compare coping strategies and services used by survivors to deal with violence, perceptions about GBV and women's knowledge of their legal rights.[2,15]

Additional, indirect objectives were to (a) increase national capacity among those working on domestic violence, (b) raise awareness and sensitivity to GBV among researchers, policymakers and health care workers and (c) establish a network of people committed to work on GBV.[2] To effectively achieve these objectives, the NSDVVN replicate the internationally validated methodology of the WHO Multi-Country Study on Women's Health and Domestic Violence, with some adaptations.[2,15] As such, NSDVVN indicators mirrored those collected in the WHO multi-country study, but were adjusted to include five questions related to HIV, four questions on child abuse and one question regarding public knowledge of the Vietnamese Domestic Violence Law.[2]

The main implementing agency, GSO, was charged with the overall planning, management and implementation of the project including pre-testing the questionnaire, recruiting and training fieldworkers, supervising the fieldwork, managing and processing data, conducting report-writing workshops, organizing a press conference and disseminating study results. WHO provided technical

assistance and project coordination support including liaising with UN agencies in the JP and facilitating communication with project stakeholders. The NSDVVN research team consisted of two representatives from GSO, one representative from Ministry of Health, two national consultants, an international consultant and a staff member of WHO Viet Nam. The National Survey Steering Committee (NSSC) was established to support and guide the national project team in administration and follow-up. The NSSC was chaired by the Vice General Director of the GSO and included representatives from within GSO and other involved governmental ministries in order to provide country-level oversight to the survey.[2]

As an activity under the UN JP, planning for the production of a summary report and widespread dissemination of results to policymakers,[31] health care professionals, program implementers, NGOs and the general public was stipulated from the start.[2] To facilitate this, stakeholders were engaged and consulted regularly during the research planning and implementation phases. Prior to the initiation of the study, a consultation workshop was held to incorporate stakeholder feedback into the finalized methodology, questionnaire and final draft research plan. Key stakeholders include:

- The National Assembly, including the Committee on Social Affairs and National Assembly Office Department of Social Affairs;
- National ministries including MOLISA, MOCST, various MINISTRY OF HEALTH departments, the Ministry of Planning and Investment, the Ministry of Justice, the Ministry of Police and Security, as well as representatives from the National Committee for the Advancement of Women;
- Mass organizations including the Women's Union, Centre for Women and Development, the Youth Union and Farmers Union;
- UN agencies and the United Nations Working Group on GBV;
- National NGOs such as the Centre for Studies and Applied Sciences in Gender-Family-Women and Adolescents, Consultation of Investment and Promotion and the Centre for Creative Initiatives in Health and Population as well as international NGOs like the Population Council;
- Academic institutions including the Institution for Social Development Studies, the Institute for Family and Gender Studies and the Viet Nam Academy of Social Science; and
- Embassies and bilateral aid and development agencies such as the Swiss Agency for Development and Cooperation (SDC), the Spanish Agency for International Development Cooperation (AECID) and the Australian Agency for International Development (AusAID).[2]

While 2009 was a year for research, 2010 would be a year for intervention, transforming data into meaningful, acceptable and stakeholder-supported results that could be used to inform and improve

policy and programmatic decisions. Another stakeholder workshop was held to present preliminary findings and a draft report so as to collect and incorporate their feedback. Ministries were again consulted for discussion and finalization just before the launch of the draft report.[2]

Consistent stakeholder engagement and buy-in through workshops and consultations, support from the national government for gender equality as well as structured, ongoing support from the coordinated UN Joint Program greatly facilitated the successful implementation of NSDVVN and dissemination of results.[2,31] Through the JP, additional, complementary initiatives were resourced and planned, such as UNODC-supported GBV training for law enforcement officers and others in the Justice sector,[31,33] as well as capacity building activities in gender mainstreaming across various sectors so as to promote gender equality.[31] Outside of UN support, but in line with its recommendations, AusAID has committed $96.4 million over four years to reduce the impacts of GBV while advancing care and justice for survivors[34] through partnerships with the UN and civil society organizations.[35,36]

Implementation

Once the project team and steering committee were assembled, the country project team began to adapt and finalize the WHO multi-country study questionnaire within the Vietnamese context. The questionnaire was first reviewed by the research team, translated into Vietnamese and then presented to stakeholders and experts on gender in Viet Nam for their input. Only minor modifications were made, including the addition of questions related to HIV, child abuse and the DV Law so as to assess current knowledge of the law by respondents in the latter case. The final draft questionnaire was pretested in Ha Noi and Tien Giang, at which point respondents answered questions from the questionnaire and provided feedback on the clarity, acceptability and delivery of questionnaire items.[2] The only other deviations from the original WHO methodology were that the NSDVVN would be administered to a larger sample size, and that the NSDVVN assessed the GBV experiences of women aged 18-60 as opposed to the usual 15-49 age range so as to avoid parental consent procedures for women under 18 and to include the experiences of older women. The study also included never-married, divorced and widowed women as opposed to only married women, but the interviewers were trained to pose questions about partner violence only to women who reported ever having had a partner or husband.[2,15]

Upon finalizing the study questionnaire, the research team began to recruit, select and train Vietnamese women who would conduct the quantitative research. 82 women between 30 and 60 years of age with previous experience in survey work (staff of either GSO or Provincial Statistics Office) were recruited to undergo two weeks of interviewer training, with the intent of assembling a

group of 71 fieldworkers and some alternates. Fieldworkers were trained in November 2009 according to the WHO standardized training curriculum, which was adapted and shortened given the prior experience of trainees. Training included gender sensitization, interview techniques, questionnaire review and a pilot study. Fourteen quantitative research field teams of five people were formed, each with a team leader, field editor and three interviewers, with the expectation that each interviewer would complete three interviews per day over two months (in sum conducting less than 100 interviews per person so as to avoid interviewer burnout). Team leaders oversaw all team activities, and field editors ensured that questionnaires were completed fully and correctly; team leaders and field editors underwent additional, specialized training. Fieldwork was successfully completed from December 2009 to February 2010, and there was a 78% response rate for invited women attending the interviews (see below).[2]

Qualitative research consisted of 30 in-depth interviews and four focus groups in each of three provinces. This work was completed by three teams, each composed of four senior researchers (three of whom were part of the core research team) and one assistant researcher who had undergone specialized training. Specific guides for interviewers and focus group facilitators were adapted from WHO interview guides, in consultation with other UN experts and GSO. As with the quantitative research, interview guides were pre-tested in advance and adjusted before being used to collect information. Of note, communes that were included in the quantitative component of the study were avoided by the qualitative study teams in order to protect respondent safety and confidentiality. In April 2010, 90 in-depth interviews were conducted with GBV survivors; key informants from the Women's Union, police, health care system and the Communist Party as well as village leaders; and with men and women from the community. Twelve focus groups of either men or women from two separate age groups were also completed.[2]

Additional measures were taken to protect the safety and privacy of respondents. First, all staff signed confidentiality agreements on the final day of training as part of their work contracts. Confidentiality of respondents' identities was further maintained through a coding system, and only the team leader had access to women's names. Second, women who were selected to participate were not interviewed in their own homes. This provided privacy and saved time, as interviewers did not have to find and travel to individuals' homes. Instead, respondents received advance letters inviting them to participate in the study by coming to a central community location at a designated time and date. The invitation letter contained elements of informed consent such as confidentiality, voluntary participation and the right to refuse to answer under the safe name of the study. Interviews were then conducted in neutral, central locations including community centers, and informed consent was obtained for the real subject of the study when an interviewer was alone with a

respondent. Team leaders would guard against interview interruption, but in the case of an interruption for any reason, interviewers were trained to end the discussion or change the subject. Interviewers were also taught strategies for creating safe, trustworthy spaces for respondents as well as ways in which to reduce respondent distress related to the content of the questionnaire. Third, respondents received a small booklet containing information on GBV and available support services for survivors in Viet Nam, as well as pamphlets on other health topics for women so as to reduce suspicion about the study and, again, protect respondents. Finally, to further maintain confidentiality and protect survey participants, interviewers were not permitted to spend the night in communities where interviews had been conducted that day, thereby avoiding questions from community members about the topic of research.[2]

As described above, the UN JP-funded project taken on by Viet Nam consisted not only of research planning and implementation, but also included research dissemination and preparation of a summary report.[31] Stakeholder involvement facilitated by WHO and other UN agencies[31] proved to be crucial for the successful implementation of the NSDVVN.[2] High-level governmental support for the project from MOLISA, Ministry of Health and other ministries as well as the National Assembly was continuous throughout the course of the project and demonstrated government support for the work and the greater prioritization of gender equality. Proactive involvement of organizations such as the Women's Union as well as local government, community leaders and health providers not only made the quantitative research possible in the contexts of women's lives, but resulted in active support for the qualitative work as well.[2] These factors, in addition to political will by the Vietnamese government, a noted lack of national knowledge on GBV despite existing policy on GBV,[7] access to an internationally validated and replicable research methodology[15] and the establishment of a coordinated UN program calling for increased gender-sensitive research mapped to funding sources[31] collectively enabled the NSDVVN. As discussed above, the UN JP, through the Millennium Development Goals Achievement Fund, supported $370,590 in funding and assisted GSO to secure an additional $88,810 for the completion of the NSDVVN, with a total project cost of $459,400.[31]

Evaluation of results and impacts, including on social determinants and health inequities

Too little time has elapsed since the completion of the NSDVVN to assess its full impact on public health programming and policymaking, but the research team considers it the "most important priority [that] the results described in [the study report] will be used widely to…guide and inform targeted polices, strategies and programs in support of the overall objective: to protect women from domestic violence."[2] The NSDVVN and its findings will be integral for strengthening the existing

Domestic Violence law, aspects of which can now be re-emphasized, re-directed and/or re-prioritized according to the study results. As such, the NSDVVN not only augments the policy's impact, but represents a key step in the full and adaptive implementation of the policy itself.

As detailed above, the NSDVVN closely followed an internationally validated methodology for gathering national prevalence data on GBV, with considerable efforts made by well-trained interviewers and study team leaders to preserve respondent safety and confidentiality.[2] Further confidence in the NSDVVN stems from consistency of results between this study and earlier research done with the same questionnaire on a small sample population in the rural district of Ba Vi.[12]

Immediate impacts of the NSDVVN pertain to interviewer and respondent attitudes upon completion of the fieldwork. Respondents were asked at the end of the interview if they felt "better, the same or worse compared with before the interview," and 80% of respondents reported feeling better after participating in the interview.[2] Interestingly, women who had experienced violence from a partner were more likely to feel better after the interview than women who had not experienced violence, and this effect was even greater among women who had survived more severe forms of GBV. For example, almost 90% of women who had experienced both physical and sexual violence reported feeling better after responding to the questionnaire. Statements from respondents indicated that women felt valued and grateful to have been heard, and interviewers, too, experienced positive effects from having contributed to the study.[2] These findings suggest that it is not only the experience of GBV but also the sociocultural barriers to reporting or responding to violence that contribute to poor mental health outcomes among GBV survivors. It is this kind of qualitative information – more than prevalence and incidence rates alone, that enables sensitive re-direction and re-prioritization of existing polices and programmes in a reflexive, policy process that is responsive to determinants of health.

In addition to the high prevalence of physical and sexual violence, emotional and economic abuse uncovered by the NSDVVN, the study also found that a large majority of women believe that violent behaviors by husbands are "normal" and, as such, acceptable – these beliefs further limit confiding in others or reporting violence.[2] Widespread acceptance of violence and low public knowledge of laws related to GBV and gender equality additionally demonstrate that "it is not enough simply to have a law."[10] Community-based awareness-raising campaigns to "counter the attitudes and beliefs that condone male partner violence against women as normal and acceptable," efforts to reduce stigma around GBV and other gender-transformative measures should be implemented.[2] This research may have influenced the Plan on Communications of Laws on Gender Equality adopted in May 2010, which includes raising awareness of gender issues among civil servants and the general

public, as well as the draft Communication Strategy for the Family, which has a specific focus on GBV prevention.[2]

One additional area of impact must be noted for the implementation of the NSDVVN: the research project team, fieldworkers and co-implementing bodies have benefited from capacity building in gender-related research,[2] thereby fulfilling Joint Outcomes 1 and 3 of the UN JP for Viet Nam: "Improved skills, knowledge and practices for the implementation, monitoring, evaluation and reporting of the Law on Gender Equality and the Law on Domestic Violence Prevention and Control," and "Strengthened evidence-based data and data systems for promoting gender equality," respectively.[31] Although the NSDVVN recruited fieldworkers with previous survey experience, participation in this research has undoubtedly contributed to professional development and future employment possibilities.

Furthermore, as with the aforementioned communication strategies, the NSDVVN may have contributed to political momentum toward gender equality through the forthcoming National Strategy to Promote Gender Equality 2011-2020 (NSGE), which was developed in collaboration with UN-WOMEN.[37] The UN JP plays a crucial, complementary and facilitative role with respect to the NSGE, especially for gender mainstreaming "by bringing together organizations that work on advocacy at a national level with those engaged in local programming and research…[providing] an opportunity to see research results and pilot programming contribute more directly to national policy development and planning."[32]

In early 2011, the NSGE was endorsed by the Prime Minister and later approved into policy; plans for the NSGE implementation were announced at a policy dialogue in March 2011. The NSGE will "specify indicators and measures to promote gender equality, enhance women's empowerment and narrow the gender gaps in the education and training, science and technology and politics sectors," thereby attempting to further the implementation and impact of the 2006 Gender Equality Law and related legislation.[38] The main targets of the ambitious NSGE include:

- The number of women in the ranks of Party Executive members will rise to 25 percent in the 2016-2020 period; and the number of female deputies to National Assembly and People's Council to at least 30 percent in the 2011-2015 period and 35 percent in the 2016-2020 period;
- The number of business female owners will increase to 30 percent by 2015 and 35 percent by 2020 and the number of trained female workers in rural areas to 25 percent by 2015 and 50 percent by 2020;

- The number of women in poor rural areas and ethnic-inhabited areas having access to preferential loans under poverty reduction programmes and official credit resources will reach 80 percent by 2015;
- The number of ministries and ministerial-level agencies and People's Committees at all levels having key female leaders will reach 80 percent by 2015 and 95 percent by 2020;
- Sex ratio at birth will be no more than 113 boys per 100 girls by 2015 and 115 boys per 100 girls by 2020; and
- The number of gender preconception publications will be reducing by 60 percent by 2015 and by 80 percent by 2020.[39,40]

Importantly, by requiring each province and ministry to prepare its own Plan of Action within the National Programme on Gender Equality for 2011 to 2015,[37] the NSGE also re-emphasizes gender mainstreaming, the "process of assessing the implications for women and men of any planned action, including legislation, policies or programmes…a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally…The ultimate aim is to achieve gender equality."[41] The UN JP plays a crucial, complementary and facilitative role with respect to the NSGE, especially for the process of gender mainstreaming. The uniquely collaborative structure of the UN JP aligns resources and pertinent coordinating agencies with sector-specific intended outcomes of the NSGE through a cooperation framework, as was discussed at the 2011 Gender Programme Coordination Group (PCG) Annual Review.[42] The 2012-2016 One UN plan for Viet Nam will additionally require "national and sub-national institutions, in partnership with communities, [to] more actively address inequalities through implementation and monitoring of laws, policies and programmes that promote gender equality and women's empowerment,"[38] further harmonizing and reinforcing the NSGE.

The UN JP itself will be guided and overseen by a National Steering Committee (NSC), which will be responsible for annually reviewing the JP. Progress made in the implementation of the UN JP will additionally be assessed (and redirected when necessary) quarterly by a sub-group of participating UN agencies and Viet Nam government partners according to pre-selected process indicators (Appendix 1).

References

[1] Commission on Social Determinants of Health. *Closing the gap in a generation: Health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*. Geneva: World Health Organization Commission on Social Determinants of Health; 2008.

[2] General Statistics Office Viet Nam. *"Keeping silent is dying": Results from the National Study on Domestic Violence Against Women in Viet Nam*. Ha Noi: 2010.

[3] United Nations General Assembly. *Declaration on the Elimination of Violence Against Women 48/104*. 20 December 1993. Retrieved from http://www.un.org/documents/ga/res/48/a48r104.htm.

[4] *Beijing Declaration and Platform for Action*. Adopted by the Fourth World Conference on Women, Beijing, China, 4-15 September 1995. New York, NY, United Nations, 1995 (document A/CONF.177/20). Retrieved from http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf.

[5] United Nations Population Fund (UNFPA). "Gender Equality: Ending widespread violence against women." http://www.unfpa.org/gender/violence.htm. Accessed 22 July 2011.

[6] Heise, L. L., Pitanguy, J., Germain, A. *Violence against women: The hidden health burden*. World Bank Discussion Paper No. 255. Washington, D.C.: World Bank; 1994.

[7] Gardsbane, D., Ha, V. S., Taylor, K., Chanthavysouk, K. *Gender-Based Violence: Issue Paper.* Ha Noi: United Nations; May 2010.

[8] General Statistics Office Viet Nam. *"Keeping silent is dying": Results from the National Study on Domestic Violence Against Women in Viet Nam – Summary Report*. Ha Noi; 2010.

[9] Loi, V. M., Huy, V. T., Minh, N. H., Clement, J. *Gender-based Violence: The Case of Viet Nam*. Ha Noi: World Bank; 1999.

[10] UNFPA. *Gender-Based Violence Programming Review*. October 2007.

[11] E.g. Ministry of Culture, Sports and Tourism/General Statistics Office/UNICEF/Institute for Family and Gender Studies. *Result of Nation-Wide Survey on The Family in Viet Nam 2006: Key Findings.* Ha Noi; June 2008.

[12] Vung, N. D., Ostergren, P. O., Krantz, G. "Intimate partner violence against women in rural Viet Nam – Different socio-demographic factors are associated with different forms of violence: need for new intervention guidelines?" *BMC Public Health*. 2008; 8: 55.

[13] Luke, N., Schuler, S. R., Mai, B. T. T., Thien, P. V., Minh, T. H. "Exploring couple attributes and attitudes and marital violence in Viet Nam." *Violence Against Women*. 2007; 13(1): 5-27.

[14] Gardsbane, D. (1 May 2011). "The 'Happy Family': Raison d'être for Preventing Gender-Based Violence?" SfAA News, A Publication of the Society for Applied Anthropology. http://sfaanews.sfaa.net/2011/05/01/the-%E2%80%9Chappy-family%E2%80%9D-raison-detre-for-preventing-gender-based-violence/. Accessed 30 July 2011.

[15] García-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., Watts, C. *WHO Multi-country Study on Women's Health and Domestic Violence Against Women: Initial results on prevalence, health outcomes and women's responses*. Geneva: World Health Organization; 2005.

[16] *Vienna Declaration and Programme of Action.* Adopted by the World Conference on Human Rights, Vienna, Austria, 14-25 June 1993 (document A/CONF.157/23). Retrieved from http://www.unhchr.ch/huridocda/huridoca.nsf/%28symbol%29/a.conf.157.23.en.

[17] *Programme of Action of the International Conference on Population and Development*. Adopted by the International Conference on Population and Development, Cairo, Egypt, 5-13 September 1994. New York, NY, United Nations, 1994 (document A/CONF.171/13). Retrieved from http://www.un.org/popin/icpd/conference/offeng/poa.html.

[18] World Bank/Asian Development Bank/DFID/CIDA. *Viet Nam: Country Gender Assessment.* The World Bank Group; 2006. Retreived from http://web.worldbank.org/external/default/main?pagePK=51187349&piPK=51189435&theSitePK=387565&menuPK=64187510&searchMenuPK=387593&theSitePK=387565&entityID=000310607_20070124141846&searchMenuPK=387593&theSitePK=387565.

[19] UNICEF (2 March 2010). "At a glance: Viet Nam - Statistics." http://www.unicef.org/infobycountry/kiribati_statistics.html. Accessed 24 July 2011.

[20] Hien, P. T. "Sexual Coercion within marriage in Quang Tri, Viet Nam." *Culture, Health & Sexuality*. 2008; 10(S): S177-87.

[21] Lee, S. *How do women fare in education, employment and health? A gender analysis of the 2006 Viet Nam household living standard survey – Final Report*. Ha Noi: World Bank; 2008.

[22] Thuy, N. T. B., Nga, D. N., Moser, A., Pham, A. *Socio-Economic Impacts of WTO Accession on Rural Women: Qualitative Research in Hai Duong and Dong Thap Viet Nam*. ILSSA, UNIFEM and AusAID; 2009.

[23] Rushing, R. "Migration and Sexual Exploitation in Viet Nam." *Asian and Pacific Migration Journal*. 2006; 15(4): 471-94.

[24] The Socialist Republic of Viet Nam Ministry of Health. *Estimates and Projection of HIV/AIDS in Viet Nam 2007-2012*. 2009.

[25] The Socialist Republic of Viet Nam. Ordinance on Prostitution Prevention and Control; Ordinance on Administrative Violations 04/2008/PL-UBTVQH12.

[26] Vijeyarasa, R. "The State, the family and language of 'social evils': re-stigmatizing victims of trafficking in Viet Nam." *Culture, Health & Sexuality*. 2010, 12(S1): S89-102.

[27] Ngo, A. D., McCurdy, S. A., Ross, M. W., Markham, C., Ratliff, E. A., Pham, H. T. B. "The Lives of female sex workers in Viet Nam: Findings from a qualitative study." *Culture, Health & Sexuality*. 2007, 9(6): 555-70.

[28] Rosenthal, D. & Oanh, T. T. "Listening to female sex workers in Viet Nam: Influences on safe-sex practices with clients and partners." *Sex Health*. 2006; 3(1): 21-32.

[29] UNFPA (1 May 2011). "Partnering with Sex Workers in Viet Nam to Contain the HIV Epidemic and Protect Human Rights." http://unfpa.org/public/site/asiapacific/pid/7671. Accessed 30 July 2011.

[30] United Nations Treaty Collection (23 July 2011). "Chapter IV Human Rights. 8. Convention on the Elimination of All Forms of Discrimination Against Women." http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en. Accessed 24 July 2011.

[31] Ministry of Labor, Invalids and Social Affairs (MOLISA). *UN-GOV Joint Programme on Gender Equality 2009-2011: Detailed Project Outline of ODA Programme.* Ha Noi; March 2009.

[32] United Nations Viet Nam. *Factsheet: UN-Government Joint Programme on Gender Equality.* Ha Noi; 2009.

[33] United Nations Office on Drugs and Crime (6 June 2010). "Preventing and responding to domestic violence: Vietnamese police and legal officers learn more." http://www.unodc.org/eastasiaandpacific/en/2010/06/domestic-violence/story.html. Accessed 30 July 2011.

[34] The Hon Kate Ellis MP, Minister for the Status of Women (9 May 2011). "Speeches: Remarks at the Parliamentary Roundtable on Ending Gender Based Violence in the Asia Pacific Region." http://www.kateellis.fahcsia.gov.au/speeches/Pages/remarks_ending_gender_based_violence_09052011.aspx. Accessed 13 July 2011.

[35] Aid Budget Statement 2011-2012 (10 May 2011). *Australia's International Development Assistance Program 2011-2012: An effective aid plan for Australia: Reducing poverty, saving lives and advancing Australia's national interests.* Retrieved from http://cache.treasury.gov.au/budget/2011-12/content/download/ms_ausaid.pdf.

[36] "2011-2012 International Development Assistance Budget: Media Release" 10 May 2011. The Hon Kevin Rudd MP, Australian Minister for Foreign Affairs. http://foreignminister.gov.au/releases/2011/kr_mr_110510b.html Accessed 13 July 2011.

[37] UN-WOMEN Viet Nam Country Office. *Terms of Reference: National Consultant Team Leader*. May 2011. Retrieved from www.unifem-eseasia.org/docs/tor/20110510_TOR_NC_UN_Women.pdf.

[38] United Nations Viet Nam (9 March 2011). "100th Anniversary of International Women's Day: Equal access to education, training and science and technology – pathway to decent work for women." http://www.un.org.vn/en/media-releases/107-un-press-releases/1722-100th-anniversary-of-the-international-womens-day-equal-access-to-education-training-and-science-and-technology-pathway-to-decent-work-for-women.html. Accessed 4 August 2011.

[39] WHO Western Pacific Regional Office. "Understanding and responding to gender-based violence in the Region: Examples from Kiribati, Samoa and Viet Nam," a presentation at the Regional Meeting on Social Determinants of Health and Health Equity. Manila: 7-9 June 2011.

[40] Voice Of Viet Nam News (9 March 2011). "Viet Nam promotes gender equality." VOV News, http://english.vovnews.vn/Home/Vietnam-promotes-gender-equality/20113/124584.vov. Accessed 4 August 2011.

[41] UN Economic and Social Council (UNECOSOC) (1997). *Gender Mainstreaming. Extract from the Report of the Economic and Social Council for 1997 (A/52/3)*, 18 September 1997. Vienna: UN Department of Economic and Social Affairs, 1997.

[42] UN-WOMEN. *Viet Nam Government and UN review joint work programme.* UN Women East and Southeast Asia News Roundup: Ha Noi; April 2011. Retrieved from http://www.unifem-eseasia.org/docs/newsletter/2011/UN_Women_East_and_Southeast_Asia_Newsletter_April2011_Viet_Nam_UN_Review.pdf.

[42] World Health Organization (WHO) (2002). *Integrating Gender Perspectives in the Work of WHO: WHO Gender Policy*, including *Gender Glossary*. Geneva: WHO, 2002.

[42] Women and Gender Equity Knowledge Network (WGEKN) (2007). *Unfair, Unequal, Ineffective and Inefficient; Gender Inequity in Health: Why it exists and how we can change it*. Final Report to the WHO Commission on Social Determinants of Health. WGEKN, 2007.

www.who.int/social_determinants/